STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 000	INITIAL COMMENTS An Abbreviated Survey investigating KY00033997, KY00034103, KY00034127, KY00034202, KY00034203, and KY00034222 was initiated on 07/26/2021. After supervisory review with the State Survey Agency (SSA), the survey transitioned to a Standard Recertification/Extended and Abbreviated Survey, on 08/09/2021, which concluded on 09/02/2021. In addition, a COVID-19 Focused Infection Control Survey was conducted, which identified the facility was not in compliance with 42 CFR 483.80, Infection Control, F 880, and had not implemented the Centers for Medicare and Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Total census 93 at the start of the Abbreviated Survey; total census 88 at the start of the Standard Recertification Survey. Complaints KY00034103 and KY00034127 were unsubstantiated with no deficient practice identified. Complaints KY00033997, KY00034202, KY00034203, and KY00034222 were substantiated with deficient practice identified. On 01/26/2021 at 6:30 PM, Resident #242 suffered a cardiopulmonary arrest and Licensed Practical Nurse (LPN) #15 called a Code Blue for full CPR to be given. The Staff Development Coordinator/Quality Improvement (SDC/QI) nurse initiated CPR for approximately two (2) minutes. Then, LPN #15 assessed Resident #242 to have a pulse and stated to stop CPR. However, the previous Administrator directed the SDC/QI nurse	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 000	Continued From page 1	F 000		

to continue chest compressions until the resident had a pulse of sixty (60) beats per minute or there was a physician's order to stop. The previous Administrator placed her hands over the SDC/QI nurse's hands and forced chest compressions for approximately one (1) more minute until Emergency Medical Service (EMS) arrived on site and transported the resident to the local hospital.

The facility's failure to ensure appropriate cardiopulmonary resuscitation (CPR) was provided to Resident #242, who required such care prior to the arrival of emergency medical personnel, has caused or is likely to cause serious injury, serious harm or death to other residents in the facility.

On 07/09/2021, two Licensed Practical Nurses (LPN #1 and #2) were implicated in stealing a skid of thirty (30) tablets of Resident #17's Percocet (a narcotic opioid used to treat pain) 5/325 mg. Despite this, neither nurse was suspended pending investigation, nor did the facility take other action to prevent misappropriation.

On 07/18/2021, Licensed Practical Nurse (LPN) #2 discovered Resident #32 and Resident #84 both had two (2) Roxicodone (Schedule II narcotic to treat pain) pills replaced with Primidone (anti-convulsive) and taped into the Roxicodone blister pack. The Police and Adult Protective Services (APS) were notified and came to the facility.

On 07/18/2021, LPN #1 was found by Police to have in her possession controlled medications that included Oxycodone (Scheduled II narcotic), Tramadol (opiate narcotic analgesic),

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 000	Continued From page 2	F 000		

Hydrocodone (Scheduled II narcotic), and Gabapentin (Scheduled III anticonvulsant). Additionally, LPN #1 was found to have Primidone (non-controlled anticonvulsive) on her person, which she admitted she used to replace Resident #32's and Resident #84's controlled narcotic medications, which she had misappropriated.

Ten (10) additional residents had a total of fourteen (14) controlled medications missing and not signed out properly, on 07/18/2021, some of which were the same type of medications found on LPN #1 by the Police: Resident #71, #8, #56, #1, #79, #47, #34, #60, #48, and #65.

Review of a Uniform Citation, dated 07/18/2021, revealed LPN #1 was charged with two (2) counts of Wanton Endangerment in the First Degree; thirteen (13) counts of Theft by Unlawful Taking, Controlled Substance; three (3) counts of Possession of a Controlled Substance; and two (2) counts of Abuse and Neglect of an Adult Person.

On 07/20/2021, the Director of Nursing (DON) determined, in an audit, the Shift Change Count Sheet signed by LPN #2 had one (1) less in the count of narcotic skids from the previous Shift Change Count Sheet. The facility determined Resident #9 had a missing skid of Percocet, and LPN #2 was suspended.

The facility's failure to take immediate action and to follow their policies to prevent further abuse and to ensure all residents were free from abuse and to prevent further misappropriation of residents' property so that their controlled medications were available to the residents per

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 000	Continued From page 3	F 000		

the Physician's Orders has caused or is likely to cause serious injury, serious harm or death to other residents in the facility.

Immediate Jeopardy (IJ) was identified on 08/20/2021, and was determined to exist on 01/26/2021 in the areas of 42 CFR 483.21 Comprehensive Resident Centered Care Plans, F-658 Scope and Severity (S/S) of a "J", 42 CFR 483.24 Quality of Life, F-678 (also Substandard Quality of Care (SQC)) S/S of a "J", 42 CFR 483.70 Administration, F-835 S/S of a "K" and F-837, Governing Body S/S of a "K"; 42 CFR 483.12 Freedom from Abuse, Neglect, and Exploitation, F-602 (SQC) S/S of a "K" Free from Misappropriation/Exploitation, F-610 (SQC) S/S of a "K" Investigate/Prevent/Correct Alleged Violation, and 42 CFR 483.45 Pharmacy Services, F-755 S/S of a "K" Pharmacy Services/Procedures/Pharmacist/ Records; and 42 CFR 483.12 Freedom from Abuse, Neglect, and Exploitation, F-600 (SQC) S/S of a "J" Free from Abuse. The facility was notified of the Immediate Jeopardy on 08/20/2021.

The facility provided an acceptable Immediate Jeopardy Removal Plan, on 09/01/2021, alleging removal of the Immediate Jeopardy, on 08/31/2021. The State Survey Agency validated removal of the Immediate Jeopardy as alleged on 08/31/2021, prior to exit on 09/02/2021, with remaining non-compliance in the areas of 42 CFR 483.12 Freedom from Abuse, Neglect, and Exploitation F-600, at a Scope and Severity of a "D", F-602 and F-610 at a Scope and Severity (S/S) of an "E"; 42 CFR 483.21 Comprehensive Resident Centered Care Plans, F-658 at a S/S of an "D"; 42 CFR 483.24 Quality of Life, F-678 at a S/S of an "D"; 42 CFR 483.45 Pharmacy

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 000	Continued From page 4 Services, F-755 at a S/S of an "E"; and 42 CFR 483.70 Administration, F-835 and F-837 at a S/S of an "E" while the facility develops and implements a Plan of Correction and the facility's Quality Assurance (QA) monitors to ensure compliance with systemic changes. Additional deficiencies were cited at 42 CFR 483.10 Resident Rights F-550 at a S/S of a "D" and F-571 at a S/S of a "E"; 42 CFR Resident Assessment F-641 at a S/S of a "G"; 42 CFR 483.21 Comprehensive Resident Centered Care Plans F-656 at a S/S of a "G" and F-657 at a S/S of an "E"; 42 CFR 483.25 Quality of Care F-688 and F-689 both at a S/S of a "G"; 42 CFR 483.60 Food and Nutrition Services F-801 at a S/S of a "D" and F-812 at a S/S of an "F"; and 42 CFR 483.80 Infection Control F-880 at a S/S of an "E".	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis,	F 550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 550	Continued From page 5	F 550		

severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.

§483.10(b) Exercise of Rights.
The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.

§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, medical record review, and review of the facility's Resident Rights document, it was determined the facility failed to ensure each resident was treated with respect and dignity and care provided in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 550	Continued From page 6	F 550		

facility failed to protect and promote the rights of the residents for two (2) of forty-four (44) residents; Resident #13 and #31.

Observations, on 08/10/2021, by the State Survey Agency (SSA) Surveyor of Resident #13 revealed the resident was lying in bed with his/her bare legs exposed; the resident was wearing only a brief from the waist down and was uncovered. Observations, on 08/12/2021, by the SSA Surveyor of Resident #31 revealed the resident was lying in bed wearing only briefs with the resident's room door wide open. For Resident #13 and #31, staff entered and exited the residents' rooms without notifying nursing staff the residents were exposed or providing privacy with a cover or by pulling the privacy curtain.

The findings include:

Review of the facility's "Resident Rights" document, undated, revealed the resident had the right to live with dignity and to be treated with respect. Further, the document stated residents had the right to personal privacy.

1. Review of Resident #13's medical record revealed the facility admitted the resident, on 07/28/2017, with diagnoses including Dementia, Major Depressive Disorder, Arthritis, and Schizoaffective Disorder.

Review of Resident #13's Comprehensive Care Plan, revised on 11/06/2019, revealed the resident required assistance for dressing. The goal was the resident would be appropriately dressed. The intervention was the resident required extensive assistance of one (1) staff for dressing.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 550	Continued From page 7	F 550		

Review of Resident #13's Quarterly Minimum Data Set (MDS) Assessment, dated 08/10/2021, revealed the facility assessed the resident to have no behaviors present, including no rejection of care. Additionally, the resident was assessed to have short- and long-term memory problems; and moderately impaired cognitive skills for daily decision making. Further review revealed the resident required extensive assistance of one (1) staff with personal hygiene and had not received therapies.

Observation of Resident #13, on 08/10/2021 at 11:45 PM, revealed two (2) Maintenance staff in the resident's room, both between Resident #13's bed (bed A) and the bed by the window (bed B); the staff were standing behind the privacy curtain between Bed A and Bed B. The curtain was pulled halfway between the beds. Further observation revealed Resident #13, was lying in bed (visible from the hallway), with his/her legs bare from the waist down and uncovered; the resident was wearing only a brief from the waist down. The resident was fidgeting with a thin throw, grasping its edge and pulling at it, up and down. Further observation revealed both Maintenance staff exited the resident's room and did not notify nursing staff the resident was exposed. Registered Nurse (RN) #3 stood outside Resident #13's room on the medication cart preparing medications for administration but did nothing to provide privacy for Resident #13.

Additional observation, on 08/10/2021 at 12:10 PM, revealed Maintenance staff #1 returned to the hallway and entered Resident #13's room without knocking on the door. Maintenance staff #1 stood between Bed A and Bed B working on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 550	Continued From page 8	F 550		

Bed B's bed remote with his back to Resident #13. He then opened the privacy curtain by pushing the curtain back between the beds to the wall. Resident #13 was lying in bed, with his/her legs bare from the waist down and uncovered; the resident was wearing only a brief from the waist down. Further observation revealed RN #3 stood outside Resident #13's room on the medication cart preparing medications for administration and walked past Resident #13's door two (2) times. Maintenance staff #1 exited the resident's room and did not notify nursing staff the resident was exposed.

Interview with Maintenance staff #1, on 08/10/2021 at 12:15 PM, revealed he had worked at the facility for eleven (11) years. Per the interview, he had been provided Resident Rights training by the facility. Additionally, he stated he usually would knock on residents' doors before entering, ensure privacy curtains were pulled, and would let nursing staff know if a resident needed to be covered up; however, he said he forgot to do it that today. Further, he stated he was aware those things ensured Resident Rights of dignity and privacy.

Interview with RN #3, on 08/10/202 at 12:24 PM, revealed she had worked at the facility for two (2) months. Per the interview, she was aware of Resident Rights to include dignity and privacy. Additionally, she stated all staff should ensure Resident Rights and knock on doors before entering, ensure privacy curtains were closed, and ensure residents were dressed appropriately or covered up. Further, RN #3 stated she would continuously round on the hallways and watch the residents; however, today she was passing medications and did not notice Resident #13 was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 550	Continued From page 9	F 550		

uncovered or that the maintenance staff was in the resident's room. Further, she stated it was not acceptable that Resident #13 did not have on pants and was exposed or that staff entered his/her room and did not knock or notify staff the resident was exposed.

2. Review of Resident #31's medical record revealed the facility admitted the resident, on 04/02/2013, with diagnoses including Intracranial Injury with Loss of Consciousness of Unspecified Duration, Cerebral Infarction, Motor Vehicle Accident, Legal Blindness, Anxiety Disorder, and Major Depression.

Review of Resident #31's Quarterly Minimum Data Set (MDS) Assessment, dated 05/31/2021, revealed the facility assessed the resident as having a Brief Interview for Mental status (BIMS) of six (6) of fifteen (15) for cognitively impaired. Continued review of the Quarterly MDS, Section G, revealed the resident was a two (2) person assist for bed mobility, dressing, and toileting.

Observation, on 08/12/2021 at 11:45 AM on the North Unit, revealed Resident #31 visibly lying in bed wearing only his/her brief, with the resident's door wide open. Continued observation, on 08/12/2021 until 12:00 PM, revealed staff walking by the room with Resident #31 fully visible from the hallway. State Registered Nurse Aide (SRNA) #22 entered Resident #31's room, with the resident's roommate, and did not cover or pull the curtain for Resident #31.

Interview with SRNA #22, North Unit, on 08/12/2021 at 10:00 AM, revealed Resident #31 was often uncovered and exposed, lying in bed in his/her brief. He further stated the resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 550	Continued From page 10	F 550		

should have been covered or the curtain pulled for privacy, and it was a dignity issue.

Interview with SRNA #14, North Unit, on 08/12/2021 at 1:40 PM, revealed Resident #31 should have been covered or the curtain pulled for privacy. SRNA #14 stated Resident #31 had a history of playing with his/her briefs or kicking off the blankets. SRNA #14 stated it was a dignity issue with staff passing by and not covering up or pulling the curtain.

Interview with Licensed Practical Nurse (LPN) #9, on 08/12//2021 at 1:45 PM, revealed Resident #31 should have been covered up or the curtain pulled. LPN #9 stated, first, staff should have knocked at the door and asked to cover up the resident; and it was a dignity concern. In addition, LPN #9 stated staff should be educated to cover the resident, pull curtains, dress the resident in pants, or close the resident's door.

Interview with Registered Nurse (RN) Quality Improvement/Infection Control Preventionist/Staff Development Coordinator, on 08/16/2021 at 10:30 AM, revealed Resident #31 uncovered himself/herself. She stated staff should cover the resident or pull the curtain. Further she stated she expected staff to round and check on Resident #31 and keep him/her covered due to the concern for his/her dignity.

Interview with the Director of Nursing (DON), on 08/18/2021 at 10:54 AM, revealed Resident #31 should have been covered or the curtain pulled. She stated SRNA # 22 could have covered or pulled the curtain after the staff member brought the roommate into the resident's room. Further, the DON stated this was a dignity issue.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 550	Continued From page 11	F 550		

Interview with RN #4/Unit Manager, on 08/13/2021 at 4:20 PM, revealed she expected Resident Rights to be honored by all staff in the facility. Additionally, she expected staff to ensure residents were dressed appropriately or covered up while in bed. Per the interview, staff should knock on doors before entering and ensure privacy curtains were pulled. Further, she stated it was important to provide care to residents in a dignified manner and to ensure their privacy.

Additional interview with the DON, on 08/13/2021 at 2:31 PM, revealed she had worked at the facility as the DON for one (1) year. Per the interview, she expected Resident Rights to be followed. Additionally, she expected all interactions with residents by all staff to honor Resident Rights. Further, she stated it was important that staff guaranteed residents were treated with dignity and respect because the facility was their home.

Interview with the Administrator, on 08/16/2021 at 3:30 PM, revealed he had worked at the facility since 07/27/2021. Per the interview, he stated the facility expected Resident Rights to be honored. Additionally, he stated he expected staff to make every effort to ensure dignity and privacy, as required in the facility's Resident Rights. The Administrator stated continued observations from leadership in the facility and the facility's grievance program were processes in place to ensure Resident Rights were maintained in the facility. Further, he stated it was important that staff immediately acted toward ensuring residents were provided dignity and privacy because residents deserved to be treated respectfully.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 571 SS=E	Limitations on Charges to Personal Funds CFR(s): 483.10(f)(11)(i)-(iii)	F 571		

§483.10(f)(11) The facility must not impose a charge against the personal funds of a resident for any item or service for which payment is made under Medicaid or Medicare (except for applicable deductible and coinsurance amounts). The facility may charge the resident for requested services that are more expensive than or in excess of covered services in accordance with §489.32 of this chapter. (This does not affect the prohibition on facility charges for items and services for which Medicaid has paid. See §447.15 of this chapter, which limits participation in the Medicaid program to providers who accept, as payment in full, Medicaid payment plus any deductible, coinsurance, or copayment required by the plan to be paid by the individual.)
(i) Services included in Medicare or Medicaid payment. During the course of a covered Medicare or Medicaid stay, facilities must not charge a resident for the following categories of items and services:
(A) Nursing services as required at §483.35.
(B) Food and Nutrition services as required at §483.60.
(C) An activities program as required at §483.24(c).
(D) Room/bed maintenance services.
(E) Routine personal hygiene items and services as required to meet the needs of residents, including, but not limited to, hair hygiene supplies, comb, brush, bath soap, disinfecting soaps or specialized cleansing agents when indicated to treat special skin problems or to fight infection, razor, shaving cream, toothbrush, toothpaste, denture adhesive, denture cleaner, dental floss, moisturizing lotion, tissues, cotton balls, cotton swabs, deodorant, incontinence care and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 571	Continued From page 13	F 571		

supplies, sanitary napkins and related supplies, towels, washcloths, hospital gowns, over the counter drugs, hair and nail hygiene services, bathing assistance, and basic personal laundry.
(F) Medically-related social services as required at §483.40(d).
(G) Hospice services elected by the resident and paid for under the Medicare Hospice Benefit or paid for by Medicaid under a state plan.
(ii) Items and services that may be charged to residents' funds. Paragraphs (f)(11)(ii)(A) through (L) of this section are general categories and examples of items and services that the facility may charge to residents' funds if they are requested by a resident, if they are not required to achieve the goals stated in the resident's care plan, if the facility informs the resident that there will be a charge, and if payment is not made by Medicare or Medicaid:
(A) Telephone, including a cellular phone.
(B) Television/radio, personal computer or other electronic device for personal use.
(C) Personal comfort items, including smoking materials, notions and novelties, and confections.
(D) Cosmetic and grooming items and services in excess of those for which payment is made under Medicaid or Medicare.
(E) Personal clothing.
(F) Personal reading matter.
(F) Gifts purchased on behalf of a resident.
(H) Flowers and plants.
(I) Cost to participate in social events and entertainment outside the scope of the activities program, provided under §483.24(c).
(J) Non-covered special care services such as privately hired nurses or aides.
(K) Private room, except when therapeutically required (for example, isolation for infection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 571	Continued From page 14	F 571		

control).
(L) Except as provided in (e)(11)(ii)(L)(1) and (2) of this section, specially prepared or alternative food requested instead of the food and meals generally prepared by the facility, as required by §483.60.
(1) The facility may not charge for special foods and meals, including medically prescribed dietary supplements, ordered by the resident's physician, physician assistant, nurse practitioner, or clinical nurse specialist, as these are included per §483.60.
(2) In accordance with §483.60(c) through (f), when preparing foods and meals, a facility must take into consideration residents' needs and preferences and the overall cultural and religious make-up of the facility's population.
(iii) Requests for items and services.
(A) The facility can only charge a resident for any non-covered item or service if such item or service is specifically requested by the resident.
(B) The facility must not require a resident to request any item or service as a condition of admission or continued stay.
(C) The facility must inform, orally and in writing, the resident requesting an item or service for which a charge will be made that there will be a charge for the item or service and what the charge will be.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review, and review of the facility's documents and policy, it was determined the facility failed to have an effective system in place to limit charges on residents' personal funds. In addition, the facility failed to protect residents' personal funds from unnecessary purchasing of items for residents using Stimulus money and for any item not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 571	Continued From page 15	F 571		

required to achieve the goals stated in the residents' care plans for five (5) of forty-four (44) sampled residents, Resident #30, #34, #36, #77, and #246.

Residents #30, #34, #36, #77, and #246 did not elect to have the facility be the designated representative payee, therefore, the former Administrator had no authority to sign the Authorization for Miscellaneous Payments form and Withdrawal Receipts for the sampled Residents.

In addition, Residents #30, #34, #36, #77, and #246 had items purchased for them using their personal funds that the facility should have provided such as special wheelchairs, beds and mattresses, and their personal funds paid for these items.

The findings include:

Review of the facility's policy titled, "Resident Fund Management System," no date, revealed that each resident that entered the facility had the opportunity to establish a Resident Trust account (RTA). There was no minimum or maximum deposit to open the account, and it was solely for the convenience of the resident. Per the policy, it stated to protect the integrity of the RTA and minimize the risk of embezzlement, there was a division of duties in the facility. The Administrator was the primary check signer, along with the Director of Nursing (DON); and the Business Office Manager (BOM) should monitor the balance report monthly to identify any Medicaid recipient whose balance was within two hundred dollars ($200) of the State's limit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 571	Continued From page 16	F 571		

Review of 42 CFR 483.10(f)(11) revealed the facility must not impose a charge against the personal funds of a resident for any item or service for which payment was made under Medicaid or Medicare (except for applicable deductible and coinsurance amounts). In addition, the regulation stated the facility could only charge a resident for any non-covered item or service if such item or service was specifically requested by the resident. Further review revealed the facility must inform, orally and in writing, the resident requesting an item or service for which a charge would be made that there would be a charge for the item or service and what the charge would be.

Review of the facility's document Guideline: Stimulus and Representative Payee Responsibilities, dated 05/29/2020 and updated 07/21/2021, revealed Stimulus money was to be used solely at the discretion of the resident or responsible party. Under no circumstances should the Stimulus money be used to pay resident liability at the facility. The Stimulus money did not count as resources to affect federal programs like Medicaid for a year and any attempt by the facility to seize the money was unlawful. Further, the Guideline stated that an Interdisciplinary Team (IDT) meeting should be held with residents and responsible parties to discuss what could/could not be purchased with the Stimulus monies, who should be invited, and what to do if the facility staff became aware of misuse of the monies.

Review of the Quality Assurance Performance Improvement (QAPI) Meeting minutes, dated 07/21/2021, revealed Corporate became aware the RTA Stimulus checks were used to purchase

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 571	Continued From page 17	F 571		

Durable Medical Equipment (DME) that should have been supplied by the facility. On 07/22/2021, per the minutes, the Regional Business Office (RBO) and Corporate Compliance (CC) conducted an investigation and audits of accounts and items purchased. Items identified that the facility should have paid for were to be reimbursed by 07/27/2021. RBO and CC would conduct monthly audits of RTA's for two (2) months to validate purchases met regulations. On 07/23/2021 a QAPI meeting was held to discuss the process improvement plan (PIP) of self-identified issues and all actions taken. The Investigation Summary dated 07/21/2021 revealed that facility staff, in good faith, was assisting residents to "spend down" their RTA in order to maintain Medicaid eligibility. Continued review revealed education was provided in May 2020 to assist facilities with understanding the current guidelines for spending down the RTA. The Summary stated the facility believed they were following the guidance correctly.

Review of the Stimulus Payment Tracking Report, dated 01/01/2021 through the present, revealed all four (4) sampled residents received Stimulus money that was added to their RTA's. Continued review revealed that at various times in 2021, there were large sums of money authorized to be disbursed from their RTA to pay for personal items.

1. Review of Resident #77's RTA revealed he/she received Stimulus money, on 05/28/2020 for $1200, 01/04/2021 for $600, and 04/07/2021 for $1400. On 02/08/2021, authorization for miscellaneous payments from patient trust accounts revealed the facility, as Resident/Legal

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 571	Continued From page 18	F 571		

Representative, authorized payment of $3,334.74 for personal items that included a forty inch television for $482.99 and an Optima Evolution Chair for $2,522.99; that authorization form was signed by the previous Administrator.

Review of Resident #77's progress notes, dated October 2020 until March 2021, revealed no documented evidence the POA was contacted related to the television or chair. There were multiple notes where the POA was notified of positive COVID results and testing for COVID. Review of Occupational Therapy notes revealed no documented evidence of an assessment of the evolutionary chair. Interview, on 08/18/2021 at 10:48 AM, with the DON revealed there were no therapy notes about the resident's evolutionary chair. Review of Resident #77's care plan, dated 10/2019, revealed the evolutionary chair was for comfort and positioning.

Review of Resident #77's financial statements, dated 08/13/2021, revealed a total of $2,853.42 was refunded to Resident #77's RTA account. This amount included the cost of the chair, taxes, shipping, and interest for April-July 2021.

Attempts to reach Resident #77's Power-of-Attorney (POA) via phone, on 08/11/2021 at 10:15 AM and 08/18/2021 at 9:30 AM, were unsuccessful; the voice mail was not set up.

2. Review of Resident #36's RTA revealed he/she received Stimulus monies on 04/07/2021 for $1400. On 06/09/2021, authorization for miscellaneous payments from patient trust accounts revealed the facility, as Resident/Legal Representative, authorized payment of $1,286.82

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 571	Continued From page 19	F 571		

for personal items that included a forty inch television for $299.99 and a microAIR MA500 alternating pressure low air loss mattress system for $894.99; that authorization form was signed by the previous Administrator.

Interview with Resident #36, on 08/17/2021 at 8:48 AM, revealed he/she was resting in bed, winged mattress observed, head of bed elevated; when asked about the previous mattress (air mattress), the resident stated he/she had told them he/she did not want the mattress. Resident #36 stated he/she was unable to remember who she told, just "the one that brought it." The resident also stated the winged mattress was comfortable. Resident #36, per the interview, stated there had not been the need for a new television, and she did not request it. Although, Resident #36 stated, this one was bigger, she could see better, and it could be given to his/her daughter.

Interview with Licensed Practical Nurse (LPN) #7, on 08/14/2021 at 10:29 AM, revealed she did not know whose idea it was to get Resident #36 the air mattress. She stated she was confused as to why because the resident had a winged mattress to prevent falling out of bed, and an air mattress made it easier to slide out of bed. The winged mattress was taken off the bed, and the air mattress was put on the bed. LPN #7 stated Resident #36 slid out of the bed three (3) times that night, with no serious injuries, and night shift staff took it upon themselves to remove the air mattress and put the winged mattress back on the bed. Per LPN #7, Resident #36 never complained that the winged mattress was uncomfortable.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 571	Continued From page 20	F 571		

Interview with the Minimum Data Set (MDS) Registered Nurse (RN) #7, on 08/17/2021 at 9:20 AM, revealed that typically mattresses were used as a fall interventions and was unaware Resident #36 had issues with the winged mattress. She stated a resident getting a new mattress would not be a decision she would make by herself because there were different factors involved. She stated Resident #36 had not been on the air mattress for a day before he/she fell out of the bed, and it was again replaced by the winged mattress. Per the interview, she stated the decision to replace the mattress was made by the former Administrator, and she was uncertain of her reasoning.

Interview with Staff Development Coordinator/Quality Improvement (SDC/QI) nurse, on 08/17/2021 at 10:21 AM, revealed all she knew was that the former Administrator ordered Resident #36 the air mattress for comfort. However, she stated Resident #36 had not complained the bed was uncomfortable nor had requested a new mattress.

Review of Resident #36 financial statements, dated 07/27/2021, revealed $970.83 was refunded to Resident #36's RTA account.

3. Review of Resident #30's RTA revealed he/she received Stimulus money on 05/03/2020 for $1200, on 01/04/2021 for $600, and on 04/07/2021 for $1400. On 03/26/2021, authorization for miscellaneous payments from patient trust accounts revealed Resident #30, as the Resident/Legal Representative, authorized payment, by signature, of $1245.49 for personal items that included a forty inch television for $482.99 and a Lift Chair for $617.00.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 571	Continued From page 21	F 571		

Review of an authorization, dated 06/09/2021, signed by the previous Administrator and co-signed by Resident #30, revealed an order for a floor lamp, top of the line bedside table, and a case of pillow covers.

Interview with Resident #30, on 08/10/2021 at 3:50 PM, revealed when the resident was asked about the RTA and who bought items such as clothing for him/her, the resident stated he/she did not need anything. Resident #30 seemed a little confused.

Attempt to interview Resident #30, on 08/19/2021 at 11:52 AM, was unsuccessful. Resident #30 ignored the State Survey Agency (SSA) Surveyor's conversation and stared blankly, straight ahead. Resident #30's roommate stated Resident #30 would ignore someone if he/she did not want to talk. Observation of Resident #30's room, at this time, revealed the floor lamp, lift chair, television, and top of the line bedside table in the room.

Review of Resident #30's financial statements, dated 07/23/2021, revealed a total of $507.61 was refunded to Resident #30's RTA account.

4. Review of Resident #34's RTA revealed he/she received Stimulus monies on 04/29/2020 for $1200, on 01/04/2021 for $600, and on 04/02/2021 for $1400. On 02/10/2021, an authorization for miscellaneous payments from patient trust accounts revealed Resident #34 as his/her Resident/Legal Representative, with his/her signature, and it was co-signed by the former Administrator. Further review revealed the authorization was for payment of $3639.85, for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 571	Continued From page 22	F 571		

personal items that included a forty inch television for $482, a microAIR MA500 alternating pressure low air loss mattress system for $892.99, a Matrix 4100 bed frame for $932.99, a 4-drawer chest for $390.00, and a 3-drawer bedside cabinet for $237.00.

Interview with Resident #34, 08/19/2021 at 10:20 AM revealed he/she "ordered'em" but was not able to say how he/she knew to order those specific items and did not look at a catalogue.

Observation of Resident #34's room, with the DON at the same time, revealed the cabinet, chest and television were in Resident #34's room. However, per observation, the bedframe was not in his/her room.

Interview with the DON, on 08/19/2021 at 10:20 AM, revealed the mattress was on his/her bed but was unaware of where the bedframe was. The DON stated she would get with Maintenance and locate the bed frame. She also stated she was unaware of any items ordered for residents because the former Administrator kept staff out of the loop as to what she was doing with the Stimulus money.

Interview with the Maintenance Director, on 08/19/2021 at 1:40 PM, revealed he inspected all resident electrical items for safety. He stated Resident #34 did receive a new bed frame and mattress, which was ordered by the former Administrator. However, he stated, the bed did not have a headboard nor a footboard. In addition, he stated the wheel locking mechanism did not meet safety standards for locking tightly enough to prevent the bed from slipping if a resident tried to get out of the bed. Therefore, he

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 571	Continued From page 23	F 571		

stated, the bed frame was never put in Resident #34's room. He stated the former Administrator said she would take care of making it right, and the bed frame was still in the Maintenance storage area. The Maintenance Director stated the former Administrator acted alone when ordering the resident items.

Review of Resident #34's financial statements, dated 07/23/2021, revealed a total of $3238.88 was refunded to Resident #34's RTA account.

5. Telephone interview with Resident #246's daughter/POA, on 08/19/2021 at 10:36 AM, revealed the resident had been a patient at the facility but was now deceased. She stated the facility said they had to do something with the resident's Stimulus money and had to spend down the RTA within the year, and several items were purchased. Further, she stated, after Resident #246 passed away, his/her sister did pick up the television that had been purchased, but the resident already had one, and she did not know why the facility bought a new one. Additionally, she stated the family was able to take home the lightweight wheelchair ($129.31) that was used to take Resident #246 out of the facility for visits, and she did not know about RoHo cushion ($75.00) purchase. She stated the lift chair ($617.00) and the Panacea Reclining Wheelchair ($363.99), which had been purchased, were left at the facility because they were too heavy for the family to move. She stated the family was not reimbursed for the $1700 spent. The interview ended by Resident #246's daughter stating that if facility staff felt like the resident needed those items, that was fine, but she did not sign anything nor was the RTA reimbursed any monies. She stated the facility

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 571	Continued From page 24	F 571		

called her after several items had been purchased.

Review of the Stimulus Payment Tracking Report revealed the facility reimbursed Resident #246's RTA account $1657.60 on 07/13/2021.

Interview with the Accounts Receivable/Resident Trust Accounts Clerk, on 08/13/2021 at 2:05 PM, revealed the facility was given information in 05/2020, she thought from Corporate, that Resident Stimulus checks would not affect RTA for a year. She stated Stimulus monies were not used until this year (2021) to buy residents durable medical equipment (DME). She stated the former Administrator initiated using RTA for DME that should have been paid for by facility.

Additional interview with the Accounts Receivable/Resident Trust Accounts (RTA) Clerk, on 08/19/2021 at 9:15 AM, revealed when she questioned the former Administrator about using Stimulus monies, the Administrator told her purchased items could be used or were needed by the residents. The Clerk stated she signed the requisition slips as a witness for all the ordered items because she was told by the former Administrator she was always the witness. Further, she stated when she showed the former Administrator the 05/2020 Corporate documentation regarding RTA's and purchases, the former Administrator told her that as long as they could use the purchased items at the facility, it was okay. Further interview revealed the Clerk did not report the former Administrator's actions to the Regional Vice President or the Corporate Compliance Hotline because the former Administrator had told her it was okay to use the monies. She stated, after Corporate was aware

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 571	Continued From page 25	F 571		

that RTA's had been used to buy DME for residents, the affected residents were reimbursed.

Interview with the DON, on 08/13/2021 at 4:20 PM, revealed she had no direct knowledge of Stimulus purchases or reimbursements. She did remember, in a daily morning meeting (unable to remember when, formal notes not taken), the Administrator talked about using Stimulus monies to buy residents special air mattresses that the facility should supply. The DON stated when the former Administrator was questioned if she was allowed to do that, the Administrator stated it was okay as long as a resident would be using it. The DON stated staff did not question her again about anything with resident financials. She stated she did not report this to anyone because she had not been notified of the Principal (Corporate) directive regarding Stimulus checks, and therefore, did not know to notify Corporate Compliance or the Regional Vice President.

Interview with the DON and Interim Administrator, on 08/16/2021 at 2:30 PM, revealed they were unaware of what system or process was in place that caught the DME purchases. The Interim Administrator stated he did not arrive at facility until 07/26/2021 and that was one reason he did not know.

Interview with the Interim Administrator, on 08/20/2021 at 10:24 AM, revealed the Administrator did not have any ability to move money or access the general accounting ledger. Administrators could order stuff but could not move money around or take money out of a resident trust. He stated the Regional Vice President (RVP) was oversight manager for the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 571	Continued From page 26	F 571		

Administrator. He stated, until July, there was no awareness the former Administrator had used RTA's money to purchase items the facility should have furnished and that this had happened as early as January or February 2021. He stated the facility needed a more regular audit of the business office, and this was going to be put in place. He stated the facility did have audits that looked into those things that were usually done annually, or sometimes semi-annually. He stated there were different price levels where the RVP was triggered to look at a purchase. He stated he expected if the Administrator was using resident money for DME purchases, someone would call Corporate. He stated he believed staff had been intimidated by the former Administrator. He stated he wished the incidents had been reported earlier to someone.

Interview with the Regional Vice President (RVP), on 08/20/2021 at 3:03 PM, revealed there was a letter sent out in 05/2021 regarding how Stimulus checks should be spent and Stimulus monies would not affect resident Medicaid status for at least a year. An additional update was sent 07/21/2021 reiterating Stimulus expenditures and the public health emergency was in effect until October 2021. He stated he was not aware Stimulus monies were used inappropriately and that is something that is taken very seriously. He stated the facility had addressed it through a review, going back, and looking at processes from a Quality Assurance standpoint. The facility had made some refunds of purchased items that the facility should or would have normally purchased. He stated those items were not expensive enough to require prior approval. The RVP stated he did not have a great answer regarding what system should have caught this,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 571	Continued From page 27 but he thought the former Administrator had worked her way around the system.	F 571		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy, it was determined the facility failed to ensure residents were free from abuse for two (2) of forty-four (44) sampled residents (Resident #32 and Resident #84). On 07/18/2021, Licensed Practical Nurse (LPN) #2 discovered Resident #32 and Resident #84 both had two (2) Roxicodone (Schedule II narcotic to treat pain) pills replaced with Primidone	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 600	Continued From page 28	F 600		

(anti-convulsive) and taped into the Roxicodone blister pack.

Review of a Uniform Citation (police report), dated 07/18/2021, revealed LPN #1 was charged with two (2) counts of Wanton Endangerment, First Degree. LPN #1 admitted to the police that she switched out medications for Primidone fifty (50) milligrams (mg), not caring what effects it would have on the residents.

The facility's failure to take immediate action to prevent further abuse and to follow their policy to ensure all residents were free from abuse has caused or is likely to cause serious injury, serious harm or death to other residents in the facility. Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) were identified on 08/20/2021, and were determined to exist on 07/18/2021, in the area of 42 CFR 483.12 Freedom from Abuse, F-600, Free from Abuse. The facility was notified of the IJ and SQC on 08/20/2021.

Additionally, it was determined the facility failed to protect residents from abuse for an additional four (4) residents (Residents #21, #45, #28, and #63). On 05/18/2021, Resident #28 pushed Resident #63 down, resulting in a hematoma to Resident #63's head. On 06/27/2021, Resident #45 attacked Resident #21, resulting in multiple scratches and abrasions to Resident #21.

The facility provided an acceptable Immediate Jeopardy Removal Plan on 09/01/2021, with the facility alleging removal of the Immediate Jeopardy, on 08/31/2021. The State Survey Agency validated removal of the Immediate Jeopardy, as alleged on 08/31/2021, prior to exit on 09/02/2021. The facility's remaining

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 600	Continued From page 29	F 600		

non-compliance was at a Scope and Severity of an "E" while the facility develops and implements a Plan of Correction and the facility's Quality Assurance (QA) monitors to ensure compliance with systemic changes.

The findings include:

Review of the facility's policy titled, "Abuse, Neglect, or Misappropriation of Resident Property Policy," last revised 03/10/2017, revealed the facility would do whatever was in its control to prevent abuse. The policy stated the Administrator was responsible to ensure complaints of abuse were investigated and to report allegations to the appropriate agencies. Under the section on Prevention, the policy revealed staff would investigate allegations in a timely manner and develop corrective measures as indicated. Under the section on Investigation, the policy revealed the Administrator was responsible to direct the investigation and to ensure appropriate agencies were notified. The appropriate agencies, per the policy, included the Division of Licensure and Regulation (State Survey Agency) and Adult Protective Services.

1a. Review of a draft of a KYIBRS (Kentucky Incident Based Reporting System) Report of incident 21-0927-092, revealed police were contacted, on 07/18/2021, by Social Services Clinician I (SSCI) informing them LPN #1 was actively stealing resident medications at the facility. The Police Report revealed LPN #1 was asked to empty her pockets and had an unmarked pill bottle with several different types of pills inside, along with several loose pills in her pocket. Further review revealed the evidence found on LPN #1 included: one (1) Primidone 50

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 600	Continued From page 30	F 600		

mg tablet along with three (3) empty packs; one (1) Oxycodone 10/325 mg tablet; one (1) Tramadol 50 mg tablet; two (2) Hydrocodone 10/325 mg tablets; three (3) Gabapentin 600 mg tablets; five (5) Gabapentin 300 mg tablets; one (1) empty skid (a blister pack when full contained thirty (30) tablets) of Roxicodone labeled for Resident #32; and, one (1) pack of birth control pills labeled for LPN #1.

Continued review of the report, revealed LPN #1 admitted to taking medications from the facility, as well as changing some narcotics out and replaced them with Primidone 50 mg, without regard for how this would affect the involved residents. LPN #1 stated, if the police drug tested her, she would have Hydrocodone, Percocet, Gabapentin, and Marijuana in her system. Per the report, LPN #1 stated she did not document narcotics removed from her medication cart until the end of the shift and stated this was common practice among nurses at the facility. Therefore, the medication could be missing and even taken by the resident but not yet signed out on the narcotic record. The report stated LPN #1 was charged with two (2) counts of Wanton Endangerment in the First Degree; thirteen (13) counts of Theft by Unlawful Taking (TBUT), Controlled Substance; three (3) counts of Possession of a Controlled Substance; and two (2) counts of Abuse and Neglect of an Adult Person.

Interview with the Registered Nurse (RN) Facility Consultant, on 07/27/2021 at 1:15 PM, and again, on 08/18/2021 at 2:32 PM, revealed she had been brought in from corporate as a result of the facility's issues that needed to be addressed. She stated there had been an audit, on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 600	Continued From page 31	F 600		

07/09/2021, by pharmacy in which it was determined there was a missing skid of Percocet (Schedule II narcotic given to relieve pain) 5/325 mg (milligrams) that belonged to Resident #17. She stated the investigation revealed three (3) skids of thirty tablets (30) each had been delivered by pharmacy, on 06/28/2021, as documented by Licensed Practical Nurse (LPN) #2. However, in an interview, LPN #1 stated she had received only two (2) skids of thirty (30) tablets of Percocet 50 mg. The Facility Consultant stated she was on a trigger call (a call between management staff and corporate regarding facility concerns and reportable incidents) with the Administrator, on 07/09/2021, regarding this incident but could not remember who else had been on the call. She stated she did not believe suspending the nurses involved or drug testing the nurses involved were discussed during the trigger call.

Interview with LPN #2, on 07/29/2021 at 4:29 PM, revealed on the night of 06/28/2021, LPN #1 approached her repeatedly to let her know when the pharmacy came in. LPN #2 was working on the South Unit, and the South Unit nurse was responsible for signing for deliveries from pharmacy. LPN #2 stated she signed for three (3) skids of thirty (30) Percocet 5/325 mg tablets, all for Resident #17, on the night of 06/28/2021. Continued interview revealed that she was informed after the discovery of a missing skid, on 07/09/2021, that LPN #1 alleged that she only received two (2) skids.

Interview with the Director of Nursing (DON), on 08/04/2021 at 8:28 AM, and again, on 08/05/2021 at 12:35 PM, revealed no one had reported to her any missing Percocets that belonged to Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 600	Continued From page 32	F 600		

#17. She stated the first she heard of missing Percocets was when pharmacy determined a skid was missing, which belonged to Resident #17, in an audit conducted on 07/09/2021. She revealed she had reported this to the Administrator and sent the information in a self-report to the police on 07/09/2021. Continued interview revealed when police came to the facility, she never spoke with them, the Administrator did. She stated pharmacy had delivered three (3) skids of thirty (30) Percocet 50 mg tablets for Resident #17, on 06/28/2021; however, LPN #1 stated she only received two (2) skids. The DON stated she thought there was a trigger call that day, but she was not on the trigger call. The DON stated neither LPN #1 nor LPN #2 were suspended.

Interview with the Ombudsman, on 07/26/2021 at 3:15 PM, revealed she interviewed the DON following an incident, on 07/09/2021, after a skid of Percocet tablets was reported missing. She stated, when asked about suspending staff implicated in drug diversion on 07/09/2021, the DON replied she was not sure which of the two (2) nurses was responsible. The Ombudsman stated, when the DON was asked why she did not suspend both staff members, the DON shrugged her shoulders.

Continued interview with the RN Facility Consultant, on 07/27/2021 at 1:15 PM, revealed, on 07/18/2021, she was contacted by the DON, who informed her LPN #2 had found two (2) pills taped into a Roxicodone skid belonging to Resident #32 which were not Roxicodone, followed by a second resident, Resident #84, who also had two (2) pills taped into a Roxicodone skid which were not Roxicodone. She stated the pills used to replace the Roxicodone were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 600	Continued From page 33	F 600		

determined to be Primidone, an anti-seizure medication. The Facility Consultant stated police were present and had already detained LPN #1. Additionally, she stated it was discovered LPN #1 had taken narcotic medications from skids, but had not signed them out for Residents #71, #56, #1, #47, #34, #60, #48, #65, #79, and #8. (see F-602)

Interview with LPN #2, on 07/29/2021 at 4:29 PM, revealed she was working the night of 07/18/2021, and was administering medications, when she noted Resident #32's narcotic skid had tape on it, and the medications taped inside were thicker than the other medications in the skid. She stated she contacted the DON and had State Registered Nurse Aide (SRNA) #20 witness as she searched the rest of the cart and found two (2) more medications taped in place of Resident #84's narcotics. She revealed she contacted Adult Protective Services (APS), and was advised by Social Services Clinician I (SSCI) to have other staff witness her medication administration involving any narcotics. LPN #2 stated she had State Registered Nurse Aide #8 and SRNA #20 witness every narcotic pulled from the medication cart and administered.

Continued interview with LPN #2, on 07/29/2021 at 4:29 PM, revealed, following the arrival of the DON and the Administrator, staff identified multiple narcotic skids with tape on them, and staff was busy wasting these medications, on the night of 07/18/2021 through the morning of 07/19/2021. She stated some skids had tape all over them and had to be wasted, while others just had pills removed due to tape. She stated when individual pills were taken from her medication cart, both she and the removing staff signed on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 600	Continued From page 34	F 600		

the narcotics sheet, but the Administrator and DON had taken the Shift Change Count Sheet, which tracked the number of controlled substance skids in the cart. LPN #2 stated she started another sheet and counted forty-two (42) sheets.

Interview with SRNA #20, on 08/11/2021 at 4:13 PM, revealed LPN #2 showed him, on 07/18/2021, taped skids belonging to Resident #32 of two (2) Roxicodone tablets that had been replaced with something else. He revealed, due to that, she wanted to check the rest of the narcotics in the drawer, and they found Resident #84 also had two (2) Roxicodone tablets removed from a skid and replaced with something else. He revealed LPN #2 reported this to the DON, and he knew they had looked at LPN #2's cart while he was still on the floor.

Interview with the DON, on 08/04/2021 at 8:28 AM, revealed she received a call from LPN #2, on the night of 07/18/2021 at 7:30 PM. She stated LPN #2, stated that she had found two (2) of Resident #32's narcotics that had been replaced with other pills. She stated she also received a text, on 07/18/2021 at 7:47 PM from LPN #2, that she had found a second resident, Resident #84, who had two (2) narcotics replaced with other pills. The DON stated she alerted the Administrator. The Administrator then had a trigger call, at 7:52 PM, with the Facility Consultant, the Clinical Director, and the Regional Vice President.

Continued interview with the DON, on 08/04/2021 at 8:28 AM, revealed she and the Administrator came in a little after 9:00 PM on 07/18/2021; police and the SSCI were already present in the facility. She stated they did cart audits, and the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 600	Continued From page 35	F 600		

Administrator made copies of everything that was missing that night. However, the DON was unaware of where those copies were. She stated she and the Administrator went through the carts, and were following corporate guidance to destroy any medications that were taped in skids. Per the interview, she stated she and the Administrator went through LPN #1's medication cart together, and she went through another medication cart with LPN #12 while the Administrator went through a medication cart with LPN #2. The DON said she timed any medications she wasted. Further, she reported all medication carts were audited by 2:00 AM on 07/19/2021, when she left the facility. The DON stated she did not have a full record of what was wasted, on the evening of 07/18/2021 through the morning of 07/19/2021.

Interview with Registered Nurse (RN) #4, on 07/28/2021 at 1:20 PM, revealed she was called in, on the night of 07/18/2021 by the DON, to help audit medication carts. She stated several narcotics were missing from the medication cart belonging to LPN #1. RN #4 stated no residents she worked with had complained to her about not receiving their pain medications.

Interview with LPN #12, on 08/13/2021 at 8:21 AM, revealed she was working the night of 07/18/2021 when another nurse and SSCI came around checking medication carts. She stated her medication cart had no discrepancies, and the only medication cart she thought had an issue was LPN #1's. LPN #12 stated she had never had any issues with LPN #1 and had never had any residents complain about her.

1b. Review of Resident #84's medical record revealed the facility admitted the resident, on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 600	Continued From page 36	F 600		

09/11/2020, with diagnoses that included End Stage Renal Disease, Dementia in Other Diseases Classified Elsewhere without Behavioral Disturbance, and Dependence on Renal Dialysis.

Record review revealed the facility assessed Resident #84, in a Quarterly Minimum Data Set (MDS) Assessment, dated 04/26/2021, as fourteen (14) of fifteen (15) on the Brief Interview for Mental Status (BIMS), indicating no cognitive impairment. Continued review of Resident #84's medical record revealed a Physician's Order, dated 03/23/2021, for Neurontin (Gabapentin, an anti-seizure medication also used for nerve pain) 100 mg at bedtime. The record revealed another Physician's Order, on 05/10/2021 for Roxicodone (Oxycodone) 5 mg every eights (8) hours as needed for pain.

Review of Resident #84's Controlled Substance Count Record for Roxicodone 5 mg, delivered on 06/10/2021, revealed frequent use once a day, with use twice a day on multiple occasions. LPN #1 had signed out eight (8) tablets on the record, with two (2) tablets documented as replaced with Primidone on 07/18/2021.

Interview with Resident #84, on 07/28/2021 at 2:45 PM, revealed he/she received his/her medications on time, and whenever he/she experienced pain, staff provided him/her with pain medications. Resident #84 stated he/she had never received the wrong medications, as far as he/she was aware.

Interview with LPN #6, on 08/10/2021 at 2:40 PM, revealed she had observed, on Resident #84's Medication Administration Record (MAR) that Resident #84 did routinely receive pain

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 600	Continued From page 37	F 600		

medication when LPN #1 worked at night, although he did not routinely receive them when LPN #6 was working during the day.

Interview with Advanced Practice Registered Nurse (APRN) #1, on 08/11/2021 at 11:44 AM, revealed she was concerned with residents not receiving their controlled pain medication because these residents would not have adequate pain control. She revealed she was aware of the situation with Resident #84, and although her primary concern would have been with the resident having uncontrolled pain, she stated, if Resident #84 started exhibiting new symptoms, no one would have been able to connect those symptoms to a medication the resident was not prescribed but was receiving. Further, she stated Resident #84 had a stroke previously, so receiving an anti-convulsant could affect him/her greatly.

Review of Resident #32's medical record revealed the resident was admitted to the facility, on 04/01/2020, with diagnoses to include Chronic Obstructive Pulmonary Disease Unspecified, Chronic Pain Syndrome, and Unspecified Dementia with Behavioral Disturbance. The facility assessed Resident #32, in a Quarterly MDS Assessment, dated 06/01/2021, as a seven (7) of fifteen (15) on the BIMS, indicating severely impaired cognition. Further review of the record revealed a 04/01/2020 order for Roxicodone 5 mg every eight (8) hours as needed for pain. Review of a Clinical Laboratory Report, dated 07/22/2021, revealed Resident #32 had a Urinary Tract Infection (UTI), with a new order for Cipro (an antibiotic) 500 mg twice a day for ten (10) days, initiated on 07/22/2021.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 600	Continued From page 38	F 600		

Review of Resident #32's Controlled Substance Count Record for Roxicodone 5 mg, initiated on 06/15/2021, revealed the last two (2) medications on the skid had been replaced with Primidone on 07/18/2021.

Additional interview with LPN #6, on 08/19/2021 at 8:39 AM, revealed there had been no evidence Resident #32 was not receiving his/her pain medication or getting another medication in place of it. She revealed Resident #32 did not ask for pain medication often. LPN #6 stated Resident #32 had frequent UTI's, which would be exhibited in Resident #32 by confusion, saying off-the-wall things, having delusions, and sometimes fatigue, which were behaviors exhibited by Resident #32 around 07/18/2021.

Interview with LPN #9, on 08/19/2021 at 8:50 AM, revealed when Resident #32 had a UTI, he/she would be confused, might not know where he/she was or why, and yell out. She revealed Resident #32 did not use many as needed pain medications.

Interview with the Medical Director, on 08/10/2021 at 4:11 PM, revealed when medications were not administered as prescribed, it could lead to problems; and, in the case of residents with pain medications, it could lead to untreated pain. Regarding Resident #32, he stated he had ordered lab work because he was concerned Resident #32 might have been overdosed but found that was not the case. The Medical Director stated the DON had been keeping him informed on issues surrounding the drug diversion situation at the facility, as well as their plans to address the issues.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 600	Continued From page 39	F 600		

Interview with the Interim Administrator, on 08/20/2021 at 10:24 AM, revealed his expectation was the facility would have a good investigation program, a good audit program, and a good count program for narcotics that started when residents were admitted to the facility, to limit the possibility of drug diversion occurring.

The previous Administrator was not available during the course of the survey, and did not return calls, the last of which was attempted on 08/20/2021 at 9:48 AM.

Interview with the DON, on 08/04/2021 at 7:35 AM, revealed her expectation that abuse allegations be reported immediately and that staff should act to protect residents from abuse. She stated, if abuse involved resident-to-resident, they must be separated to ensure their safety. She stated, if abuse involved a staff member and a resident, the staff member must be removed from resident care to ensure residents were safe. The DON stated, when she received a report, she reported it to the Administrator, and the Administrator would call corporate if he/she assessed the incident as being reportable.

Interview with the Regional Vice President, on 08/20/2021 at 3:03 PM, revealed he was part of the trigger call that occurred on 07/09/2021. He stated the facility reported the incident and also notified police of the missing skid of Percocet. However, he stated as staff was unable to determine which nurse might have taken the medications, neither nurse was suspended at that time. He stated he had not been informed of any prior allegations of LPN #1 diverting medications, and as Regional Vice President, he would have expected to be notified of those types of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 600	Continued From page 40	F 600		

allegations.

2. Review of a Long Term Care Facility Self-Reported Incident Form, dated 06/27/2021, revealed, on 06/27/2021, Resident #21 alleged Resident #45 attacked him/her when Resident #21 tried to stop Resident #45 from pulling flowers in the courtyard. Continued review revealed the facility made appropriate contacts and initiated an investigation. Report of the five day follow-up revealed Resident #21 was assessed and treated, and Resident #45 was placed and remained on one-to-one (1:1) supervision until he/she was sent to another facility for psychiatric evaluation and treatment.

Review of Resident #45's medical record revealed the facility admitted the resident, on 03/12/2020, with diagnoses that included Unspecified Dementia with Behavioral Disturbance, Paranoid Personality Disorder, and Psychotic Disorder due to Known Physiological Condition. The facility assessed Resident #45, in a Quarterly MDS Assessment, dated 06/15/2021, as three (3) of fifteen (15) on the BIMS, indicating severe cognitive impairment.

Review of Resident #45's Comprehensive Care Plan, dated 05/04/2020, revealed a care plan for verbal/physical aggression with interventions for staff to include not invading the resident's personal space and removing the resident to a quiet area during periods of anger or if appropriate. Further review revealed that staff was not present in the courtyard at the time of the incident, and other residents invaded Resident #45's personal space in response to his/her behaviors.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 600	Continued From page 41	F 600		

Review of Resident #45's Physician's Progress Note, dated 06/29/2021, revealed the Medical Director (MD) had been present in the facility, on 06/29/2021, and observed Resident #45 in the courtyard attempting to pull flowers and becoming physically aggressive with staff. Continued review revealed the MD had been concerned regarding the episode on 06/27/2021. The MD considered the episode on 06/27/2021 to be life threatening to both Resident #45 as well as to Resident #21 and Resident #1 (also in the courtyard), and recommended Resident #45 be transferred to a geriatric psychiatric unit.

Review of Resident #21's medical record revealed the facility admitted the resident on 07/11/2019, with diagnoses to include Alzheimer's Disease with Late Onset, Dementia in Other Diseases Classified Elsewhere, and Other Chronic Pain. The facility assessed the resident, in an Annual MDS Assessment, dated 05/24/2021, as fifteen (15) of fifteen (15) on the BIMS, indicating no cognitive impairment.

Review of Resident #1's medical record revealed the facility admitted the resident, on 12/22/2016, with diagnoses to include Cerebral Palsy Unspecified, Other Specified Anxiety Disorders, Chronic Pain Syndrome, and Deaf Nonspeaking Not Elsewhere Classified. The facility assessed Resident #1, in a Quarterly MDS Assessment, dated 05/03/2021, as fifteen (15) of fifteen (15) on the BIMS, indicating no cognitive impairment.

Interview with RN #4, who was also the Unit Manager, on 07/28/2021 at 1:20 PM, revealed she heard about a situation where Resident #21 was scratched by Resident #45. RN #4 stated she heard Resident #21 "got on" Resident #45 for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 600	Continued From page 42	F 600		

pulling flowers up because Resident #45 thought they were weeds. RN #4 stated, "I guess (he/she) didn't like being yelled at. I do not know what they did after that incident, besides the usual. Anything like that, we always get the abuse training."

Interview with LPN #3, on 07/29/2021 at 9:23 AM, revealed Resident #21 came up to the nurse's station after the incident on 06/27/2021, and she bandaged the resident and called the doctor. She stated Resident #21 had skin tears all the way up his/her right arm, an abrasion on his/her leg, redness to his/her neck, and a scratch under one (1) of his/her eyes. LPN #3 stated the residents were all out in the courtyard and had been making comments to Resident #45 all day, as he/she was pulling up flowers. LPN #3 stated staff had encouraged the residents to come and get them if Resident #45 started pulling up flowers again, but instead, per her interview with Resident #21, Resident #1 was making gestures at Resident #45, trying to get him/her to stop pulling up flowers. Continued interview revealed when Resident #45 "went after" Resident #1, who was not touched by Resident #45, Resident #21 intervened. LPN #3 revealed Resident #45 had exhibited aggression toward staff before, but not toward other residents. She stated Resident #45 was placed on one-to-one (1:1) supervision, and she took care of Resident #21, calling the doctor and the family. LPN #3 stated Resident #45's nurse and the Assistant Director of Nursing (ADON), took care of initiating the investigation. Further, she stated the facility had transferred Resident #45 to another facility, for psychiatric care, and since his/her return to the facility, the resident had been well behaved.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 600	Continued From page 43	F 600		

Interview with Resident #21, on 07/30/2021 at 3:04 PM, revealed Resident #45 was "crazy". Resident #21 revealed Resident #45 was yelling at everyone and tried to pull Resident #1 out of his/her wheelchair. Resident #21 stated he/she told Resident #45 to quit, and he/she scratched Resident #21's arm, choked him/her, banged his/her head against a brick wall (back of head), and kicked his/her leg (left, lower, outer). Resident #21 stated staff intervened, got Resident #45 in the building, and started doctoring Resident #21's arm. Observation revealed the resident appeared very animated, clearly anxious when talking about the incident. Resident #21 stated he/she had not had any issues since then, and the couple of times Resident #45 had been walking near, staff directed him/her away.

Interview with Courtesy Aide (CA) #1, on 07/30/2021 at 3:25 PM, revealed she was coming out of the unit and was in the dining room area, around 6:00 PM on 06/27/2021, when she heard a resident yelling. She stated she observed that in the courtyard Resident #21 was in his/her wheelchair and was trying to push Resident #45 off of him/her. She stated she dropped everything, ran out to the courtyard, and separated Resident #45 and Resident #21, until a nurse arrived. She stated Resident #45 was yelling, cursing, and saying it was all Resident #21's fault. She stated she thought nurses were administering medications at that time. The CA stated Resident #21 was in bad shape, crying, and was still in his/her wheelchair. She stated it looked like there were scratch marks on Resident #21's right arm, his/her face was red, and part of his/her neck, too. In addition, she stated she did not see Resident #45 striking Resident #21. Per

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 600	Continued From page 44	F 600		

the interview, she stated a Personal Care Assistant (PCA) was in the courtyard with her, and the CA told her to go get a nurse. When the nurse came out, she stated, the nurse took Resident #21 inside and told the CA to take Resident #45 to his/her room for one-to-one (1:1) supervision, which she did until 11:00 PM, when her shift ended. She stated, after the incident, Resident #45 calmed down.

Interview with Registered Nurse (RN) #2, on 08/03/2021 at 3:33 PM, revealed she was in the dining room with a State Registered Nurse Assistant (SRNA), on 06/27/2021, at the time of the incident, feeding residents. She stated, they heard a commotion at the inside door to the courtyard, and the SRNA went out first. She stated the SRNA came and got her to go to the courtyard. She stated she saw Resident #21, who was upset, crying, and bloody. In addition, she said she saw several SRNA's and staff members in the courtyard, and she was told Resident #45 had gone to the courtyard and was pulling up flowers. Then, she stated, when other alert and oriented residents, in the courtyard, told Resident #45 to stop, he/she turned and became violent. RN #2 revealed she was told Resident #45 choked Resident #21, twisted his/her arm, and kicked him/her. She stated there was a "marking" around Resident #21's neck, multiple skin tears to the right arm, and a skin tear or laceration to either the right or left leg. RN #2 stated Resident #21 was pretty upset, and other residents out there were also upset. Per the interview, RN #2 said she told CA #1 to take Resident #45 back to his/her room, to separate him/her from everybody else.

Continued interview with RN #2, on 08/03/2021 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 600	Continued From page 45	F 600		

3:33 PM, revealed she assessed other residents to ensure no one else was injured. Then, she stated Resident #1 was also involved, as he/she was the first one to speak up to Resident #45. RN #2 reported Resident #1 was trying to get Resident #45 to stop and must have been making noises or gestures. She stated Resident #45 turned on Resident #1, and apparently, that was when Resident #21 jumped in to help Resident #1, who was not injured. RN #2 stated Resident #45 was placed on one-to-one (1:1) observation, and she notified the DON and spoke with the on-call doctor, who gave a one-time order for Haldol (an anti-psychotic medication) or Ativan (an anti-anxiety medication) for Resident #45 "but only if we absolutely needed to use it, but preferred we didn't." RN #2 stated Resident #45 was sent out to another facility at some point after that.

Interview with the Facility Consultant, on 07/27/2021 at 1:15 PM, revealed it was her initial understanding that Resident #21 was at the nurse's station, where they noticed a skin tear on his/her arm, and when asked what happened, Resident #21 said Resident #45 had attacked him/her when he/she tried to stop him/her from pulling up flowers in the garden. As the story unfolded, she stated, it turned out another resident, Resident #1, was out there as well. Resident #1 noticed Resident #45 was pulling up flowers, not weeds. He/she tried to intervene, and Resident #45 told Resident #1 to get away. Then, Resident #21 tried to intervene between the two (2) of them, as Resident #1 was his/her friend. RN #2 stated she saw Resident #21 in the hallway, and he/she had, what appeared to be, eight (8) skin tears on his/her right arm. Resident #45 was put on one-to-one (1:1) supervision.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 600	Continued From page 46	F 600		

3. Review of a Long Term Care Facility Self-Reported Incident Form, dated 05/18/2021, revealed on 05/18/2021, on the secure dementia unit, the DON witnessed Resident #28 push Resident #63, causing Resident #63 to fall. Continued review of the facility's five-day final report revealed Resident #28 was agitated, and Resident #63 was in his/her path. Resident #28 said some profanities to Resident #63, and before staff could intervene, Resident #28 pushed Resident #63, who fell backwards and struck his/her head on the floor. Per the report, Resident #28 was placed on one-to-one (1:1) supervision. Resident #63 was assessed, and complained of left lower back pain. Further review revealed Resident #63 was determined to have a hematoma to the left back side of the head. The report stated Resident #63 was transferred to the Emergency Room (ER), where computed tomography (CT) scans showed normal results.

Review of Resident #28's medical record revealed the facility admitted the resident, on 10/21/2019, with diagnoses to include Alcohol Dependence with Alcohol Induced Persistent Dementia, Unspecified Dementia with Behavioral Disturbance, and Restlessness and Agitation. The facility assessed Resident #28, in a Quarterly MDS Assessment, dated 05/27/2021, as three (3) of fifteen (15) on the BIMS, indicating severe cognitive impairment.

Review of Resident #28's care plan, dated 10/25/2019, revealed a behavioral care plan for anxiety and anger when others were in his/her personal space. Interventions included documenting behaviors and notifying the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 600	Continued From page 47	F 600		

physician, psychiatric evaluations as ordered, and medications as ordered.

Review of Resident #63's medical record revealed the facility readmitted the resident on 03/09/2021, with diagnoses to include Vascular Dementia with Behavioral Disturbance, Unspecified Hearing Loss Bilateral, and Repeated Falls. The facility assessed Resident #63, in a Significant Change MDS Assessment, dated 06/29/2021, as moderately cognitively impaired.

Interview with the ADON, on 07/27/2021 at 3:11 PM, revealed she was walking out of a resident's room on the secure unit when she observed Resident #28 walking down the hallway mumbling things under his/her breath, and Resident #63 was standing in the hall outside of his/her door. She stated Resident #28 walked up to Resident #63, said some curse words, then pushed Resident #63 with both hands, causing Resident #63 to fall. She stated Resident #63 had not said anything to Resident #28. The ADON revealed she went to Resident #63, started assessing him/her and getting vitals. She stated Resident #28 was placed on one-to-one (1:1) supervision, and Resident #63 was sent out to the local ER due to a hematoma to the back of his/her head. The ADON stated Resident #28 was disoriented and did not have a reason for his/her behaviors.

Interview with SRNA #2, on 07/27/2021 at 3:48 PM, revealed she was not present on 05/18/2021, but heard Resident #28 had pushed Resident #63 down. She stated Resident #28 could have significant mood swings. She stated the following day, Resident #63 was walking fine and was talking incoherently as always.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 600	Continued From page 48	F 600		

Interview with SRNA #6, on 07/28/2021 at 11:20 AM, revealed she routinely worked on the secure unit and had been there consistently for the past five (5) months. She revealed Resident #28 could "sometimes get in a mood", but it was not typical behavior for Resident #28 to push somebody out of his/her way.

Interview with the Facility Consultant, on 07/27/2021 at 1:15 PM, revealed the ADON observed Resident #28 push Resident #63, on 05/18/2021, resulting in a fall with injury. She stated Resident #28 was placed on one-to-one (1:1) supervision, which gradually went to every fifteen (15) minute checks and was finally discontinued, on 06/04/2021, as there had been no further incidents.

The facility provided an acceptable Immediate Jeopardy Removal Plan, on 09/01/2021, that alleged removal of the Immediate Jeopardy (IJ) on 08/31/2021. The facility implemented the following:

1. On 07/09/2021, a Performance Improvement Plan (PIP) was initiated related to Missing Narcotics which was reported to the Office of Inspector General- Division of Health Care (State Survey Agency), at 4:30 PM on 07/09/2021.

2. On 07/09/2021, the Unit Manager and MDS Nurses audited narcotics in the remaining medication carts as the North back hall had a blister pack missing. All count sheets were found to match the number of skids. Staff signing in and out of a medication cart was expected on controlled substance check sheets.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 600	Continued From page 49	F 600		

3. On 07/09/2021, the Staff Development Coordinator (SDC) initiated staff education. The topics included narcotic count, counting sheets added and subtracted, signing packing slips, and logging narcotics into the narcotic books.

4. On 07/12/2021, 07/13/2021, 07/20/2021 to 07/22/2021, 07/24/2021 to 08/13/2021, and 08/22/2021 to 08/29/2021, an RN Corporate (Facility) Consultant worked in the facility. An RN Corporate Nurse would continue to be at the facility five (5) days a week through September 2021, ensuring residents remained free from abuse, neglect, and exploitation, and policy and procedures were followed, including the active plan of correction. An RN Corporate Nurse could complete any audit in place of the assigned auditor and would help ensure the facility followed policy and took immediate action to prevent further abuse, neglect, and exploitation.

5. On 07/12/2021, the DON initiated additional education which included signing as needed (PRN) medications on the back of the medication administration record (MAR), giving discontinued narcotics to the DON, and labeling declining count sheets.

6. On 07/18/2021, the Licensed Practical Nurse (LPN) #1 was removed from the facility and arrested by Police. LPN #1 was automatically suspended.

7. On 07/18/2021, an Addendum was added to the PIP due to findings that Percocet tablets were replaced with Primidone on Resident #84 and Resident #32 medications.

8. On 07/18/2021, an ad hoc meeting was held

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 600	Continued From page 50	F 600		

to review the additional action steps with the interdisciplinary team (IDT). The IDT was comprised of the Administrator, DON, Quality Improvement Nurse/Staff Development Coordinator (SDC/QI), Minimum Data Set (MDS) Nurse, Unit Manager, Activity Director, Social Services Director, and Dietary Manager. The IDT agreed actions taken would include abuse/neglect education, abuse/neglect monitoring via progress note review, safe surveys with residents, and staff surveys regarding abuse/neglect.

9. On 07/19/2021, the DON, Unit Manager, Administrator, Corporate RN, or a support RN began reconciling the narcotic packing slips to the narcotics received. The reconciliation would be completed three (3) times per week to ensure the correct number of delivered narcotics were logged into the narcotic count book and the number of declining count sheets were updated. Any discrepancies would be reported immediately to the DON and/or administration.

10. On 07/19/2021, staff nurses performed assessments on all residents, including assessing pain. For residents with a BIMS of eight (8) or below, the assessment included observation of non-verbal signs of pain to include: breathing, facial expression, body language, and consolability. No concerns were identified.

11. On 07/19/2021, the APRN assessed Residents #32 and #84.

12. On 07/20/2021, the Administrator suspended LPN #2.

13. On 07/20/2021, the DON, ADON, SDC, MDS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 600	Continued From page 51	F 600		

Nurses, Weekend Supervisor, Social Services Director (SSD), Activities Director (AD), and/or support RN nurses began interviewing three (3) random residents, with a BIMS of nine (9) or above, weekly to ensure they had no concerns related to when or how their narcotic medications were administered. Any concern regarding narcotic administration would be reported to the DON or Administrator for review at the morning interdisciplinary team (IDT) meeting. The three (3) audits would continue five (5) times a week until the Quality Assurance Performance Improvement (QAPI) committee determined a reduction could be made. The results of these audits would be reviewed in the monthly QAPI meeting. The QAPI Committee consisted of the Administrator, DON, Infection Preventionist, Medical Director, Social Worker, Medical Records Director, Dietary Manager, and Housekeeping Supervisor, plus additional staff members as deemed necessary.

In addition, each off-going (leaving work, completed shift) licensed nurse/Kentucky Medication Aide (KMA) would report any concerns regarding narcotic administration and complete a concern form indicating a resident had expressed concern regarding their narcotic medication administration. The completed concern would include who the concern was reported to. Any resident concern regarding narcotic medication administration would be reported to the DON or Administrator for review at the morning IDT meeting. The results of these audits would be reviewed in the monthly QAPI meeting.

14. On 07/20/2021, the DON audited the Shift Change Controlled Substance Count Check

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 600	Continued From page 52	F 600		

sheets and found Licensed Practical Nurse (LPN #2) had recorded on the log sheet a reduced number of sheets counted. The nurse documented four (4) less sheets than the previous shift. There was no documented explanation why there were four (4) less sheets than the previous shift. The facility suspended the nurse and reported the information to the OIG, APS (Adult Protective Services), and police.

15. On 07/20/2021 to 07/21/2021, the Social Worker and Admissions Coordinator completed interviews with all residents with a BIMS above 8. Residents were asked about concerns with how and when medications were administered. Any concerns, which included but was not limited to pain, were documented and reported to the Administrator.

16. On 07/21/2021, the DON, ADON, Unit Manager, SDC/QI, Weekend Supervisor, MDS Nurses, the Corporate RN, and/or a support RN would audit the storage and documentation of narcotics when checking medication carts to ensure narcotics were stored appropriately and documentation was correct. The audits included: locking carts, MAR's, shift change count sheets, signatures, declining count sheets, wasted narcotics, back side of narcotic medication skids, skid cards in numerical order, no missing skids, all narcotics accounted for, and/or pharmacy packing slips. Audits would occur five (5) times per week until the QAPI committee determined frequency could be reduced. Any concern regarding documentation or storage of narcotic administration would be addressed at the time of the audit and reported to the DON or Administrator. All new concerns would be reviewed in the morning IDT meeting. Any

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 600	Continued From page 53	F 600		

concerns and trending would be reviewed and discussed weekly on Fridays.

17. On 07/21/2021, the Regional Vice President interviewed and suspended the facility's Administrator.

18. On 07/20/2021 through 07/25/2021, the RN Corporate Nurses provided education on Abuse, Neglect, and the Misappropriation of Resident Property Policy. The education included: screening of employees, training of employees, prevention, identification, investigation, protection, and reporting/response. One hundred five (105) of one hundred eight (108) employees completed the education at that time. The three (3) remaining employees have since received the education. This education has been added to the new employee orientation for all facility and agency staff.

19. On 07/22/2021, the DON and RN Consultants educated all nurses and Kentucky Medication Aides (KMA) on the Controlled Substance Policy which included the proper way to count narcotics and the correct record keeping for narcotics. As of 07/22/2021, twenty-nine (29) of thirty-one (31) nurses and KMA's were educated. One (1) nurse was on vacation and had since returned. One (1) nurse was on Family Medical Leave Act (FMLA) and remained on FMLA. This education included the off-going nurse should have the record for comparison to actual narcotics seen by the on-coming staff member. Narcotics should be signed out at the time they were removed from the packet; a nurse must witness destruction of a dropped or refused narcotic before signing as a witness. KMA's could not be the second signature. (A KMA could

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 600	Continued From page 54	F 600		

not witness for a nurse.) Nurses and KMA's could not tape a medication to hold it in a card. If a narcotic came loose, it must be wasted, and two (2) signatures must be present. This education also included signing the Shift Change Controlled Substance Count Check sheet at the beginning and end of the shift. This education included that the signature was the nurse's affirmation that the count was correct and must be signed when counting. It could not be signed early or late. Nurses and KMA's were also educated regarding deliveries of multiple cards of narcotics. The nurse receiving the narcotics and the nurse whose medication cart would hold the narcotics must both sign for the receipt. If the same nurse was both receiving and had the medication cart, a second nurse must sign also.

20. On 07/26/2021, the DON, Unit Manager, SDC, Nurse Supervisor, MDS Nurse, and Corporate RN consultants began administering a medication administration post-test to all licensed nurses and KMA's. The quiz covered both medication administration and physician notification and validated the licensed nurses and the KMA's continued competency in a written form. Any licensed nurse or KMA not scoring one-hundred percent (100%) on the quiz would receive additional education.

21. On 07/27/2021, the DON and SDC began abuse/neglect monitoring via nursing progress note review. The past twenty-four (24) hours of nursing notes were printed off and read, looking for any indication of abuse/neglect/exploitation.

22. On 07/27/2021, the DON, SDC, Unit Manager, RN's, and Administrators from "sister facilities", and RN Corporate nurses continued

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 600	Continued From page 55	F 600		

safe surveys, with residents, and staff surveys regarding abuse/neglect.

23. On 07/29/2021, the DON facilitated a Medical Director Update telephone call.

24. On 08/01/2021, the DON e-mailed the narcotic abuse/neglect PIP to the Medical Director.

25. On 08/10/2021, the DON facilitated a QAPI Committee meeting with the Medical Director present. The committee discussed the facility's survey status, including the abuse/neglect PIP. Review of actions taken and audit results concluded in the recommendation for the facility to: 1) continue with the narcotics PIP; 2) provide on-going education; and, 3) continue auditing.

26. On 08/11/2021, the DON completed narcotic cart audits on each of the five (5) medication carts. Audit result: no issues were identified. The Corporate RN Consultant noted the front-north narcotic drawer had a screw sticking out that caused tears and punched holes in the back of multiple narcotic skids. The screw was covered.

27. On 08/12/2021, the DON completed narcotic cart audits on each of the five medication carts. Audit result: no issues.

28. On 08/13/2021, the SDC completed narcotic cart audits on each of the five (5) medication carts. Audit result: no issues.

29. On 08/18/2021, the SDC completed narcotic cart audits on each of the five medication carts. Audit result: no issues.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 600	Continued From page 56	F 600		

30. On 08/19/2021 the DON facilitated a Medical Director update telephone call.

31. On 08/20/2021, the DON notified the Medical Director of eight (8) IJ tags and the PIP's that were being worked on.

32. On 08/20/2021, the Administrator, DON, SDC, and Corporate Support staff began additional Code of Conduct in-servicing. The in-service included a quiz. The quiz questions included employees following laws, reporting systems, when to report, who to report to, and where to find more information. The employees were able to verbalize their role in protecting residents and preventing abuse, neglect, and exploitation.

33. On 08/20/2021, the facility verified the facility rebilled and/or paid for the misappropriated medications.

34. On 08/25/2021, the Regional Vice President announced the transition to the new Administrator. The Regional Vice President and Interim Administrator provided education to the new Administrator, including the requirements of the tags F-600 Abuse/Neglect/Exploitation and F-610 Investigate/Prevent/Correct Alleged Violation.

35. On 08/26/2021, the DON facilitated a Medical Director update telephone meeting, including the DON, Regional Vice President, Medical Director, Interim Administrator, new Administrator, and RN Consultant. The discussion included the facility's immediate jeopardy (IJ) status, including the tag F-610 Investigate/Prevent/Correct Alleged

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 600	Continued From page 57	F 600		

Violation. Review of actions taken and audit results concluded in the recommendation for the facility to: 1) provide continued education and 2) continue auditing.

36. On 08/28/2021, the SDC and RN Corporate Nurse provided education to three (3) new dietary employees, including abuse/ neglect, and Investigate/Prevent/Correct Alleged Violation if they saw abuse.

37. On 08/28/2021, the SDC monitored and audited the north-front medication cart and verbally quizzed the medication cart nurse related to preventing and protecting residents from further misappropriation of property (controlled medications). The medication cart nurse passed the quiz with one-hundred percent (100%) correct answers.

38. On 08/28/2021, the SDC, Support RN Nurse, and Corporate RN Consultant monitored medication carts, narcotic medication documentation, and the facility's progress.

39. On 08/28/2021, the RN Corporate Nurse worked with the new Administrator and reviewed the steps to take for a thorough investigation. The Administrator was assigned/responsible for investigations, preventing, and correcting any alleged violations. Review of the Action Checklist for abuse/neglect was also included. This continued on 08/29/2021, at which time the Administrator was able to verbalize the importance of, and timeline for, reporting any allegation of misappropriation of property. The Administrator also articulated corrective actions to protect, thoroughly investigate, and resolve alleged violations.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 600	Continued From page 58	F 600		

40. On 08/29/2021, the DON, four (4) Support RN Nurses, and a Corporate RN Nurse interviewed staff and residents, inspected medication carts, and reviewed narcotic documentation. No new staff concerns were received. No new resident concerns were received, as residents stated they were receiving their medications. No narcotic medications were identified as missing.

41. Starting 08/29/2021, the facility's IDT would have a meeting five (5) times a week to review concerns. The Administrator or DON would identify an investigator to conduct the investigation. The Cardinal IDT tool would be utilized to track the investigation and ensure the investigation was completed timely and thoroughly.

42. The Pharmacy Consultant would visit the facility at least monthly to validate narcotics were being monitored and counted per standard of practice.

The State Survey Agency validated the implementation of the facility's Immediate Jeopardy Removal Plan as follows:

1. Review of a Quality Assurance (PIP), dated 07/09/2021, revealed, as a result of the missing blister pack of thirty (30) Percocet identified in a pharmacy audit, the facility identified only one (1) staff was signing for narcotics arriving at the facility, and initiated education on controlled substances, to include having a second person sign for controlled substances arriving at the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 600	Continued From page 59	F 600		

Review of a Long Term Care Facility Self-Reported Incident Form, dated 07/09/2021, confirmed the facility reported the incident of misappropriation to all appropriate parties, to include the Office of Inspector General (State Survey Agency) on 07/09/2021.

2. Review of documentation confirmed facility staff audited narcotics in all medication carts on 07/09/2021. Review of audits revealed no other missing narcotics.

3. Review of a Complete In-Service Training Report with Staff Attending, dated 07/09/2021, confirmed the SDC initiated staff education, attended by licensed nursing staff and KMA's. Education covered the need for both the off going and on coming shift to sign the Shift Change Controlled Substance Count Check sheet at change of shift, the importance of completing an appropriate narcotic count at shift change, adding and subtracting sheets from the Shift Change Controlled Substance Count Check sheet, and the employee accepting delivery for narcotics must sign each individual sheet of the packing slips.

Interview with the SDC, on 09/02/2021 at 4:49 PM, revealed she provided all nurses and KMA's a packet of education on medication administration as well as having each nurse sign for delivery of narcotics.

4. Interview, on 09/02/2021 at 9:10 AM, with the Clinical Director revealed that she, prior to her arrival, the Facility Consultant, had been in the facility on the dates documented in the IJ Removal Plan. She revealed her daily routine consisted of talking to residents on both the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 600	Continued From page 60	F 600		

South and North halls of the building, observing staff providing care, and talking with staff. She revealed she assessed and interviewed for evidence of abuse. She revealed she also conducted chart reviews and validated the facility was continuing audits and doing everything they were supposed to be doing. The Clinical Director stated she had made surprise visits to the facility at 2:00 AM, as well as on weekends, to determine any resident concerns and ensure staff was following procedures they had been educated on.

5. Review of Complete In-Service Training Report with Staff Attending, dated 07/12/2021, confirmed the DON initiated staff education for licensed nursing staff and KMA's. Education covered (1) All PRN (as needed) medications must be signed on the back of the MAR, (2) all narcotics no longer in use must stay locked up in the medication cart until they could be given to the DON, and (3) declining count sheet must be labeled with room numbers at the top of the sheet.

Interview with the DON, on 09/02/2021 at 9:10 AM, revealed it had been determined not everything was signed out consistently on the back of the MAR, so the education initiated, on 07/12/2021, emphasized to staff the need to do this, including documenting the effectiveness of pain medication administered to residents.

6. Review of a Kentucky Incident Based Reporting System (KYIBRS) Report, dated 07/18/2021, revealed LPN #1 had been arrested and charged with thirteen (13) counts of Theft by Unlawful Taking, three (3) counts of Possession of Controlled Substances, two (2) counts of Wanton Endangerment, and two (2) counts of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 600	Continued From page 61 Abuse and Neglect of an Adult Person. Review of LPN #1's employee file confirmed LPN #1 had been terminated from employment on 07/18/2021. 7. Review of the Narcotic PIP confirmed, as a result of the 07/18/2021 incident in which two (2) residents had narcotics replaced with non-prescribed medications, a PIP addendum was in place to identify the scope of residents affected, as well as further staff education on controlled substances and monitoring by management staff. 8. Review of meeting minutes, dated 07/18/2021, confirmed the IDT met and were in agreement to provide abuse/neglect education, abuse/neglect monitoring via progress note review, safe surveys with residents, and staff surveys regarding abuse and neglect. 9. Review of Packing Slips revealed two (2) staff nurses were consistently signing for incoming narcotics, with nursing staff additionally initialing the count slips for medications specifically received for their medication carts. The review confirmed all packing slips were being signed; however, there was not consistent documentation indicating the slips had been reviewed by either the DON, Unit Manager, Administrator, a Corporate RN, or a Support RN. One (1) packing slip, dated 07/22/2021, was signed for by one (1) nurse. Further review determined this nurse received consultation and reeducation by the Facility Consultant regarding the need for two (2) signatures always.	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 600	Continued From page 62	F 600		

Interview with the DON, on 09/02/2021 at 9:10 AM, revealed when reviewing packing slips, she confirmed there were two (2) signatures and checked to ensure everything listed on the packing slips was on the medication cart; then she would initial the packing slips to show she reviewed them.

10. Review of Pain Assessments revealed Pain Assessments were completed for all facility residents on 07/19/2021. No concerns were identified. Additionally, Resident Interview Medication Administration papers were reviewed, with no concerns identified.

Interview with the DON, on 09/02/2021 at 9:10 AM, revealed no new or untreated pain was identified through the pain assessments conducted on 07/19/2021.

11. Review of Ambulatory Nursing Home Report confirmed APRN #1 assessed Resident #84 on 07/19/2021. No concerns were identified with the assessment of Resident #84.

Review of the physician visit by the Medical Director (MD) with Resident #32, on 07/20/2021, revealed possible indicators Resident #32's opiates had been replaced with Primidone. MD documentation revealed Resident #32's condition improving at the time of documentation. MD documentation further revealed APRN #2 had visited with Resident #32 on 07/19/2021.

12. Review of a Long Term Care Facility - Self-Reported Incident Form, dated 07/20/2021, confirmed LPN #2 had been suspended from the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 600	Continued From page 63	F 600		

13. Review of Resident Interview Medication Administration confirmed facility staff interviewed three (3) or more residents each week beginning on 07/20/2021 regarding any concerns with medication administration, and if so who they reported to and when. No concerns were noted in review of resident interviews.

Review of Shift Change Narcotic Review sheets, also used to document nurse and KMA concerns regarding narcotics administration, revealed no forms had been completed, indicating no concerns had been reported as of the review date of 09/02/2021.

Interview with the DON, on 09/02/2021 at 9:10 AM, revealed she frequently interviewed residents as part of the audit process, asking about any concerns regarding their medications. She revealed, if residents were to express a concern, she would educate them on reporting and share their concerns in QAPI meetings. To date, she revealed no residents or staff had expressed any concerns to her regarding narcotics administration.

14. Review of documentation confirmed the DON audited medication carts, on 07/20/20, and determined Resident #9 was missing skid two (2) of two (2) for Percocet and Resident #76 was missing skid four (4) of four (4) for Norco (a narcotic pain medication). Review of Shift Change Controlled Substance Count Check sheets confirmed one (1) sheet ended at forty-six (46), while the following sheet started at forty-two (42).

15. Resident Interview Medication Administration documentation was reviewed. Residents were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 600	Continued From page 64	F 600		

questioned the Regional Vice President by the Social Services Director or the Admissions Coordinator about whether or not they had concerns regarding administration of their medications. If residents indicated concerns, this was explored further, to include to whom the residents reported concerns and when. No issues were identified during documentation review.

16. Review of Narcotic Cart Audit forms, dated 07/21/2021 confirmed the DON audited the storage and documentation of all facility medication carts. Continued review of audits revealed audits were occurring five (5) or more times each week. Review of Narcotic Cart Audit forms revealed required education was given, on 07/22/2021, for a KMA who had pulled narcotics but did not sign at the time the narcotics were given.

17. Interview with the Regional Vice President, on 09/02/2021 at 7:07 PM, confirmed the previous Administrator had been suspended on 07/21/2021, as a result of concerns regarding the way the Administrator handled the drug diversion issue. The Regional Vice President stated he was present at the facility acting in the capacity of Administrator from 07/21/2021 through 07/23/2021, with an Interim Administrator present at the facility, beginning 07/27/2021, until a new Administrator started on 08/26/2021.

18. Review of Complete In-Service Training Report with Staff Attending, with a start date of 07/20/2021, revealed staff was educated on the facility Abuse, Neglect, and Misappropriation of Resident Property Policy, revised 03/10/2017. The focus of the training appeared to be on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 600	Continued From page 65	F 600		

reporting and following the chain of command in reporting if the situation had not been addressed. The chain of command consisted of the employee's supervisor, the DON, the Administrator, and followed by the Corporate Compliance line or the Regional Vice President. The training also noted calls to the Corporate Compliance line could be anonymous. Review of sign in sheets for training revealed the last employee completed the training, on 08/10/2021.

Interviews, on 09/02/2021, with Housekeeper #4, at 2:27 PM; the Admissions Coordinator, at 2:48 PM; RN #3, at 3:14 PM; and SRNA #23, at 3:21 PM, revealed they all had received education on abuse/neglect and misappropriation. In addition, each was able to identify their immediate supervision and that they would go up the chain of command if their concern was not addressed.

19. Review of a Complete In-Service Training Report with Staff Attending, initiated on 07/19/2021, revealed licensed nursing staff and KMA's were educated on the Controlled Substances policy, dated 09/2020. Although the policy itself did not cover damaged skids, documentation revealed the training covered not taping the backs of skids.

Interview with the DON, on 09/02/2021 at 9:10 AM, revealed education emphasized skids could not be taped, and discussed the proper way to waste narcotics. She revealed a nurse could sign for a KMA to waste narcotics, however, a KMA could not sign for a nurse. She stated drugs were all to be wasted in the Drug Buster, which was a chemical container that drugs were placed in for disposal. She stated staff was educated on the requirement for two (2) staff to sign for receipt of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 600	Continued From page 66	F 600		

narcotics.

Interviews, on 09/02/2021 with LPN #11, at 3:03 PM, and RN #3 at 3:14 PM, revealed both had been educated on the proper way to do a narcotic count at shift change, counting skids, comparing to the number of controlled substance sheets, and wasting medications, with another nurse witnessing and signing, in the Drug Buster kept in the medication rooms. Both stated education also covered the importance of signing and completing pain assessments on the back of the MAR for PRN (as needed) medications and signing with another nurse when narcotics arrived. LPN #11 also stated, if a skid was damaged, to report it to the DON, and if a medication was in danger of falling out of a damaged skid, it was to be wasted with another nurse witnessing and signing. LPN #11 revealed she had seen and experienced management staff, including the DON, going around doing medication cart audits, and she stayed with her medication cart while was being audited.

Interview with SRNA #20, on 09/02/2021 at 3:39 PM, a KMA, revealed he received the same education nursing staff received. He revealed he had received multiple educations. The KMA stated the education included the importance of signing out narcotics when he gave them and not waiting until the end of shift to sign them out. He revealed he signed them out right after they were given, and if a resident refused, he would mark it as a refusal and have a nurse witness and sign the medication as wasted. He stated, if a pill or skid was compromised, or if anything looked tampered with, he would alert the DON so she could assess and determine if medications needed to be wasted. He revealed corporate

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 600	Continued From page 67	F 600		

nurses had audited his drug cart recently.

20. Review of the facility's Narcotic Administration Quiz revealed licensed nurses and KMA's completed written quizzes, beginning on 07/26/2021. Quiz responses reviewed were appropriate, with no concerns identified during review of them.

21. Interview with the DON, on 09/02/2021 at 9:10 AM, revealed the DON and the SDC printed and reviewed all resident progress notes, highlighting anything potentially indicative of abuse or neglect. She revealed, in addition to reviewing any incidents and accidents, they looked for any documentation of resident injuries or behaviors. She stated this was an ongoing process and was reviewed in IDT meetings.

22. Review of Safe Surveys with residents, and untitled surveys with employees, revealed staff conducted surveys, on 07/27/2021, with no concerns identified.
Interview with Housekeeper #4, on 09/02/2021 at 2:27 PM, revealed she had completed a staff survey asking if she had any concerns.

23. Review of documentation confirmed the Medical Director was updated regarding the PIP's for Abuse and Narcotics and ongoing audits on 07/29/2021.

24. Review of an email, with the Abuse PIP and Narcotic PIP attached, confirmed it was sent to the Medical Director, on 08/01/2021.

25. Review of a QAPI Committee meeting agenda, from 08/10/2021, revealed the Abuse PIP was in the monitoring phase, with monitoring

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 600	Continued From page 68	F 600		

continuing. Review of a sign in sheet, dated 08/10/2021, revealed the Medical Director was in attendance at the meeting.

Interview with the Medical Director, on 08/10/2021 at 4:11 PM, revealed the DON had been in contact with him two (2) to three (3) times a week and had provided him all the PIP's that had been planned out. The Medical Director revealed he was extremely pleased at the progress the facility had made addressing their problems.

26. Review of the Narcotic Cart Audit sheets used for facility narcotic cart audits revealed staff were auditing to ensure (1) All staff were signing the Controlled Substance Count Sheet (CSCS) at shift change, (2) All narcotic sheets had been counted, (3) the number of narcotic count sheets matched the number of skids on the cart, (4) Skids on the cart did not have tape on their backs, (5) Skids were checked to ensure there were no missing skids, (6) CSCS were being logged in and out of the cart on the Shift Change Controlled Substance Count Check form as the sheet count number changed (new skids arrived, skids were completed), and (6) All narcotics were signed out and accounted for.

Review of a Narcotic Cart Audit completed, on 08/11/2021 at 11:42 AM, by the DON revealed the audit was completed with no issues noted or corrective action required or taken. The Corporate RN Consultant noted the front-north narcotic drawer had a screw sticking out that caused tears/punched holes in the back of multiple narcotic skids: The screw was covered.

27. Review of Narcotic Cart Audit completed, on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 600	Continued From page 69	F 600		

08/12/2021 at 5:10 PM, by the DON revealed the audit was completed with no issues noted or corrective action required or taken.

28. Review of the Narcotic Cart Audit completed, on 08/13/2021 at 2:25 PM, by the DON revealed the audit was completed with no issues noted or corrective action required or taken.

29. Review of the Narcotic Cart Audit completed, on 08/18/2021 at 10:30 AM, by the SDC revealed the audit was completed with no issues noted or corrective action required or taken.

30. Documentation review confirmed the DON provided the Medical Director an update call on 08/19/2021.

31. Review of facility documentation confirmed the DON informed the Medical Director, on 08/20/2021 of the eight (8) IJ tags and the PIP's that were being worked on.

32. Review of Code of Conduct in-servicing, revealed the sign-in sheet documented all staff had completed training. Review of employee quiz information revealed employees were educated on reporting of fraud or abuse, as well as the availability of the Corporate Compliance line, and the ability to make anonymous reports if desired, with the goal of ensuring all potential violations were reported and addressed.

Interview with SRNA #24 and the Occupational Therapist, on 09/02/2021 at 3:30 PM, revealed both had received training on the Code of Conduct, which included abuse, neglect, misappropriation, what to report, who to report to, and when to report. Both revealed if they were to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 600	Continued From page 70	F 600		

report an allegation to their supervisor and did not feel like it was being addressed, they could contact the DON and Administrator, as well as call or fax the Corporate Compliance line.

33. Review of facility documentation, not labeled or dated, revealed a total of one hundred and eight (108) narcotics were documented as missing, which included three (3) skids of thirty (30) medications each that were missing, and four (4) non-controlled medications that were documented as missing. The document listed residents by name, along with discrepancies noted, the cost for each individual dose, resident payors, and the total cost of all medications reimbursed, which was three hundred and four dollars and ninety-seven ($304.97) cents.

34. Review of an Appointment Letter as facility Administrator revealed appointment of a new Administrator, on 08/26/2021, with an Administrator job description, reporting to the Regional Vice President, who also signed the letter on 08/26/2021.

Interview with the Administrator, on 09/02/2021 at 6:32 PM, confirmed he spoke with the Interim Administrator and the Regional Vice President over the phone, on 08/25/2021, and they discussed with him the IJ tags the facility had been cited, to include abuse and misappropriation tags. He stated they wanted to make sure he was aware of the situation he would be coming into. He stated the Regional Vice President had stressed the importance of reporting allegations and keeping him informed.

35. Review of the document Communication with Medical Director, signed by the Medical Director

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 600	Continued From page 71	F 600		

on 08/28/2021, confirmed the Medical Director was provided an update by the DON on the Immediate Jeopardy (IJ) citations and corrective actions the facility was taking to address the citations.

Interview with the Administrator, on 09/02/2021 at 6:32 PM, revealed he was present for the phone call with the Medical Director, on 08/26/2021, in which the jeopardy citations were discussed, as well as the audits the facility had been doing and the education the facility had provided. He revealed they went down each one of the tags, discussing issues and what was being done to address issues.

36. Review of three (3) Employee Affirmation Statements, dated 08/28/2021, revealed three (3) new dietary employees had received and reviewed the Code of Conduct as part of their orientation. Further, review of In-Service Training Report, dated 08/28/2021, revealed new staff had received training on abuse, neglect, and misappropriation investigating and reporting.

37. Review of Shift Change Narcotic Review sheet completed by the SDC, on 08/28/2021, confirmed the north-front medication cart was audited, and LPN #6 was verbally quizzed, with no concerns identified.

38. Review of Shift Change Narcotic Review sheets, completed by the SDC, support RN's, and corporate RN's, revealed medication carts and narcotic documentation were monitored on 08/28/2021, 08/29/2021, and 08/30/2021, with no issues identified.

Interview with the Clinical Director, on 09/02/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 600	Continued From page 72	F 600		

at 9:10 AM, revealed she, the SDC, and a sister facility nurse went to each medication cart, on 08/28/2021 at shift change with their audit tools, and went through the packet of audit tools with medication cart staff, asking questions about documentation and reporting. She revealed this process was repeated on 08/29/2021 with a nurse from a different sister facility. She revealed there had been no concerns with the audits.

39. Interview with the Administrator, on 09/02/2021 at 6:32 PM, confirmed the Clinical Director had thoroughly reviewed with him abuse reporting and investigating.

Interview with the Clinical Director, on 09/02/2021 at 9:10 AM, revealed she reviewed an investigation file with the Administrator on 08/29/2021. She revealed they went down the Action Checklist, reviewed the process, and the Administrator made notes to himself on what he needed to do and on what he could do at that time. The Clinical Director stated the Administrator had interviewed residents, called residents' representatives, and was very thorough in his investigation of misappropriation.

40. Review of the facility's Weekend Audits, dated 08/28/2021, confirmed the Administrator and a support RN interviewed staff and residents regarding abuse, code of conduct, and medication administration. Staff members were able to answer questions accurately, and residents did not express any concerns during interviews. Further, nursing staff conducted an audit of narcotic documentation and did not determine any concerns.

41. Review of the Cardinal IDT Meeting minutes

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 600	Continued From page 73 for 08/30/2021, 08/31/2021, and 09/01/2021 revealed evidence the facility had initiated five (5) times weekly IDT meetings. 42. Interview with the Consultant Pharmacist confirmed she visited the facility monthly and conducted a narcotics audit during her monthly visits. Interview with the DON, on 09/02/2021 at 9:10 AM, confirmed the Consultant Pharmacist conducted monthly visits, reviewed charts, and conducted a medication administration audit. She stated the only time the Consultant Pharmacist was not coming were times, during the last year, when the facility was in lock-down due to the pandemic.	F 600		
F 602 SS=K	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's guidelines and policies, it was determined the facility failed to ensure residents were free from misappropriation of property (narcotic pain medication) for fourteen	F 602		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 602	Continued From page 74	F 602		

(14) of forty-four (44) sampled residents.

On 07/09/2021, two Licensed Practical Nurses (LPN #1 and #2) were implicated in stealing a skid of thirty (30) tablets of Resident #17's Percocet (a narcotic opioid used to treat pain) 5/325 milligram (mg). Despite this, neither nurse was suspended pending investigation, nor did the facility take other action to prevent misappropriation.

On 07/18/2021, an additional ten (10) sampled residents had controlled medications taken, (Residents #1, #8, #34, #47, #48, #56, #60, #65, #71, and #79); and two (2) residents had controlled medications taken and replaced with a non-prescribed medication (Resident #32 and Resident #84).

On 07/20/2021, it was discovered Resident #9 had a missing skid of thirty (30) tablets of Percocet. LPN #2 was suspended pending investigation.

The facility's failure to take immediate action to prevent further misappropriation of residents' property; and failure to follow their policy has caused or is likely to cause serious injury, serious harm or death to other residents in the facility. Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) were identified on 08/20/2021 and were determined to exist on 07/09/2021, in the area of 42 CFR 483.12 Freedom from Abuse, F-602 Free from Misappropriation/Exploitation. The facility was notified of the IJ and SQC on 08/20/2021.

In addition, the facility failed to protect residents' personal funds, using their Stimulus money, from

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 602	Continued From page 75	F 602		

misappropriation by authorizing unnecessary purchases of items that were not required to achieve the goals stated in the residents' care plans and for not limiting charges on residents' personal funds to the amount not covered by Medicare or Medicaid for five (5) of forty-four (44) sampled residents (Residents #30, #34, #36, #77, and #246).

The facility provided an acceptable Immediate Jeopardy Removal Plan on 09/01/2021, with the facility alleging removal of the Immediate Jeopardy, on 08/31/2021. The State Survey Agency validated removal of the Immediate Jeopardy, as alleged on 08/31/2021, prior to exit on 09/02/2021. The facility's remaining non-compliance was at a Scope and Severity of an "E" while the facility develops and implements a Plan of Correction and the facility's Quality Assurance (QA) monitors to ensure compliance with systemic changes.

The findings include:

Review of the facility's policy titled, "Abuse, Neglect, or Misappropriation of Resident Property," last revised 03/10/2017, revealed the facility would do whatever was in its control to prevent misappropriation of resident property. Under the section on Prevention, the policy revealed staff would investigate allegations in a timely manner and develop corrective measures as indicated. Under the section on Investigation, the policy revealed the Administrator was responsible to direct the investigation and to ensure appropriate agencies were notified. The appropriate agencies included the Division of Licensure and Regulation and Adult Protective Services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 602	Continued From page 76	F 602		

Review of the facility Drug Free Workplace Policy (DFWP), revised 12/2018, revealed the company recognized the need for a safe and healthy work environment free from the use of prohibited drugs and alcohol. The policy stated employees who abused drugs or alcohol posed a serious risk to the safety, security, and welfare of residents and the company. The policy revealed all applicants for Registered Nurse (RN), Licensed Practical Nurse (LPN), or Medication Aide were required to submit a urine sample as a condition of employment. The policy defined Prohibited Conduct as possessing or using any prohibited drug or alcohol while at the workplace, while at work, or during working hours. Further Prohibited Conduct, per the policy, included refusing to submit to a drug or alcohol test required by the policy, or failing a drug or alcohol test administered in accordance with the policy. The Drug and Alcohol Testing Policy, as documented in the DFWP, revealed employees could be asked to submit to various testing for drugs and alcohol, and included the company's right to test employees in situations such as, but not limited to, a workplace injury, following an incident that resulted in an investigation such as instances of resident abuse or medication diversion, or any time at the sole discretion of the company. The policy required employees consent to the Drug Free Workplace Policy (DFWP), by signing an acknowledgement of receipt of the policy.

Review of the employee file for LPN #1 revealed a DFWP Acknowledgement of Receipt of Policy, signed on 04/07/2021.

Review of the employee file for LPN #2 revealed a DFWP Acknowledgement of Receipt of Policy,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 602	Continued From page 77	F 602		

signed on 04/25/2020.

1. Review of Resident #17's medical record revealed the resident was admitted by the facility, on 03/27/2020 with diagnoses to include Hemiplegia and Hemiparesis following Cerebral Infarction Affecting Left Non-Dominant Side, Anxiety Disorder Unspecified, and Unspecified Dementia without Behavioral Disturbance. The facility assessed Resident #17, in a Quarterly Minimum Data Set (MDS) Assessment, dated 05/17/2021, as a three (3) of fifteen (15) on the Brief Interview for Mental Status (BIMS) assessment, indicating severe cognitive impairment. Continued review revealed an order for Percocet (Schedule II narcotic pain reliever) 5/325 milligrams (mg) every eight (8) hours as needed (PRN).

Interview with the Facility Consultant, on 07/27/2021 at 1:15 PM, and again, on 08/18/2021 at 2:32 PM, revealed she had been brought in from corporate as a result of facility issues that needed to be addressed. She stated there had been an audit, on 07/09/2021, by pharmacy where a missing skid of Percocet 5/325 mg belonging to Resident #17 was discovered. The investigation revealed three (3) skids of thirty (30) tablets each had been delivered by pharmacy, on 06/28/2021, as documented by Licensed Practical Nurse (LPN) #2. However, she stated LPN #1 reported she had received only two (2) skids of thirty (30) tablets of Percocet.

Interview with the Consultant Pharmacist, on 08/13/2021 at 10:31 AM, revealed any time she noted a concern or anything that raised her attention, she included it in her pharmacy report. She revealed, on 07/09/2021, she noted a skid of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 602	Continued From page 78	F 602		

Percocet 5/325 mg missing for Resident #17 and provided that information to the facility in her report.

Review of a Packing Slip, dated 06/28/2021, revealed LPN #2 signed for ninety (90) Percocet 5/325 mg tablets, three (3) skids, for Resident #17.

Interview with LPN #2, on 07/29/2021 at 4:29 PM, revealed, on the night of 06/28/2021, LPN #1 had approached her repeatedly to let her know when the pharmacy arrived to deliver medications, as LPN #2 was working on the South Unit, and the South Unit nurse was responsible for signing for deliveries from pharmacy. LPN #2 stated she signed for three (3) skids of thirty (30) tablets each of Percocet 5/325 mg for Resident #17, on the night of 06/28/2021. However, she stated she was informed, after the discovery of a missing skid on 07/09/2021, that LPN #1 alleged only receiving two (2) skids.

Review of Resident #17's Controlled Substance Count Record for Percocet 5/325 mg revealed a sheet, 2 of 3, delivered on 06/28/2021, with a receiving signature and date on the sheet. Despite repeated requests, the facility was unable to provide either sheet 1 of 3, or a Controlled Substance Count Record for Percocet 5/325 mg covering the time frame 06/19/2021 through 07/08/2021. Sheet 3 of 3 was the sheet missing as identified by pharmacy on 07/09/2021. Review of sheet 2 of 3 revealed LPN #1 signed the first tablet out, at 12:00 AM on 07/09/2021, with LPN #7 replacing her on the medication cart on the morning of 07/09/2021. Review of Resident #17's MAR for 07/2021 revealed eighty-two (82) doses of Percocet 5/325 mg had been

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 602	Continued From page 79	F 602		

administered; however, no staff signed on the back of the MAR indicating the administration or the results, with a pain assessment.

Interview with the DON, on 08/04/2021 at 8:28 AM, and again, on 08/05/2021 at 12:35 PM, revealed the first she heard of missing Percocet was when the pharmacy had determined a skid to be missing belonging to Resident #17 in an audit conducted on 07/09/2021. She stated pharmacy had delivered three (3) skids of thirty (30) tablets each of Percocet 5/325 mg for Resident #17, on 06/28/2021, as signed by LPN #2. However, she stated LPN #1 stated she only received two (2) skids from LPN #2. The DON revealed neither LPN #1 nor LPN #2 were suspended.

2. Interview with the Facility Consultant, on 07/27/2021 at 1:15 PM, revealed, on 07/18/2021, the DON informed her LPN #2 had found two (2) pills taped into a Roxicodone skid belonging to Resident #32, which were not Roxicodone; followed by a second resident, Resident #84, who also had two (2) pills taped into an Roxicodone skid which were not Roxicodone. She revealed the pills used to replace the Roxicodone were identified as Primidone, an anti-seizure medication. The Facility Consultant revealed police were present and had already detained LPN #1. She stated it was additionally discovered LPN #1 had taken medications from skids but not signed them out for Residents #1, #8, #34, #47, #48, #56, #60, #65, #71, and #79.

Review of a draft of a KYIBRS (Kentucky Incident Based Reporting System) Report of incident 21-0927-092, received on 07/18/2021 at 8:30 PM, revealed police were contacted on 07/18/2021 by Social Services Clinician I (SSCI) informing them

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 602	Continued From page 80	F 602		

LPN #1 was actively stealing resident medications at the facility. The Police report revealed LPN #1 was asked to empty her pockets and had an unmarked pill bottle with several different types of pills inside, along with several loose pills in her pocket. Review of the evidence revealed the following were found on LPN #1: one (1) Primidone 50 mg tablet along with three (3) empty packs, one (1) Oxycodone 10/325 mg, one (1) Tramadol 50 mg, two (2) Hydrocodone 10/325 mg, three (3) Gabapentin 600 mg, five (5) Gabapentin 300 mg, one (1) empty skid of Roxicodone labeled for Resident #32, and one (1) pack of birth control pills labeled for LPN #1. Continued review of the report revealed LPN #1 admitted to taking medications from the facility, as well as changing some narcotics out and replacing them with Primidone 50 mg, without regard for how this would affect the residents. When asked by officers what drugs would be found in her system upon drug testing her, LPN #1 revealed she would have Hydrocodone, Percocet, Gabapentin, and Marijuana (a recreational psychoactive drug) in her system. LPN #1 stated she did not document narcotics removed from her medication cart until the end of the shift and stated this was common practice among nurses at the facility. LPN #1 was charged with two (2) counts of Wanton Endangerment in the First Degree; thirteen (13) counts of Theft by Unlawful Taking, Controlled Substance; three (3) counts of Possession of a Controlled Substance; and two (2) counts of Abuse and Neglect of an Adult Person.

Interview with LPN #2, on 07/29/2021 at 4:29 PM, revealed she was working the night of 07/18/2021, and was administering medications, when she noted Resident #32's narcotic skid had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 602	Continued From page 81	F 602		

tape on it, and the medications taped inside were thicker than the other medications in the skid. She stated she contacted the DON and had State Registered Nurse Aide (SRNA) #20 witness as she searched the rest of the medication cart, and found two (2) more medications taped in place of Resident #84's narcotics.

Interview with SRNA #20 on 08/11/2021 at 4:13 PM revealed LPN #2 showed him on 07/18/2021 taped skids belonging to Resident #32 of two (2) Roxicodone that had been replaced with something else. He revealed, due to that, she wanted to check the rest of the narcotics in the drawer, and they found Resident #84 also had two (2) Roxicodone tablets removed from a skid and replaced with something else.

Continued interview with the DON, on 08/04/2021 at 8:28 AM, revealed she received a call from LPN #2 on the night of 07/18/2021 at 7:30 PM, who revealed she had found two (2) of Resident #32's narcotics had been replaced with other pills. The DON stated she received a text, at 7:47 PM from LPN #2, that she had found a second Resident, #84, who also had two (2) narcotics replaced with other pills.

Continued interview with the DON, on 08/04/2021 at 8:28 AM, revealed she and the Administrator came to the facility, a little after 9:00 PM on 07/18/2021, and did medication cart audits, and the Administrator made copies of everything that was missing that night, however the DON was unaware of where those copies were. She stated she and the Administrator were following corporate guidance to destroy any medications that were taped in skids. She stated she and the Administrator went through LPN #1's cart

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 602	Continued From page 82	F 602		

together and all medication carts were audited by 2:00 AM on 07/19/2021, when she left the facility. The DON revealed she did not have a full record of what was wasted on the evening of 07/18/2021 through the morning of 07/19/2021.

Interview with RN #4, on 07/28/2021 at 1:20 PM, revealed she was called to the facility, on the night of 07/18/2021, by the DON to help audit medication carts. She revealed several narcotics were missing from the cart belonging to LPN #1.

Interview with LPN #12, on 08/13/2021 at 8:21 AM, revealed she was working, on the night of 07/18/2021, when another nurse and the SSCI came around checking medication carts. She revealed her cart had no problems, and the only cart she thought had an issue was LPN #1's cart.

A) Review of Resident #65's medical record revealed the facility assessed Resident #65, in a Quarterly MDS Assessment, dated 06/29/2021, as fifteen (15) of fifteen (15) on the BIMS, indicating no cognitive impairment. Continued review revealed orders for Neurontin (Gabapentin) 200 mg three times per day, dated 06/04/2021; and Roxicodone 5 mg every six (6) hours, dated 06/21/2021.

Review of Resident #65's Controlled Substance Count Record for Roxicodone 5 mg revealed a missing (not documented) tablet on 07/18/2021.

B) Review of Resident #34's medical record revealed Resident #34 was admitted by the facility, on 12/09/2019, and was assessed in a Quarterly MDS Assessment, dated 06/29/2021, as fifteen (15) of fifteen (15) on the BIMS, indicating no cognitive impairment. Continued

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 602	Continued From page 83	F 602		

review revealed orders for Neurontin 100 mg every AM, dated 04/19/2021; and orders for Neurontin 300 mg at bedtime, dated 04/16/2021.

Review of Resident #34's Controlled Substance Count Record for Neurontin 300 mg revealed one (1) missing tablet on 07/18/2021, typically given between 8:00 PM and 9:00 PM, not signed out.

C) Review of Resident #48's medical record revealed the resident was admitted by the facility, on 07/27/2018, and was assessed in a Quarterly MDS Assessment, dated 06/15/2021, as thirteen (13) of fifteen (15) on the BIMS, indicating no cognitive impairment. Continued review revealed an order for Tramadol (a synthetic opioid pain reliever) 50 mg three times per day, dated 05/25/2021.

Review of Resident #48's Controlled Substance Count Record for Tramadol 50 mg revealed one (1) missing tablet, typically given at 8:00 PM, noted by the DON, on 07/18/2021 at 11:45 PM.

D) Review of Resident #84's medical record revealed Resident #84 was admitted by the facility, on 09/11/2020, and was assessed in a Quarterly MDS Assessment, dated 04/26/2021, as fourteen (14) of fifteen (15) on the BIMS, indicating no cognitive impairment. Continued review of Resident #84's medical record revealed an order, dated 03/23/2021, for Neurontin 100 mg at bedtime; and an order, dated 05/10/2021 for Roxicodone 5 mg every eight (8) hours PRN.

Review of Resident #84's Controlled Substance Count Record for Roxicodone 5 mg, delivered on 06/10/2021, revealed frequent use of once a day, with use twice a day on multiple occasions. LPN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 602	Continued From page 84	F 602		

#1 signed out eight (8) tablets on the record, with two (2) tablets documented as replaced with Primidone on 07/18/2021. Review of the MAR for 07/2021 revealed a dose of Roxicodone 5 mg was administered on 07/08/2021, but not documented on the controlled Substance Count Record. Further review revealed ten (10) documented administrations during 07/2021 on the MAR, with only six (6) documented on the back of the MAR. Review of the 06/2021 MAR revealed, of twenty-two (22) doses administered, only six (6) were documented on the back of the MAR. The last dose administered on the MAR was, on 07/18/2021 at 8:00 PM, by LPN #2.

Interview with LPN #6, on 08/10/2021 at 2:40 PM, revealed she had observed, on the MAR, that Resident #84 did routinely receive pain medications with LPN #1 at night, although he did not routinely receive them when LPN #6 was working during the day.

E) Review of Resident #32's medical record revealed the resident was admitted by the facility, on 04/01/2020, and was assessed in the Quarterly MDS Assessment, dated 06/01/2021, as a seven (7) of fifteen (15) on the BIMS, indicating severely impaired cognition. Continued review revealed an order for Roxicodone 5 mg every eight (8) hours PRN, dated 04/01/2020.

Review of Resident #32's Controlled Substance Count Record for Roxicodone 5 mg, initiated on 06/15/2021, revealed the last two (2) medications on the skid had been replaced with Primidone. Review of Resident #32's MAR for 07/2021 revealed two (2) doses of Roxicodone 5 mg documented as given for 07/03/2021; however, the back of the MAR only listed one (1) dose was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 602	Continued From page 85	F 602		

given, as did the Controlled Substance Count Record. Review of the MAR for 06/2021 revealed twenty-three (23) doses of Roxicodone 5 mg administered; however, only ten (10) were documented on the back of the MAR.

F) Review of Resident #71's medical record revealed the resident was admitted by the facility, on 05/10/2018, and was assessed in the Quarterly MDS Assessment, dated 07/13/2021, as fifteen (15) of fifteen (15) on the BIMS, indicating no cognitive impairment. Continued review revealed an order for Gabapentin 300 mg three times/day, dated 07/11/2019.

Review of Resident #71's Controlled Substance Count Record for Gabapentin 300 mg, delivered on 07/13/2021, revealed a missing 8:00 PM dose on 07/18/2021, noted by the DON at 11:50 PM.

G) Review of Resident #1's medical record revealed the resident was admitted by the facility, on 12/22/2016, and was assessed in the Quarterly MDS Assessment, dated 05/03/2021, as fifteen (15) of fifteen (15) on the BIMS, indicating no cognitive impairment. Continued review revealed an order for Norco (Schedule II narcotic pain reliever) 5/325 mg twice a day, dated 07/06/2021; an order for for Lyrica (a nerve pain reliever) 150 mg twice a day, dated 06/04/2021; and an order for Gabapentin 300 mg at bedtime, dated 01/06/2021.

Review of Resident #1's Controlled Substance Count Records revealed one (1) dose each of Norco 5/325 mg, Lyrica 150 mg, and Gabapentin 300 mg were missing, on 7/18/2021, and not documented as given.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 602	Continued From page 86	F 602		

H) Review of Resident #8's medical record revealed the resident was admitted by the facility, on 03/12/2020, and was assessed in the Significant Change of Status Assessment, dated 05/05/2021, as three (3) of fifteen (15) on the BIMS, indicating severe cognitive impairment. Continued review revealed an order for Hydrocodone 5 mg four (4) times per day, dated 05/26/2021.

Review of Resident #8's Controlled Substance Count Record for Hydrocodone 5 mg revealed one (1) dose missing, on 07/18/2021, and not documented as given.

I) Review of Resident #47's medical record revealed the resident was readmitted by the facility, on 09/01/2020, and was assessed in a Quarterly MDS Assessment, dated 06/15/2021, as four (4) of fifteen (15) on the BIMS, indicating severe cognitive impairment. Continued review revealed an order for Ultram (Tramadol) 50 mg every eight (8) hours PRN, dated 05/28/2021.

Review of Resident #47's Controlled Substance Count Record for Ultram 50 mg revealed one (1) dose missing, on 07/18/2021, and not documented as given.

J) Review of Resident #56's medical record revealed the resident was admitted by the facility, on 11/25/2013 and was assessed in the Quarterly MDS Assessment, dated 06/28/2021, as six (6) of fifteen (15) on the BIMS, indicating severe cognitive impairment. Continued review revealed an order for Percocet 10/325 mg every four (4) hours PRN, dated 04/19/2021.

Review of Resident #56's Controlled Substance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 602	Continued From page 87	F 602		

Count Record for Percocet 10/325 mg revealed one (1) dose missing, on 07/18/2021, and not documented as given.

K) Review of Resident #60's medical record revealed the resident was admitted by the facility, on 11/01/2019, and was assessed in the Quarterly MDS Assessment, dated 06/29/2021, as fifteen (15) of fifteen (15) on the BIMS, indicating no cognitive impairment. Continued review revealed an order for Gabapentin 600 mg four (4) times a day, dated 01/06/2021; and an order for Hydrocodone 10 mg every eight (8) hours PRN, dated 06/21/2021.

Review of Resident #60's Controlled Substance Count Record for Hydrocodone 10 mg revealed one (1) dose missing, on 07/18/2021 and not documented as given. Further review revealed, for Gabapentin 600 mg revealed one (1) dose missing, on 07/18/2021, and not documented as given.

L) Review of Resident #79's medical record revealed the resident was admitted by the facility, on 10/08/2019 and was assessed in the Quarterly MDS Assessment, dated 04/22/2021, as thirteen (13) of fifteen (15) on the BIMS, indicating no cognitive impairment. Continued review revealed an order for Ultram 50 mg twice a day, dated 05/28/2021.

Review of Resident #79's Controlled Substance Count Record for Ultram 50 mg revealed one (1) dose missing, on 07/18/2021, and not documented as given.

3. Review of Resident #9's medical record revealed the resident was readmitted by the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 602	Continued From page 88	F 602		

facility, on 05/03/2021, and was assessed in the Admission MDS Assessment, dated 05/09/2021, as a fifteen (15) of fifteen (15) on the BIMS, indicating no cognitive impairment. Continued review of Resident #9's medical record revealed an order for Klonopin (a nerve pain reliever) 1 mg twice a day PRN, dated 05/05/2021 (was changed to twice a day, on 07/08/2021); an order for Neurontin (Gabapentin) 600 mg four (4) times a day, dated, 05/05/2021; and an order for Percocet 7.5/325 mg every eight (8) hours PRN, dated 05/27/2021 (was changed to twice a day, on 07/12/2021).

Interview with Resident #9, on 07/28/2021 at 3:01 PM, revealed one morning he/she had asked for pain medication, and staff informed him/her they could not provide it as they had been administered at 2:30 AM. The resident shared he/she had not received pain medication, at 2:30 AM, and that LPN #1 had been working the night the medication was allegedly administered. Resident #9 stated he/she consistently had pain medication signed out and not given to him/her when LPN #1 worked. Resident #9 stated he/she had reported it to other staff, but remembered reporting it to SRNA #9, who was also a Kentucky Medication Aide (KMA), able to administer medications.

Interview with SRNA #9, on 08/02/2021 at 2:55 PM, revealed Resident #9 had one (1) scheduled Percocet and one (1) scheduled as a PRN pain medication. She stated she did not recall any instance in which Resident #9 shared with her not getting a medication, but if he/she had, she would check the MAR, and if Resident #9 stated he/she had not received something documented on the MAR, she would share this information with her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 602	Continued From page 89	F 602		

charge nurse. SRNA #9 stated she had not noticed any irregularities on the MAR.

Review of Resident #9's Controlled Substance Count Record for Percocet 7.5/325 mg, initiated on 06/29/2021 revealed two (2) doses were signed by LPN #1 during her 07/05/2021, 7:00 PM to 07/06/2021, 7:00 AM shift on the North Unit. Per the record, one (1) Percocet tablet was documented as administered, on 07/05/2021 at 7:30 PM, and a second tablet was documented as administered, on 07/06/2021 at 2:30 AM. Although LPN #1 signed on the MAR for the first dose, she did not sign for a second dose, and there was no indication on the back of the MAR indicating these doses were given, for what purpose, or whether or not doses were effective. Continued review revealed Resident #9 would normally receive a dose of Percocet 7.5/325 mg between 8:00 AM and 9:00 AM each morning.

Interview with the Facility Consultant, on 07/27/2021 at 1:15 PM, revealed, on 07/20/2021, the DON determined, in an audit with LPN #5, and noted the Shift Change Count Sheet signed by LPN #2 was four (4) less than the previous Shift Change Count Sheet. The previous Shift Change Count Sheet had been misplaced, necessitating the need for LPN #2 to complete a new one at the start of her shift. She revealed the DON and LPN #5 could not find skid 2 of 2 (30 tablets) for Percocet 7.5/325 mg for Resident #9. She revealed Resident #9's medication had been delivered, on 07/15/2021, and not enough would have been administered to account for a missing skid sheet.

Review of Resident #9's Controlled Substance Count Records revealed one (1) skid, skid two (2)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 602	Continued From page 90	F 602		

of two (2), was delivered on 07/15/2021.

Review of a Shift Change Controlled Substance Count Check form for resident rooms 136 to 149 revealed an incomplete form with LPN #2 not signing in on form next to LPN #6 on 07/18/2021 at 6:30 PM, which indicated forty-six (46) count sheets remaining. There was still room at the bottom of the sheet for two more changes of shift. Review of the following form revealed LPN #2 indicated the sheet count was 42, and completed two sheets on the 07/18/2021 at 7 PM to 07/19/2021 at 7 AM shift, bringing the count to 40 sheets.

Interview with LPN #5 on 08/03/2021 at 4:20 PM revealed when she came in on the morning of 07/20/2021, the DON had asked her to go through a med cart with her. She stated they noted a narcotic skid was on skid two (2) of two (2) for a medication that had just been delivered a week before for Resident #9. She revealed there was also a discrepancy in the Shift Change Count Sheets, however, looking at the cart she would not have known that, as the previous Shift Change Count Sheet had been removed from the cart. She revealed after the previous Shift Change Count Sheet had been located, it was determined there was a discrepancy of four (4) skids unaccounted for. She revealed one (1) skid was missing for Resident #9.

Continued interview with LPN #2 revealed, following the arrival of the DON and Administrator, they identified multiple narcotic skids with tape on them, and were busy wasting medications on the night of 07/18/2021 through the morning of 07/19/2021. She revealed some skids had tape all over them, and had to be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 602	Continued From page 91	F 602		

wasted, while other just had pills removed due to tape. She revealed when individual pills were taken from her cart, both she and the removing staff signed on the narcotics sheet, but the Administrator and DON had taken the Shift Change Count Sheet, which tracked the number of controlled substance skids in the cart. She stated she started another sheet, and counted forty-two (42) sheets.

Interview with the DON on 08/04/2021 at 8:28 AM revealed she was conducting narcotic count of the carts on 07/20/2021 with LPN #5, and noticed Resident #9 was missing skid two (2) of two (2) of a prescription that had just been filled on the night 07/15/2021. She revealed LPN #2 had never signed in to the cart on 07/18/2021, and there had been forty-six (46) sheets when LPN #6 had left on 07/18/2021. She revealed the previous Shift Change Count Sheet had been misplaced (was discovered later), and when LPN #2 started a new Shift Change Count Sheet she counted forty-two (42) skids of controlled medications. She revealed of the four (4) skids missing, one was determined to be Lomotil that was wasted belonging to Resident #19, another was an empty skid belonging to Resident #84 or Resident #32 which would have come off the cart, another skid belonging to Resident #29 had been completed and pulled. She revealed it was determined Resident #9 had a missing skid of Percocet. She revealed the decision was made to suspend LPN #2 at that time.

Interview with the Medical Director, on 08/10/2021 at 4:11 PM, revealed when medications were not administered as prescribed, it could lead to problems, in the case of residents with pain medications, could lead to untreated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 602	Continued From page 92	F 602		

pain.

Interview with Advanced Registered Nurse Practitioner (ARNP) #1, on 08/11/2021 at 11:44 AM, revealed her concern with residents not receiving their controlled pain medication would be residents not having their pain controlled.

The previous Administrator was not available during the course of the survey, and did not return calls, the last of which was attempted on 08/20/2021 at 9:48 AM.

Interview with the Interim Administrator, on 08/20/2021 at 10:24 AM, revealed his expectation was the facility would have a good investigation program, a good audit program, and a good count program for narcotics that started when they come in to the facility, to limit the possibility of drug diversion occurring, which resulted in misappropriation of residents' medications.

4. Review of the facility's policy titled, "Resident Fund Management System," no date, revealed that each resident that entered the facility had the opportunity to establish a Resident Trust account (RTA). There was no minimum or maximum deposit to open the account, and it was solely for the convenience of the resident. Per the policy, it stated to protect the integrity of the RTA and minimize the risk of embezzlement, there was a division of duties in the facility. The Administrator was the primary check signer, along with the Director of Nursing (DON); and the Business Office Manager (BOM) should monitor the balance report monthly to identify any Medicaid recipient whose balance was within two hundred dollars ($200) of the State's limit.

Review of 42 CFR 483.10(f)(11) revealed the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 602	Continued From page 93	F 602		

facility must not impose a charge against the personal funds of a resident for any item or service for which payment was made under Medicaid or Medicare (except for applicable deductible and coinsurance amounts). In addition, the regulation stated the facility could only charge a resident for any non-covered item or service if such item or service was specifically requested by the resident. Further review revealed the facility must inform, orally and in writing, the resident requesting an item or service for which a charge would be made that there would be a charge for the item or service and what the charge would be.

Review of the facility's document Guideline: Stimulus and Representative Payee Responsibilities, dated 05/29/2020 and updated 07/21/2021, revealed Stimulus money was to be used solely at the discretion of the resident or responsible party. Under no circumstances should the Stimulus money be used to pay resident liability at the facility. The Stimulus money did not count as resources to affect federal programs like Medicaid for a year and any attempt by the facility to seize the money was unlawful. Further, the Guideline stated that an Interdisciplinary Team (IDT) meeting should be held with residents and responsible parties to discuss what could/could not be purchased with the Stimulus monies, who should be invited, and what to do if the facility staff became aware of misuse of the monies.

Review of the Quality Assurance Performance Improvement (QAPI) Meeting minutes, dated 07/21/2021, revealed Corporate became aware the RTA Stimulus checks were used to purchase Durable Medical Equipment (DME) that should

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 602	Continued From page 94	F 602		

have been supplied by the facility. On 07/22/2021, per the minutes, the Regional Business Office (RBO) and Corporate Compliance (CC) conducted an investigation and audits of accounts and items purchased. Items identified that the facility should have paid for were to be reimbursed by 07/27/2021. RBO and CC would conduct monthly audits of RTA's for two (2) months to validate purchases met regulations. On 07/23/2021 a QAPI meeting was held to discuss the process improvement plan (PIP) of self-identified issuesand all actions taken. The Investigation Summary dated 07/21/2021 revealed that facility staff, in good faith, was assisting residents to "spend down" their RTA in order to maintain Medicaid eligibility. Continued review revealed education was provided in May 2020 to assist facilities with understanding the current guidelines for spending down the RTA. The Summary stated the facility believed they were following the guidance correctly.

Review of the Stimulus Payment Tracking Report, dated 01/01/2021 through the present, revealed all four (4) sampled residents received Stimulus money that was added to their RTA's. Continued review revealed that at various times in 2021, there were large sums of money authorized to be disbursed from their RTA to pay for personal items.

1. Review of Resident #77's RTA revealed he/she received Stimulus money, on 05/28/2020 for $1200, 01/04/2021 for $600, and 04/07/2021 for $1400. On 02/08/2021, authorization for miscellaneous payments from patient trust accounts revealed the facility, as Resident/Legal Representative, authorized payment of $3,334.74

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 602	Continued From page 95	F 602		

for personal items that included a forty inch television for $482.99 and an Optima Evolution Chair for $2,522.99; that authorization form was signed by the previous Administrator.

Review of Resident #77's progress notes, dated October 2020 until March 2021, revealed no documented evidence the POA was contacted related to the television or chair. There were multiple notes where the POA was notified of positive COVID results and testing for COVID. Review of Occupational Therapy notes revealed no documented evidence of an assessment of the evolutionary chair. Interview, on 08/18/2021 at 10:48 AM, with the DON revealed there were no therapy notes about the resident's evolutionary chair. Review of Resident #77's care plan, dated 10/2019, revealed the evolutionary chair was for comfort and positioning.

Review of Resident #77's financial statements, dated 08/13/2021, revealed a total of $2,853.42 was refunded to Resident #77's RTA account. This amount included the cost of the chair, taxes, shipping, and interest for April-July 2021.

Attempts to reach Resident #77's Power-of-Attorney (POA) via phone, on 08/11/2021 at 10:15 AM and 08/18/2021 at 9:30 AM, were unsuccessful; the voice mail was not set up.

2. Review of Resident #36's RTA revealed he/she received Stimulus monies on 04/07/2021 for $1400. On 06/09/2021, authorization for miscellaneous payments from patient trust accounts revealed the facility, as Resident/Legal Representative, authorized payment of $1,286.82 for personal items that included a forty inch

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 602	Continued From page 96	F 602		

television for $299.99 and a microAIR MA500 alternating pressure low air loss mattress system for $894.99; that authorization form was signed by the previous Administrator.

Interview with Resident #36, on 08/17/2021 at 8:48 AM, revealed he/she was resting in bed, winged mattress observed, head of bed elevated; when asked about the previous mattress (air mattress), the resident stated he/she had told them he/she did not want the mattress. Resident #36 stated he/she was unable to remember who he/she told, just "the one that brought it." The resident also stated the winged mattress was comfortable. Resident #36, per the interview, stated there had not been the need for a new television, and he/she did not request it. Although, Resident #36 stated, this one was bigger, he/she could see better, and it could be given to his/her daughter.

Interview with Licensed Practical Nurse (LPN) #7, on 08/14/2021 at 10:29 AM, revealed she did not know whose idea it was to get Resident #36 the air mattress. She stated she was confused as to why because the resident had a winged mattress to prevent falling out of bed, and an air mattress made it easier to slide out of bed. The winged mattress was taken off the bed, and the air mattress was put on the bed. LPN #7 stated Resident #36 slid out of the bed three (3) times that night, with no serious injuries, and night shift staff took it upon themselves to remove the air mattress and put the winged mattress back on the bed. Per LPN #7, Resident #36 never complained that the winged mattress was uncomfortable.

Interview with the Minimum Data Set (MDS)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 602	Continued From page 97	F 602		

Registered Nurse (RN) #7, on 08/17/2021 at 9:20 AM, revealed that typically mattresses were used as a fall interventions and was unaware Resident #36 had issues with the winged mattress. She stated a resident getting a new mattress would not be a decision she would make by herself because there were different factors involved. She stated Resident #36 had not been on the air mattress for a day before he/she fell out of the bed, and it was again replaced by the winged mattress. Per the interview, she stated the decision to replace the mattress was made by the former Administrator, and she was uncertain of her reasoning.

Interview with Staff Development Coordinator/Quality Improvement (SDC/QI) nurse, on 08/17/2021 at 10:21 AM, revealed all she knew was that the former Administrator ordered Resident #36 the air mattress for comfort. However, she stated Resident #36 had not complained the bed was uncomfortable nor had requested a new mattress.

Review of Resident #36 financial statements, dated 07/27/2021, revealed $970.83 was refunded to Resident #36's RTA account.

3. Review of Resident #30's RTA revealed he/she received Stimulus money on 05/03/2020 for $1200, on 01/04/2021 for $600, and on 04/07/2021 for $1400. On 03/26/2021, authorization for miscellaneous payments from patient trust accounts revealed Resident #30, as the Resident/Legal Representative, authorized payment, by signature, of $1245.49 for personal items that included a forty inch television for $482.99 and a Lift Chair for $617.00.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 602	Continued From page 98	F 602		

Review of an authorization, dated 06/09/2021, signed by the previous Administrator and co-signed by Resident #30, revealed an order for a floor lamp, top of the line bedside table, and a case of pillow covers.

Interview with Resident #30, on 08/10/2021 at 3:50 PM, revealed when the resident was asked about the RTA and who bought items such as clothing for him/her, the resident stated he/she did not need anything. Resident #30 seemed a little confused.

Attempt to interview Resident #30, on 08/19/2021 at 11:52 AM, was unsuccessful. Resident #30 ignored the State Survey Agency (SSA) Surveyor's conversation and stared blankly, straight ahead. Resident #30's roommate stated Resident #30 would ignore someone if he/she did not want to talk. Observation of Resident #30's room, at this time, revealed the floor lamp, lift chair, television, and top of the line bedside table in the room.

Review of Resident #30's financial statements, dated 07/23/2021, revealed a total of $507.61 was refunded to Resident #30's RTA account.

4. Review of Resident #34's RTA revealed he/she received Stimulus monies on 04/29/2020 for $1200, on 01/04/2021 for $600, and on 04/02/2021 for $1400. On 02/10/2021, an authorization for miscellaneous payments from patient trust accounts revealed Resident #34 as his/her Resident/Legal Representative, with his/her signature,. and it was co-signed by the former Administrator. Further review revealed the authorization was for payment of $3639.85, for personal items that included a forty inch television

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 602	Continued From page 99	F 602		

for $482, a microAIR MA500 alternating pressure low air loss mattress system for $892.99, a Matrix 4100 bed frame for $932.99, a 4-drawer chest for $390.00, and a 3-drawer bedside cabinet for $237.00.

Interview with Resident #34, 08/19/2021 at 10:20 AM revealed he/she "ordered'em" but was not able to say how he/she knew to order those specific items and did not look at a catalogue.

Observation of Resident #34's room, with the DON at the same time, revealed the cabinet, chest and television were in Resident #34's room. However, per observation, the bedframe was not in his/her room.

Interview with the DON, 08/19/2021 at 10:20 AM revealed the mattress was on his/her bed but was unaware of where the bedframe was. The DON stated she would get with Maintenance and locate the bed frame. She also stated she was unaware of any items ordered for residents because the former Administrator kept staff out of the loop as to what she was doing with the Stimulus money.

Interview with the Maintenance Director, on 08/19/2021 at 1:40 PM, revealed he inspected all resident electrical items for safety. He stated Resident #34 did receive a new bed frame and mattress, which was ordered by the former Administrator. However, he stated, the bed did not have a headboard nor a footboard. In addition, he stated the wheel locking mechanism did not meet safety standards for locking tightly enough to prevent the bed from slipping if a resident tried to get out of the bed. Therefore, he stated, the bed frame was never put in Resident #34's room. He stated the former Administrator

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 602	Continued From page 100	F 602		

said she would take care of making it right, and the bed frame was still in the Maintenance storage area. The Maintenance Director stated the former Administrator acted alone when ordering the resident items.

Review of Resident #34's financial statements, dated 07/23/2021, revealed a total of $3238.88 was refunded to Resident #34's RTA account.

5. Telephone interview with Resident #246's daughter/POA, on 08/19/2021 at 10:36 AM, revealed the resident had been a patient at the facility but was now deceased. She stated the facility said they had to do something with the resident's Stimulus money and had to spend down the RTA within the year, and several items were purchased. Further, she stated, after Resident #246 passed away, his/her sister did pick up the television that had been purchased, but the resident already had one, and she did not know why the facility bought a new one. Additionally, she stated the family was able to take home the lightweight wheelchair ($129.31) that was used to take Resident #246 out of the facility for visits, and she did not know about RoHo cushion ($75.00) purchase. She stated the lift chair ($617.00) and the Panacea Reclining Wheelchair ($363.99), which had been purchased, were left at the facility because they were too heavy for the family to move. She stated the family was not reimbursed for the $1700 spent. The interview ended by Resident #246's daughter stating that if facility staff felt like the resident needed those items, that was fine, but she did not sign anything nor was the RTA reimbursed any monies. She stated the facility called her after several items had been purchased.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 602	Continued From page 101	F 602		

Review of the Stimulus Payment Tracking Report revealed the facility reimbursed Resident #246's RTA account $1657.60 on 07/13/2021.

Interview with the Accounts Receivable/Resident Trust Accounts Clerk, on 08/13/2021 at 2:05 PM, revealed the facility was given information in 05/2020, she thought from Corporate, that Resident Stimulus checks would not affect RTA for a year. She stated Stimulus monies were not used until this year (2021) to buy residents durable medical equipment (DME). She stated the former Administrator initiated using RTA for DME that should have been paid for by facility.

Additional interview with the Accounts Receivable/Resident Trust Accounts (RTA) Clerk, on 08/19/2021 at 9:15 AM, revealed when she questioned the former Administrator about using Stimulus monies, the Administrator told her purchased items could be used or were needed by the residents. The Clerk stated she signed the requisition slips as a witness for all the ordered items because she was told by the former Administrator she was always the witness. Further, she stated when she showed the former Administrator the 05/2020 Corporate documentation regarding RTA's and purchases, the former Administrator told her that as long as they could use the purchased items at the facility, it was okay. Further interview revealed the Clerk did not report the former Administrator's actions to the Regional Vice President or the Corporate Compliance Hotline because the former Administrator had told her it was okay to use the monies. She stated, after Corporate was aware that RTA's had been used to buy DME for residents, the affected residents were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 602	Continued From page 102	F 602		

reimbursed.

Interview with the DON, on 08/13/2021 at 4:20 PM, revealed she had no direct knowledge of Stimulus purchases or reimbursements. She did remember, in a daily morning meeting (unable to remember when, formal notes not taken), the Administrator talked about using Stimulus monies to buy residents special air mattresses that the facility should supply. The DON stated when the former Administrator was questioned if she was allowed to do that, the Administrator stated it was okay as long as a resident would be using it. The DON stated staff did not question her again about anything with resident financials. She stated she did not report this to anyone because she had not been notified of the Principal (Corporate) directive regarding Stimulus checks, and therefore, did not know to notify Corporate Compliance or the Regional Vice President.

Interview with the DON and Interim Administrator, on 08/16/2021 at 2:30 PM, revealed they were unaware of what system or process was in place that caught the DME purchases. The Interim Administrator stated he did not arrive at facility until 07/26/2021 and that was one reason he did not know.

Interview with the Interim Administrator, on 08/20/2021 at 10:24 AM, revealed the Administrator did not have any ability to move money or access the general accounting ledger. Administrators could order stuff but could not move money around or take money out of a resident trust. He stated the Regional Vice President (RVP) was oversight manager for the Administrator. He stated, until July, there was no awareness the former Administrator had used

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 602	Continued From page 103	F 602		

RTA's money to purchase items the facility should have furnished and that this had happened as early as January or February 2021. He stated the facility needed a more regular audit of the business office, and this was going to be put in place. He stated the facility did have audits that audits that looked into those things that were usually done annually, or sometimes semi-annually. He stated there were different price levels where the RVP was triggered to look at a purchase. He stated he expected if the Administrator was using resident money for DME purchases, someone would call Corporate. He stated he believed staff had been intimidated by the former Administrator. He stated he wished the incidents had been reported earlier to someone.

Interview with the Regional Vice President (RVP), on 08/20/2021 at 3:03 PM, revealed there was a letter sent out in 05/2021 regarding how Stimulus checks should be spent and Stimulus monies would not affect resident Medicaid status for at least a year. An additional update was sent 07/21/2021 reiterating Stimulus expenditures and the public health emergency was in effect until October 2021. He stated he was not aware Stimulus monies were used inappropriately and that is something that is taken very seriously. He stated the facility had addressed it through a review, going back, and looking at processes from a Quality Assurance standpoint. The facility had made some refunds of purchased items that the facility should or would have normally purchased. He stated those items were not expensive enough to require prior approval. The RVP stated he did not have a great answer regarding what system should have caught this, but he thought the former Administrator had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 602	Continued From page 104	F 602		

worked her way around the system.

The facility provided an acceptable Immediate Jeopardy Removal Plan, on 09/01/2021, that alleged removal of the Immediate Jeopardy (IJ) on 08/31/2021. The facility implemented the following:

1. On 07/09/2021, a Performance Improvement Plan (PIP) was initiated related to Missing Narcotics which was reported to the Office of Inspector General- Division of Health Care (State Survey Agency), at 4:30 PM on 07/09/2021.

2. On 07/09/2021, the Unit Manager and MDS Nurses audited narcotics in the remaining medication carts as the North back hall had a blister pack missing. All count sheets were found to match the number of skids. Staff signing in and out of a medication cart was expected on controlled substance check sheets.

3. On 07/09/2021, the Staff Development Coordinator (SDC) initiated staff education. The topics included narcotic count, counting sheets added and subtracted, signing packing slips, and logging narcotics into the narcotic books.

4. On 07/12/2021, 07/13/2021, 07/20/2021 to 07/22/2021, 07/24/2021 to 08/13/2021, and 08/22/2021 to 08/29/2021, an RN Corporate (Facility) Consultant worked in the facility. An RN Corporate Nurse would continue to be at the facility five (5) days a week through September 2021, ensuring residents remained free from abuse, neglect, and exploitation, and policy and procedures were followed, including the active plan of correction. An RN Corporate Nurse could complete any audit in place of the assigned

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 602	Continued From page 105	F 602		

auditor and would help ensure the facility followed policy and took immediate action to prevent further abuse, neglect, and exploitation.

5. On 07/12/2021, the DON initiated additional education which included signing as needed (PRN) medications on the back of the medication administration record (MAR), giving discontinued narcotics to the DON, and labeling declining count sheets.

6. On 07/18/2021, the Licensed Practical Nurse (LPN) #1 was removed from the facility and arrested by Police. LPN #1 was automatically suspended.

7. On 07/18/2021, an Addendum was added to the PIP due to findings that Percocet tablets were replaced with Primidone on Resident #84 and Resident #32 medications.

8. On 07/18/2021, an ad hoc meeting was held to review the additional action steps with the interdisciplinary team (IDT). The IDT was comprised of the Administrator, DON, Quality Improvement Nurse/Staff Development Coordinator (SDC/QI), Minimum Data Set (MDS) Nurse, Unit Manager, Activity Director, Social Services Director, and Dietary Manager. The IDT agreed actions taken would include abuse/neglect education, abuse/neglect monitoring via progress note review, safe surveys with residents, and staff surveys regarding abuse/neglect.

9. On 07/19/2021, the DON, Unit Manager, Administrator, Corporate RN, or a support RN began reconciling the narcotic packing slips to the narcotics received. The reconciliation would be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 602	Continued From page 106	F 602		

completed three (3) times per week to ensure the correct number of delivered narcotics were logged into the narcotic count book and the number of declining count sheets were updated. Any discrepancies would be reported immediately to the DON and/or administration.

10. On 07/19/2021, staff nurses performed assessments on all residents, including assessing pain. For residents with a BIMS of eight (8) or below, the assessment included observation of non-verbal signs of pain to include: breathing, facial expression, body language, and consolability. No concerns were identified.

11. On 07/19/2021, the APRN assessed Residents #32 and #84.

12. On 07/20/2021, the Administrator suspended LPN #2.

13. On 07/20/2021, the DON, ADON, SDC, MDS Nurses, Weekend Supervisor, Social Services Director (SSD), Activities Director (AD), and/or support RN nurses began interviewing three (3) random residents, with a BIMS of nine (9) or above, weekly to ensure they had no concerns related to when or how their narcotic medications were administered. Any concern regarding narcotic administration would be reported to the DON or Administrator for review at the morning interdisciplinary team (IDT) meeting. The three (3) audits would continue five (5) times a week until the Quality Assurance Performance Improvement (QAPI) committee determined a reduction could be made. The results of these audits would be reviewed in the monthly QAPI meeting. The QAPI Committee consisted of the Administrator, DON, Infection Preventionist,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 602	Continued From page 107	F 602		

Medical Director, Social Worker, Medical Records Director, Dietary Manager, and Housekeeping Supervisor, plus additional staff members as deemed necessary.

In addition, each off-going (leaving work, completed shift) licensed nurse/Kentucky Medication Aide (KMA) would report any concerns regarding narcotic administration and complete a concern form indicating a resident had expressed concern regarding their narcotic medication administration. The completed concern would include who the concern was reported to. Any resident concern regarding narcotic medication administration would be reported to the DON or Administrator for review at the morning IDT meeting. The results of these audits would be reviewed in the monthly QAPI meeting.

14. On 07/20/2021, the DON audited the Shift Change Controlled Substance Count Check sheets and found Licensed Practical Nurse (LPN #2) had recorded on the log sheet a reduced number of sheets counted. The nurse documented four (4) less sheets than the previous shift. There was no documented explanation why there were four (4) less sheets than the previous shift. The facility suspended the nurse and reported the information to the OIG, APS (Adult Protective Services), and police.

15. On 07/20/2021 to 07/21/2021, the Social Worker and Admissions Coordinator completed interviews with all residents with a BIMS above 8. Residents were asked about concerns with how and when medications were administered. Any concerns, which included but was not limited to pain, were documented and reported to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 602	Continued From page 108	F 602		

Administrator.

16. On 07/21/2021, the DON, ADON, Unit Manager, SDC/QI, Weekend Supervisor, MDS Nurses, the Corporate RN, and/or a support RN would audit the storage and documentation of narcotics when checking medication carts to ensure narcotics were stored appropriately and documentation was correct. The audits included: locking carts, MAR's, shift change count sheets, signatures, declining count sheets, wasted narcotics, back side of narcotic medication skids, skid cards in numerical order, no missing skids, all narcotics accounted for, and/or pharmacy packing slips. Audits would occur five (5) times per week until the QAPI committee determined frequency could be reduced. Any concern regarding documentation or storage of narcotic administration would be addressed at the time of the audit and reported to the DON or Administrator. All new concerns would be reviewed in the morning IDT meeting. Any concerns and trending would be reviewed and discussed weekly on Fridays.

17. On 07/21/2021, the Regional Vice President interviewed and suspended the facility's Administrator.

18. On 07/20/2021 through 07/25/2021, the RN Corporate Nurses provided education on Abuse, Neglect, and the Misappropriation of Resident Property Policy. The education included: screening of employees, training of employees, prevention, identification, investigation, protection, and reporting/response. One hundred five (105) of one hundred eight (108) employees completed the education at that time. The three (3) remaining employees have since received the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 602	Continued From page 109	F 602		

education. This education has been added to the new employee orientation for all facility and agency staff.

19. On 07/22/2021, the DON and RN Consultants educated all nurses and Kentucky Medication Aides (KMA) on the Controlled Substance Policy which included the proper way to count narcotics and the correct record keeping for narcotics. As of 07/22/2021, twenty-nine (29) of thirty-one (31) nurses and KMA's were educated. One (1) nurse was on vacation and had since returned. One (1) nurse was on Family Medical Leave Act (FMLA) and remained on FMLA. This education included the off-going nurse should have the record for comparison to actual narcotics seen by the on-coming staff member. Narcotics should be signed out at the time they were removed from the packet; a nurse must witness destruction of a dropped or refused narcotic before signing as a witness. KMA's could not be the second signature. (A KMA could not witness for a nurse.) Nurses and KMA's could not tape a medication to hold it in a card. If a narcotic came loose, it must be wasted, and two (2) signatures must be present. This education also included signing the Shift Change Controlled Substance Count Check sheet at the beginning and end of the shift. This education included that the signature was the nurse's affirmation that the count was correct and must be signed when counting. It could not be signed early or late. Nurses and KMA's were also educated regarding deliveries of multiple cards of narcotics. The nurse receiving the narcotics and the nurse whose medication cart would hold the narcotics must both sign for the receipt. If the same nurse was both receiving and had the medication cart, a second nurse must sign also.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 602	Continued From page 110	F 602		

20. On 07/26/2021, the DON, Unit Manager, SDC, Nurse Supervisor, MDS Nurse, and Corporate RN consultants began administering a medication administration post-test to all licensed nurses and KMA's. The quiz covered both medication administration and physician notification and validated the licensed nurses and the KMA's continued competency in a written form. Any licensed nurse or KMA not scoring one-hundred percent (100%) on the quiz would receive additional education.

21. On 07/27/2021, the DON and SDC began abuse/neglect monitoring via nursing progress note review. The past twenty-four (24) hours of nursing notes were printed off and read, looking for any indication of abuse/neglect/exploitation.

22. On 07/27/2021, the DON, SDC, Unit Manager, RN's, and Administrators from "sister facilities", and RN Corporate nurses continued safe surveys, with residents, and staff surveys regarding abuse/neglect.

23. On 07/29/2021, the DON facilitated a Medical Director Update telephone call.

24. On 08/01/2021, the DON e-mailed the narcotic abuse/neglect PIP to the Medical Director.

25. On 08/10/2021, the DON facilitated a QAPI Committee meeting with the Medical Director present. The committee discussed the facility's survey status, including the abuse/neglect PIP. Review of actions taken and audit results concluded in the recommendation for the facility to: 1) continue with the narcotics PIP; 2) provide

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 602	Continued From page 111	F 602		

on-going education; and, 3) continue auditing.

26. On 08/11/2021, the DON completed narcotic cart audits on each of the five (5) medication carts. Audit result: no issues were identified. The Corporate RN Consultant noted the front-north narcotic drawer had a screw sticking out that caused tears and punched holes in the back of multiple narcotic skids. The screw was covered.

27. On 08/12/2021, the DON completed narcotic cart audits on each of the five medication carts. Audit result: no issues.

28. On 08/13/2021, the SDC completed narcotic cart audits on each of the five (5) medication carts. Audit result: no issues.

29. On 08/18/2021, the SDC completed narcotic cart audits on each of the five medication carts. Audit result: no issues.

30. On 08/19/2021 the DON facilitated a Medical Director update telephone call.

31. On 08/20/2021, the DON notified the Medical Director of eight (8) IJ tags and the PIP's that were being worked on.

32. On 08/20/2021, the Administrator, DON, SDC, and Corporate Support staff began additional Code of Conduct in-servicing. The in-service included a quiz. The quiz questions included employees following laws, reporting systems, when to report, who to report to, and where to find more information. The employees were able to verbalize their role in protecting residents and preventing abuse, neglect, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 602	Continued From page 112	F 602		

exploitation.

33. On 08/20/2021, the facility verified the facility rebilled and/or paid for the misappropriated medications.

34. On 08/25/2021, the Regional Vice President announced the transition to the new Administrator. The Regional Vice President and Interim Administrator provided education to the new Administrator, including the requirements of the tags F-600 Abuse/Neglect/Exploitation and F-610 Investigate/Prevent/Correct Alleged Violation.

35. On 08/26/2021, the DON facilitated a Medical Director update telephone meeting, including the DON, Regional Vice President, Medical Director, Interim Administrator, new Administrator, and RN Consultant. The discussion included the facility's immediate jeopardy (IJ) status, including the tag F-610 Investigate/Prevent/Correct Alleged Violation. Review of actions taken and audit results concluded in the recommendation for the facility to: 1) provide continued education and 2) continue auditing.

36. On 08/28/2021, the SDC and RN Corporate Nurse provided education to three (3) new dietary employees, including abuse/ neglect, and Investigate/Prevent/Correct Alleged Violation if they saw abuse.

37. On 08/28/2021, the SDC monitored and audited the north-front medication cart and verbally quizzed the medication cart nurse related to preventing and protecting residents from further misappropriation of property (controlled medications). The medication cart nurse passed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 602	Continued From page 113	F 602		

the quiz with one-hundred percent (100%) correct answers.

38. On 08/28/2021, the SDC, Support RN Nurse, and Corporate RN Consultant monitored medication carts, narcotic medication documentation, and the facility's progress.

39. On 08/28/2021, the RN Corporate Nurse worked with the new Administrator and reviewed the steps to take for a thorough investigation. The Administrator was assigned/responsible for investigations, preventing, and correcting any alleged violations. Review of the Action Checklist for abuse/neglect was also included. This continued on 08/29/2021, at which time the Administrator was able to verbalize the importance of, and timeline for, reporting any allegation of misappropriation of property. The Administrator also articulated corrective actions to protect, thoroughly investigate, and resolve alleged violations.

40. On 08/29/2021, the DON, four (4) Support RN Nurses, and a Corporate RN Nurse interviewed staff and residents, inspected medication carts, and reviewed narcotic documentation. No new staff concerns were received. No new resident concerns were received, as residents stated they were receiving their medications. No narcotic medications were identified as missing.

41. Starting 08/29/2021, the facility's IDT would have a meeting five (5) times a week to review concerns. The Administrator or DON would identify an investigator to conduct the investigation. The Cardinal IDT tool would be utilized to track the investigation and ensure the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 602	Continued From page 114	F 602		

investigation was completed timely and thoroughly.

42. The Pharmacy Consultant would visit the facility at least monthly to validate narcotics were being monitored and counted per standard of practice.

The State Survey Agency validated the implementation of the facility's Immediate Jeopardy Removal Plan as follows:

1. Review of a Quality Assurance (PIP), dated 07/09/2021, revealed, as a result of the missing blister pack of thirty (30) Percocet identified in a pharmacy audit, the facility identified only one (1) staff was signing for narcotics arriving at the facility, and initiated education on controlled substances, to include having a second person sign for controlled substances arriving at the facility.

Review of a Long Term Care Facility Self-Reported Incident Form, dated 07/09/2021, confirmed the facility reported the incident of misappropriation to all appropriate parties, to include the Office of Inspector General (State Survey Agency) on 07/09/2021.

2. Review of documentation confirmed facility staff audited narcotics in all medication carts on 07/09/2021. Review of audits revealed no other missing narcotics.

3. Review of a Complete In-Service Training Report with Staff Attending, dated 07/09/2021, confirmed the SDC initiated staff education, attended by licensed nursing staff and KMA's. Education covered the need for both the off going

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 602	Continued From page 115	F 602		

and on coming shift to sign the Shift Change Controlled Substance Count Check sheet at change of shift, the importance of completing an appropriate narcotic count at shift change, adding and subtracting sheets from the Shift Change Controlled Substance Count Check sheet, and the employee accepting delivery for narcotics must sign each individual sheet of the packing slips.

Interview with the SDC, on 09/02/2021 at 4:49 PM, revealed she provided all nurses and KMA's a packet of education on medication administration as well as having each nurse sign for delivery of narcotics.

4. Interview, on 09/02/2021 at 9:10 AM, with the Clinical Director revealed that she, prior to her arrival, the Facility Consultant, had been in the facility on the dates documented in the IJ Removal Plan. She revealed her daily routine consisted of talking to residents on both the South and North halls of the building, observing staff providing care, and talking with staff. She revealed she assessed and interviewed for evidence of abuse. She revealed she also conducted chart reviews and validated the facility was continuing audits and doing everything they were supposed to be doing. The Clinical Director stated she had made surprise visits to the facility at 2:00 AM, as well as on weekends, to determine any resident concerns and ensure staff was following procedures they had been educated on.

5. Review of Complete In-Service Training Report with Staff Attending, dated 07/12/2021, confirmed the DON initiated staff education for licensed nursing staff and KMA's. Education covered (1) All PRN (as needed) medications

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 602	Continued From page 116	F 602		

must be signed on the back of the MAR, (2) all narcotics no longer in use must stay locked up in the medication cart until they could be given to the DON, and (3) declining count sheet must be labeled with room numbers at the top of the sheet.

Interview with the DON, on 09/02/2021 at 9:10 AM, revealed it had been determined not everything was signed out consistently on the back of the MAR, so the education initiated, on 07/12/2021, emphasized to staff the need to do this, including documenting the effectiveness of pain medication administered to residents.

6. Review of a Kentucky Incident Based Reporting System (KYIBRS) Report, dated 07/18/2021, revealed LPN #1 had been arrested and charged with thirteen (13) counts of Theft by Unlawful Taking, three (3) counts of Possession of Controlled Substances, two (2) counts of Wanton Endangerment, and two (2) counts of Abuse and Neglect of an Adult Person.

Review of LPN #1's employee file confirmed LPN #1 had been terminated from employment on 07/18/2021.

7. Review of the Narcotic PIP confirmed, as a result of the 07/18/2021 incident in which two (2) residents had narcotics replaced with non-prescribed medications, a PIP addendum was in place to identify the scope of residents affected, as well as further staff education on controlled substances and monitoring by management staff.

8. Review of meeting minutes, dated 07/18/2021, confirmed the IDT met and were in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 602	Continued From page 117	F 602		

agreement to provide abuse/neglect education, abuse/neglect monitoring via progress note review, safe surveys with residents, and staff surveys regarding abuse and neglect.

9. Review of Packing Slips revealed two (2) staff nurses were consistently signing for incoming narcotics, with nursing staff additionally initialing the count slips for medications specifically received for their medication carts. The review confirmed all packing slips were being signed; however, there was not consistent documentation indicating the slips had been reviewed by either the DON, Unit Manager, Administrator, a Corporate RN, or a Support RN.

One (1) packing slip, dated 07/22/2021, was signed for by one (1) nurse. Further review determined this nurse received consultation and reeducation by the Facility Consultant regarding the need for two (2) signatures always.

Interview with the DON, on 09/02/2021 at 9:10 AM, revealed when reviewing packing slips, she confirmed there were two (2) signatures and checked to ensure everything listed on the packing slips was on the medication cart; then she would initial the packing slips to show she reviewed them.

10. Review of Pain Assessments revealed Pain Assessments were completed for all facility residents on 07/19/2021. No concerns were identified. Additionally, Resident Interview Medication Administration papers were reviewed, with no concerns identified.

Interview with the DON, on 09/02/2021 at 9:10 AM, revealed no new or untreated pain was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 602	Continued From page 118	F 602		

identified through the pain assessments conducted on 07/19/2021.

11. Review of Ambulatory Nursing Home Report confirmed APRN #1 assessed Resident #84 on 07/19/2021. No concerns were identified with the assessment of Resident #84.

Review of the physician visit by the Medical Director (MD) with Resident #32, on 07/20/2021, revealed possible indicators Resident #32's opiates had been replaced with Primidone. MD documentation revealed Resident #32's condition improving at the time of documentation. MD documentation further revealed APRN #2 had visited with Resident #32 on 07/19/2021.

12. Review of a Long Term Care Facility - Self-Reported Incident Form, dated 07/20/2021, confirmed LPN #2 had been suspended from the facility.

13. Review of Resident Interview Medication Administration confirmed facility staff interviewed three (3) or more residents each week beginning on 07/20/2021 regarding any concerns with medication administration, and if so who they reported to and when. No concerns were noted in review of resident interviews.

Review of Shift Change Narcotic Review sheets, also used to document nurse and KMA concerns regarding narcotics administration, revealed no forms had been completed, indicating no concerns had been reported as of the review date of 09/02/2021.

Interview with the DON, on 09/02/2021 at 9:10 AM, revealed she frequently interviewed residents

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 602	Continued From page 119	F 602		

as part of the audit process, asking about any concerns regarding their medications. She revealed, if residents were to express a concern, she would educate them on reporting and share their concerns in QAPI meetings. To date, she revealed no residents or staff had expressed any concerns to her regarding narcotics administration.

14. Review of documentation confirmed the DON audited medication carts, on 07/20/20, and determined Resident #9 was missing skid two (2) of two (2) for Percocet and Resident #76 was missing skid four (4) of four (4) for Norco (a narcotic pain medication). Review of Shift Change Controlled Substance Count Check sheets confirmed one (1) sheet ended at forty-six (46), while the following sheet started at forty-two (42).

15. Resident Interview Medication Administration documentation was reviewed. Residents were questioned the Regional Vice President by the Social Services Director or the Admissions Coordinator about whether or not they had concerns regarding administration of their medications. If residents indicated concerns, this was explored further, to include to whom the residents reported concerns and when. No issues were identified during documentation review.

16. Review of Narcotic Cart Audit forms, dated 07/21/2021 confirmed the DON audited the storage and documentation of all facility medication carts. Continued review of audits revealed audits were occurring five (5) or more times each week. Review of Narcotic Cart Audit forms revealed required education was given, on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 602	Continued From page 120	F 602		

07/22/2021, for a KMA who had pulled narcotics but did not sign at the time the narcotics were given.

17. Interview with the Regional Vice President, on 09/02/2021 at 7:07 PM, confirmed the previous Administrator had been suspended on 07/21/2021, as a result of concerns regarding the way the Administrator handled the drug diversion issue. The Regional Vice President stated he was present at the facility acting in the capacity of Administrator from 07/21/2021 through 07/23/2021, with an Interim Administrator present at the facility, beginning 07/27/2021, until a new Administrator started on 08/26/2021.

18. Review of Complete In-Service Training Report with Staff Attending, with a start date of 07/20/2021, revealed staff was educated on the facility Abuse, Neglect, and Misappropriation of Resident Property Policy, revised 03/10/2017. The focus of the training appeared to be on reporting and following the chain of command in reporting if the situation had not been addressed. The chain of command consisted of the employee's supervisor, the DON, the Administrator, and followed by the Corporate Compliance line or the Regional Vice President. The training also noted calls to the Corporate Compliance line could be anonymous. Review of sign in sheets for training revealed the last employee completed the training, on 08/10/2021.

Interviews, on 09/02/2021, with Housekeeper #4, at 2:27 PM; the Admissions Coordinator, at 2:48 PM; RN #3, at 3:14 PM; and SRNA #23, at 3:21 PM, revealed they all had received education on abuse/neglect and misappropriation. In addition, each was able to identify their immediate

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 602	Continued From page 121	F 602		

supervision and that they would go up the chain of command if their concern was not addressed.

19. Review of a Complete In-Service Training Report with Staff Attending, initiated on 07/19/2021, revealed licensed nursing staff and KMA's were educated on the Controlled Substances policy, dated 09/2020. Although the policy itself did not cover damaged skids, documentation revealed the training covered not taping the backs of skids.

Interview with the DON, on 09/02/2021 at 9:10 AM, revealed education emphasized skids could not be taped, and discussed the proper way to waste narcotics. She revealed a nurse could sign for a KMA to waste narcotics, however, a KMA could not sign for a nurse. She stated drugs were all to be wasted in the Drug Buster, which was a chemical container that drugs were placed in for disposal. She stated staff was educated on the requirement for two (2) staff to sign for receipt of narcotics.

Interviews, on 09/02/2021 with LPN #11, at 3:03 PM, and RN #3 at 3:14 PM, revealed both had been educated on the proper way to do a narcotic count at shift change, counting skids, comparing to the number of controlled substance sheets, and wasting medications, with another nurse witnessing and signing, in the Drug Buster kept in the medication rooms. Both stated education also covered the importance of signing and completing pain assessments on the back of the MAR for PRN (as needed) medications and signing with another nurse when narcotics arrived. LPN #11 also stated, if a skid was damaged, to report it to the DON, and if a medication was in danger of falling out of a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 602	Continued From page 122	F 602		

damaged skid, it was to be wasted with another nurse witnessing and signing. LPN #11 revealed she had seen and experienced management staff, including the DON, going around doing medication cart audits, and she stayed with her medication cart while was being audited.

Interview with SRNA #20, on 09/02/2021 at 3:39 PM, a KMA, revealed he received the same education nursing staff received. He revealed he had received multiple educations. The KMA stated the education included the importance of signing out narcotics when he gave them and not waiting until the end of shift to sign them out. He revealed he signed them out right after they were given, and if a resident refused, he would mark it as a refusal and have a nurse witness and sign the medication as wasted. He stated, if a pill or skid was compromised, or if anything looked tampered with, he would alert the DON so she could assess and determine if medications needed to be wasted. He revealed corporate nurses had audited his drug cart recently.

20. Review of the facility's Narcotic Administration Quiz revealed licensed nurses and KMA's completed written quizzes, beginning on 07/26/2021. Quiz responses reviewed were appropriate, with no concerns identified during review of them.

21. Interview with the DON, on 09/02/2021 at 9:10 AM, revealed the DON and the SDC printed and reviewed all resident progress notes, highlighting anything potentially indicative of abuse or neglect. She revealed, in addition to reviewing any incidents and accidents, they looked for any documentation of resident injuries or behaviors. She stated this was an ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 602	Continued From page 123	F 602		

process and was reviewed in IDT meetings.

22. Review of Safe Surveys with residents, and untitled surveys with employees, revealed staff conducted surveys, on 07/27/2021, with no concerns identified.
Interview with Housekeeper #4, on 09/02/2021 at 2:27 PM, revealed she had completed a staff survey asking if she had any concerns.

23. Review of documentation confirmed the Medical Director was updated regarding the PIP's for Abuse and Narcotics and ongoing audits on 07/29/2021.

24. Review of an email, with the Abuse PIP and Narcotic PIP attached, confirmed it was sent to the Medical Director, on 08/01/2021.

25. Review of a QAPI Committee meeting agenda, from 08/10/2021, revealed the Abuse PIP was in the monitoring phase, with monitoring continuing. Review of a sign in sheet, dated 08/10/2021, revealed the Medical Director was in attendance at the meeting.

Interview with the Medical Director, on 08/10/2021 at 4:11 PM, revealed the DON had been in contact with him two (2) to three (3) times a week and had provided him all the PIP's that had been planned out. The Medical Director revealed he was extremely pleased at the progress the facility had made addressing their problems.

26. Review of the Narcotic Cart Audit sheets used for facility narcotic cart audits revealed staff were auditing to ensure (1) All staff were signing the Controlled Substance Count Sheet (CSCS) at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 602	Continued From page 124	F 602		

shift change, (2) All narcotic sheets had been counted, (3) the number of narcotic count sheets matched the number of skids on the cart, (4) Skids on the cart did not have tape on their backs, (5) Skids were checked to ensure there were no missing skids, (6) CSCS were being logged in and out of the cart on the Shift Change Controlled Substance Count Check form as the sheet count number changed (new skids arrived, skids were completed), and (6) All narcotics were signed out and accounted for.

Review of a Narcotic Cart Audit completed, on 08/11/2021 at 11:42 AM, by the DON revealed the audit was completed with no issues noted or corrective action required or taken. The Corporate RN Consultant noted the front-north narcotic drawer had a screw sticking out that caused tears/punched holes in the back of multiple narcotic skids: The screw was covered.

27. Review of Narcotic Cart Audit completed, on 08/12/2021 at 5:10 PM, by the DON revealed the audit was completed with no issues noted or corrective action required or taken.

28. Review of the Narcotic Cart Audit completed, on 08/13/2021 at 2:25 PM, by the DON revealed the audit was completed with no issues noted or corrective action required or taken.

29. Review of the Narcotic Cart Audit completed, on 08/18/2021 at 10:30 AM, by the SDC revealed the audit was completed with no issues noted or corrective action required or taken.

30. Documentation review confirmed the DON provided the Medical Director an update call on 08/19/2021.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 602	Continued From page 125	F 602		

31. Review of facility documentation confirmed the DON informed the Medical Director, on 08/20/2021 of the eight (8) IJ tags and the PIP's that were being worked on.

32. Review of Code of Conduct in-servicing, revealed the sign-in sheet documented all staff had completed training. Review of employee quiz information revealed employees were educated on reporting of fraud or abuse, as well as the availability of the Corporate Compliance line, and the ability to make anonymous reports if desired, with the goal of ensuring all potential violations were reported and addressed.

Interview with SRNA #24 and the Occupational Therapist, on 09/02/2021 at 3:30 PM, revealed both had received training on the Code of Conduct, which included abuse, neglect, misappropriation, what to report, who to report to, and when to report. Both revealed if they were to report an allegation to their supervisor and did not feel like it was being addressed, they could contact the DON and Administrator, as well as call or fax the Corporate Compliance line.

33. Review of facility documentation, not labeled or dated, revealed a total of one hundred and eight (108) narcotics were documented as missing, which included three (3) skids of thirty (30) medications each that were missing, and four (4) non-controlled medications that were documented as missing. The document listed residents by name, along with discrepancies noted, the cost for each individual dose, resident payors, and the total cost of all medications reimbursed, which was three hundred and four dollars and ninety-seven ($304.97) cents.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 602	Continued From page 126	F 602		

34. Review of an Appointment Letter as facility Administrator revealed appointment of a new Administrator, on 08/26/2021, with an Administrator job description, reporting to the Regional Vice President, who also signed the letter on 08/26/2021.

Interview with the Administrator, on 09/02/2021 at 6:32 PM, confirmed he spoke with the Interim Administrator and the Regional Vice President over the phone, on 08/25/2021, and they discussed with him the IJ tags the facility had been cited, to include abuse and misappropriation tags. He stated they wanted to make sure he was aware of the situation he would be coming into. He stated the Regional Vice President had stressed the importance of reporting allegations and keeping him informed.

35. Review of the document Communication with Medical Director, signed by the Medical Director on 08/28/2021, confirmed the Medical Director was provided an update by the DON on the Immediate Jeopardy (IJ) citations and corrective actions the facility was taking to address the citations.

Interview with the Administrator, on 09/02/2021 at 6:32 PM, revealed he was present for the phone call with the Medical Director, on 08/26/2021, in which the jeopardy citations were discussed, as well as the audits the facility had been doing and the education the facility had provided. He revealed they went down each one of the tags, discussing issues and what was being done to address issues.

36. Review of three (3) Employee Affirmation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 602	Continued From page 127	F 602		

Statements, dated 08/28/2021, revealed three (3) new dietary employees had received and reviewed the Code of Conduct as part of their orientation. Further, review of In-Service Training Report, dated 08/28/2021, revealed new staff had received training on abuse, neglect, and misappropriation investigating and reporting.

37. Review of Shift Change Narcotic Review sheet completed by the SDC, on 08/28/2021, confirmed the north-front medication cart was audited, and LPN #6 was verbally quizzed, with no concerns identified.

38. Review of Shift Change Narcotic Review sheets, completed by the SDC, support RN's, and corporate RN's, revealed medication carts and narcotic documentation were monitored on 08/28/2021, 08/29/2021, and 08/30/2021, with no issues identified.

Interview with the Clinical Director, on 09/02/2021 at 9:10 AM, revealed she, the SDC, and a sister facility nurse went to each medication cart, on 08/28/2021 at shift change with their audit tools, and went through the packet of audit tools with medication cart staff, asking questions about documentation and reporting. She revealed this process was repeated on 08/29/2021 with a nurse from a different sister facility. She revealed there had been no concerns with the audits.

39. Interview with the Administrator, on 09/02/2021 at 6:32 PM, confirmed the Clinical Director had thoroughly reviewed with him abuse reporting and investigating.

Interview with the Clinical Director, on 09/02/2021 at 9:10 AM, revealed she reviewed an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 602	Continued From page 128	F 602		

investigation file with the Administrator on 08/29/2021. She revealed they went down the Action Checklist, reviewed the process, and the Administrator made notes to himself on what he needed to do and on what he could do at that time. The Clinical Director stated the Administrator had interviewed residents, called residents' representatives, and was very thorough in his investigation of misappropriation.

40. Review of the facility's Weekend Audits, dated 08/28/2021, confirmed the Administrator and a support RN interviewed staff and residents regarding abuse, code of conduct, and medication administration. Staff members were able to answer questions accurately, and residents did not express any concerns during interviews. Further, nursing staff conducted an audit of narcotic documentation and did not determine any concerns.

41. Review of the Cardinal IDT Meeting minutes for 08/30/2021, 08/31/2021, and 09/01/2021 revealed evidence the facility had initiated five (5) times weekly IDT meetings.

42. Interview with the Consultant Pharmacist confirmed she visited the facility monthly and conducted a narcotics audit during her monthly visits.

Interview with the DON, on 09/02/2021 at 9:10 AM, confirmed the Consultant Pharmacist conducted monthly visits, reviewed charts, and conducted a medication administration audit. She stated the only time the Consultant Pharmacist was not coming were times, during the last year, when the facility was in lock-down due to the pandemic.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 610 SS=K	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: The facility failed to initiate a timely and thorough investigation in order to prevent and protect residents from further misappropriation of	F 610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 610	Continued From page 130	F 610		

property (controlled medications), after residents made allegations of not receiving medications and that staff were taking the medications for fifteen (15) of forty-four (44) sampled residents. The residents affected were: Resident #1, #8, #9, #17, #32, #34, #47, #48, #56, #60, #65, #71, #79, #82, and #84.

On 06/25/2021, Resident #82 alleged in a written grievance that he/she had not received controlled pain medications documented as given by Licensed Practical Nurse (LPN) #1. The Director of Nursing (DON) stated the Administrator asked her to monitor and investigate for any concerns regarding PRN controlled pain medications; there was no documented evidence the facility conducted a thorough investigation into the allegation.

On 07/08/2021, Resident #9 confronted LPN #1; alleging LPN #1 was stealing his/her controlled medications. A formal grievance was initiated; however, LPN #1 was not investigated as result of this allegation.

On 07/09/2021, a pharmacy audit revealed a missing skid of thirty (30) Percocet (Scheduled II narcotic) belonging to Resident #17. LPN #2 signed for three (3) skids of thirty (30) Percocet each, for a total of ninety (90) Percocet for Resident #17, on 06/28/2021; however, LPN #1 alleged only receiving two (2) skids of thirty (30) Percocet each, for a total of sixty (60) Percocet. The facility allowed both nurses to continue to work with residents despite being in an allegation of missing controlled medications.

On 07/18/2021, LPN #2 discovered Resident #32 and Resident #84 both had two (2) Roxicodone

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 610	Continued From page 131	F 610		

(Schedule II narcotic pain reliever) tablets replaced with Primidone (anticonvulsive) and taped into the blister pack. Adult Protective Services (APS) and the Police were contacted and arrived at the facility on 07/18/2021. LPN #1 admitted to the Police, she replaced both Resident #32's and Resident #84's Roxicodone with Primidone. An additional ten (10) residents had controlled medications missing from blister packs that were not properly documented as being administered or wasted. LPN #1 was found with several controlled medications in her pockets, as well as Primidone.

(See F602 and F755).

The facility's failure to ensure a timely and thorough investigation, protection of residents, and prevention of further potential misappropriation of controlled substances after an allegation of misappropriation has caused or is likely to cause serious injury, serious harm or death to other residents in the facility. Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) were identified on 08/20/2021, and were determined to exist on 07/09/2021, in the area of 42 CFR 483.12 Freedom from Abuse, F-610, Investigation of Abuse. The facility was notified of the IJ and SQC on 08/20/2021.

The facility provided an acceptable Immediate Jeopardy Removal Plan on 09/01/2021, with the facility alleging removal of the Immediate Jeopardy, on 08/31/2021. The State Survey Agency validated removal of the Immediate Jeopardy, as alleged on 08/31/2021, prior to exit on 09/02/2021. The facility's remaining non-compliance was at a Scope and Severity of an "E" while the facility develops and implements

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 610	Continued From page 132	F 610		

a Plan of Correction and the facility's Quality Assurance (QA) monitors to ensure compliance with systemic changes.

The findings include:

Review of the facility's policy titled, "Abuse, Neglect, or Misappropriation of Resident Property Policy," last revised 03/10/2017, revealed the facility would do whatever was in its control to prevent abuse and misappropriation of resident property. The policy stated the Administrator was responsible to ensure complaints were investigated and to report allegations to the appropriate agencies. Under the section on Prevention, the policy stated staff would investigate allegations in a timely manner and develop corrective measures as indicated. Under the section on Investigation, the policy stated the Administrator was responsible to direct the investigation and to ensure appropriate agencies were notified.

Interview with the Social Services Director (SSD), on 07/27/2021 at 10:29 AM, and again, on 07/29/2021 at 3:45 PM, revealed staff reported allegations to their supervisor, which were then reported to the Administrator. The Administrator did the reporting to state agencies and initiated an investigation. The SSD revealed her role in investigations was typically interviewing other facility residents and sometimes conducting follow up interviews with the residents involved. Regarding grievances, the SSD shared any staff or resident could complete one, with the Administrator determining which individual/department would receive the grievance, and the SSD logging them in the grievance log. She revealed some staff and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 610	Continued From page 133	F 610		

residents would go straight to the Administrator with a grievance, and if the Administrator did not fill out a grievance form or discuss the grievance in daily meetings, she would not know about them. The SSD stated no one had ever told her they had initiated a grievance that she had not received.

1. Review of Resident #82's medical record revealed the resident was admitted by the facility, on 11/24/2019, with diagnoses to include Chronic Obstructive Pulmonary Disease, Peripheral Vascular Disease Unspecified, Acquired Absence of Left Leg Below Knee, and Primary Osteoarthritis Unspecified Hand. The facility assessed Resident #82, in a Quarterly Minimum Data Set (MDS) Assessment, dated 07/26/2021, as a thirteen (13) of fifteen (15) on the Brief Interview for Mental Status (BIMS), indicating no cognitive impairment. Continued review revealed an order for Hydrocodone (Schedule II narcotic pain reliever) 5/325 milligrams (mg) every four (4) hours as needed (PRN).

Review of Resident #82's Medication Administration Record (MAR) for June 2021 revealed, on 06/19/2021, one (1) dose of Hydrocodone 5/325 mg was administered, followed by two (2) doses on 06/20/2021, and a fourth dose on 06/21/2021, all administered by LPN #1. These four (4) doses were not signed out on the back of the MAR, which was used to record pre and post administration pain assessments. Prior to that, Resident #82 had received a total of five (5) doses during the preceding three (3) weeks, with only two (2) doses on consecutive days. Review of Resident #82's 06/2021 MAR revealed a total, of five (5) doses administered of Hydrocodone 5/325 mg,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 610	Continued From page 134	F 610		

four (4) of which were on consecutive days.

Interview with Registered Nurse (RN) #1, on 08/02/2021 at 3:52 PM, revealed she had reported to the Administrator, on 06/21/2021, a concern over narcotics. She stated she asked Resident #82 how he/she was doing, the resident revealed he/she was doing well, but told her a couple of nurses thought he/she was dying because he/she had received a lot of narcotics over the weekend which the resident said did not occur. Resident #82 reported he/she was not hurting and had not needed any pain medications in a few days. RN #1 stated she examined Resident #82's narcotic sheet and found LPN #1 had signed out for two (2) pain pills on Saturday and two (2) pain pills for Sunday, which Resident #82 stated he/she had not received. She revealed she sent a text to the previous Administrator regarding Resident #82's concern with narcotics. She revealed she showed the Administrator the MAR, and the Administrator stated "this was becoming a problem" and that Resident #9 had already "called state on us." She revealed the Administrator met with Resident #82 for about twenty (20) minutes, after which Resident #82 stated the Administrator told him/her she would get to the bottom of it, but as he/she had heard that before, knew they "weren't going to do crap" about it. Continued interview with RN #1 revealed Resident #82 typically took three (3) or four (4) pain pills a month for breakthrough pain.

Review of a Facility Concern/Grievance Form, dated 06/25/2021, initiated by Resident #82 with RN #1 who received the grievance, revealed uncertainty voiced by the resident if he/she had received pain medication over the weekend. RN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 610	Continued From page 135	F 610		

#1 reviewed the MAR, which revealed the Resident had taken several pain pills. However, per the form, the resident stated that he/she was not aware or could not remember taking the pain pills. The investigation was referred to the previous Administrator, whose findings were Resident #82 was uncertain whether or not he/she received pain pills. The facility action included the resident would be more vigilant regarding administration of pain pills. The Administrator signed the grievance form as resolved on 06/25/2021. This information was not used to initiate an investigation into misappropriation.

Interview with LPN #7, on 08/05/2021 at 9:09 AM, revealed she recognized Resident #82 was receiving more narcotics on the nights LPN #1 worked. She stated Resident #82 would only ask for a pain pill if he/she had to go to a doctor's appointment, as the bus ride jarred him/her, and caused pain. She stated, after Resident #82 had done this, he/she might ask for two (2) or three (3) pain pills in a twenty-four (24) hour period, and then go back to one (1) every three (3) or four (4) days. She revealed Resident #82 had not been to any appointments, so it was unexpected for him/her to have had so many administered. LPN #7 stated when she interviewed Resident #82, he/she denied having pain or requiring pain medications at the times documented. LPN #7 stated she informed the Staff Development Coordinator/Quality Improvement nurse (SDC/QI) of her suspicions. She stated this allegation of possible drug diversion did not seem to be a big concern for management staff until a skid of thirty (30) Percocet were found to be missing on 07/09/2021.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 610	Continued From page 136	F 610		

Interview with the SDC/QI, on 08/05/2021 at 12:22 PM, revealed she was uncertain when Resident #82 first identified an issue, although she thought it was early to mid-July. She revealed no one reported anything directly to her about Resident #82, although there had been a grievance regarding him/her believing he/she was not getting pain medications that had been signed out during the night. She stated if someone had reported anything to her, she would have reported it to the DON. She stated, if a nurse had a suspicion of drug diversion, he/she should contact the DON immediately and initiate a grievance form. The SDC/QI shared she would expect staff to follow the chain of command in reporting concerns, which would be nursing staff, herself, and the DON, as there was currently (as of the date of this interview) no Assistant Director of Nursing (ADON).

Interview with the DON, on 08/04/2021 at 8:28 AM, and again, on 08/05/2021 at 12:35 PM, revealed the Administrator approached her, after the grievance by Resident #82, and told her that Resident #82 might not have received his/her medication. She stated the Administrator told her she needed to start watching LPN #1. The DON revealed, in her review of MAR's, she was unable to identify LPN #1 was signing out more PRN medications than other night shift staff. The DON revealed she did not document her review of the residents' MAR's.

2. Review of Resident #9's medical record revealed the resident was readmitted to the facility, on 05/03/2021, with diagnoses to include Paraplegia Unspecified, Nicotine Dependence Unspecified Uncomplicated, Other Specified Anxiety Disorders, and Other Chronic Pain. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 610	Continued From page 137	F 610		

facility assessed Resident #9, in an Admission MDS Assessment, dated 05/09/2021, as a fifteen (15) of fifteen (15 on the BIMS, indicating no cognitive impairment. Continued review revealed 05/05/2021 orders for Klonopin (sedative, controlled medication) 1 mg twice a day PRN:, 05/05/2021 orders for Neurontin (Gabapentin, anti-seizure, used to treat nerve pain, controlled medication) 600 mg four (4) times a day; and 05/27/2021 orders for Percocet (Schedule II narcotic pain reliever) 7.5/325 mg every eight (8) hours PRN. Resident #9's orders for Klonopin were changed on 07/08/2021 to 1 mg twice a day, and his/her order for Percocet 7.5/325 mg was changed on 07/12/2021 to twice a day.

Interview with Patient Care Assistant (PCA) #3, on 08/03/2021 at 3:02 PM, revealed she responded to Resident #9's call light, on 07/08/2021, and pushed Resident #9 to the nurse's station per his/her request. She revealed Resident #9 "went off" on LPN #1, calling her names and saying that she stole Resident #9's pills.

Interview with State Registered Nurse Aide (SRNA) #11, on 08/03/2021 at 1:02 PM, revealed, on the evening of 07/08/2021, Resident #9 had PCA #3 push him/her down the hall to where LPN #1 was at the nurse's station. Further, she stated Resident #9 then screamed at LPN #1 for taking his/her pills. SRNA #11 revealed multiple nurses and other staff was present and heard Resident #9. She stated she was in a resident's room providing care with the door shut, and she was able to hear Resident #9 screaming at LPN #1.

Interview with SRNA #12, on 08/03/2021 at 3:15 PM, revealed she remembered the evening

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 610	Continued From page 138	F 610		

Resident #9 confronted LPN #1, saying he/she did not appreciate not getting his/her medication when the nurse said he/she did receive them.

Continued interview with the DON, on 08/04/2021 at 8:28 AM, revealed she stayed late, on 07/08/2021, to speak with LPN #1, who revealed she had been giving PRN pain medications to residents to ensure they were able to sleep. The DON stated she instructed LPN #1 not to do that.

Interview with LPN #5, on 08/03/2021 at 4:20 PM, revealed, on 07/06/2021, Resident #9 had indicated to her that he/she was not receiving his/her medications. She revealed Resident #9 wanted his/her pain medication, but she was unable to give it as Resident #9's pain pill had been signed out the previous evening. She revealed she alerted the DON at that time via text message of Resident #9's allegation. She stated Resident #9 was not in any pain that morning. However, she stated Resident #9's routine was to receive his/her PRN pain medication in the morning.

Interview with Resident #9, on 07/28/2021 at 3:01 PM, revealed one morning he/she had asked for pain medication, and staff informed him/her they could not provide it as they had been administered at 2:30 AM. Resident #9 shared he/she had not received pain medication at 2:30 AM, and LPN #1 had been working the night the medication was allegedly administered. Resident #9 stated he/she consistently had pain medications signed out and not given to him/her when LPN #1 worked. Resident #9 stated he/she had reported this to other staff, but remembered reporting to SRNA #9, who was also a Kentucky Medication Aide (KMA) and able to administer

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 610	Continued From page 139	F 610		

medications.

Review of Resident #9's Controlled Substance Count Record for Percocet 7.5/325 mg, initiated on 06/29/2021, revealed two (2) tablets were signed by LPN #1 during her 07/05/2021, 7:00 PM to 7:00 AM, 07/06/2021 shift on the North Unit. The record showed one (1) Percocet was documented as administered, on 07/05/2021 at 7:30 PM, and a second one (1) was documented as administered, on 07/06/2021 at 2:30 AM. Although LPN #1 signed on the MAR for one (1) dose, she did not sign for a second dose, and there was no indication on the back of the MAR indicating these doses were given, for what purpose, or whether or not the doses were effective. Continued review revealed Resident #9 would normally receive a tablet of Percocet 7.5/325 mg between 8:00 AM and 9:00 AM each morning.

Interview with LPN #12, on 08/13/2021 at 8:21 AM, revealed Resident #9 took his/her medication, would ask for it, knew what it looked like, and knew what pills he/she took. She stated, in June 2021, several staff members, including RN #1 and LPN #2, had reported Resident #9 was not receiving his/her medication to the Administrator. However, LPN #12 stated she was not aware of the Administrator doing anything with that information.

Review of a Facility Concern/Grievance Form, dated 07/08/2021, initiated by Resident #9, revealed the resident complained about not getting pain pills on night shift, which started a couple of weeks ago (not sure of the exact dates). The form stated the resident did not want the nurse involved, LPN #1, taking care of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 610	Continued From page 140	F 610		

him/her. The previous Administrator received and responded to the grievance, with action taken, which included: interviewed Resident #9, interviewed nurses (did not indicate who), reviewed MAR's, and ongoing investigation with facility and law enforcement. The form was signed as resolved by the previous Administrator on 07/09/2021. This information was not used to initiate an investigation into misappropriation.

3. Interview with the Facility Consultant, on 07/27/2021 at 1:15 PM, and again, on 08/18/2021 at 2:32 PM, revealed she had been brought in from corporate as a result of facility issues that needed to be addressed. She revealed there had been an audit, on 07/09/2021, by pharmacy which determined there was a missing skid of Percocet 5/325 mg belonging to Resident #17. The investigation revealed three (3) skids of thirty (30) tablets each of Percocet 5/325 mg had been delivered by pharmacy, on 06/28/2021 as documented by Licensed Practical Nurse (LPN) #2; however, LPN #1 stated she had received only two (2) skids of thirty (30) tablets each of Percocet 5/325 mg.

Interview with the Consultant Pharmacist, on 08/13/2021 at 10:31 AM, revealed any time she noted a concern or anything that raised her attention, she included it in her pharmacy report. She revealed on 07/09/2021, she noted a skid of Percocet missing and provided that information in her report to administrative staff.

Review of a Packing Slip, dated 06/28/2021, revealed LPN #2 signed for three (3) skids of thirty (30) tablets each of Percocet 5/325 mg, for a total of ninety (90) Percocet 5/325 mg for Resident #17.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 610	Continued From page 141	F 610		

Interview with LPN #2, on 07/29/2021 at 4:29 PM, revealed, on the night of 06/28/2021, LPN #1 had approached her repeatedly to let her know when the pharmacy came in, as LPN #2 was working on the South Unit, and the South Unit nurse was responsible for signing for deliveries from pharmacy. LPN #2 stated she signed for three (3) skids of thirty (30) tablets of Percocet 5/325 mg each for Resident #17, on the night of 06/28/2021, but was informed, after the discovery of a missing skid on 07/09/2021, LPN #1 alleged only receiving two (2) skids.

Review of Resident #17's medical record revealed Resident #17 was admitted to the facility, on 03/27/2020, with diagnoses to include Hemiplegia and Hemiparesis following Cerebral Infarction Affecting Left Non-Dominant Side, Anxiety Disorder Unspecified, and Unspecified Dementia without Behavioral Disturbance. The facility assessed Resident #17, in a Quarterly MDS Assessment, dated 05/17/2021, as a three (3) of fifteen (15) on the BIMS, indicating severe cognitive impairment. Continued review revealed an order for Percocet 5/325 mg every eight (8) hours PRN, dated 01/18/2021.

Interview with LPN #7, on 08/05/2021 at 9:09 AM, revealed she had suspicions regarding LPN #1 and was counting medications with her one evening and noted Resident #17 had one (1) Percocet tablet left in a skid and a second full skid of thirty (30) Percocet tablets. She stated, as Resident #17 would have received one (1) Percocet tablet that evening, he/she should have had a full skid remaining when she returned the following morning. However, she stated, when LPN #7 returned the following morning, the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 610	Continued From page 142	F 610		

second skid only contained twenty-nine (29) Percocet tablets, but only one (1) had been signed out by LPN #1. She stated she reported this to the SDC/QI, but was uncertain of the date, and did not say anything to LPN #1. She stated the DON was auditing her medication cart later, and the DON told her she was doing the audit because a whole skid of Percocet was missing.

Review of Resident #17's Controlled Substance Count Record revealed a sheet two (2) of three (3), delivered, on 06/28/2021, with a receiving signature and date on the sheet. Despite repeated requests, the facility was unable to provide either sheet one (1) of three (3), or a Controlled Substance Count Record for Percocet 5/325 mg covering the time frame of 06/19/2021 through 07/08/2021. Sheet three (3) of (3) was the missing sheet, as identified by pharmacy on 07/09/2021. Sheet 2 of 3 revealed LPN #1 signed the first tablet of Percocet out at midnight on 07/09/2021, with LPN #7 replacing her on the cart on the morning of 07/09/2021. Review of Resident #17's MAR for 07/2021 revealed eighty-two (82) doses (tablets) of Percocet 5/325 mg had been administered. However, review of the back of the MAR revealed no staff had signed, indicating administration or results of the medication on the resident's pain level.

There was no documented evidence Resident #17's missing single tablet of Percocet 5/325 mg, as reported by LPN #7 on 07/08/21 to the SDC/QI, was investigated.

Interview with the SDC/QI, on 08/03/2021 at 9:29 AM, and again, on 08/13/2021 at 4:00 PM, revealed staff had suspicions about LPN #1, and she and the DON had interviewed her on a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 610	Continued From page 143	F 610		

couple of occasions. She was uncertain of the dates of the interviews, but revealed they were prior to 07/16/2021. She revealed the first interview was to express concern as Resident #9 stated he/she had not received medication at night. She revealed the second interview, she believed the following night, was when a Percocet was noted missing from Resident #17 on LPN #1's medication cart that was not accounted for. She revealed LPN #1 told her that she had forgotten to write it down, but if she pulled the medication, she had given it. The SDC/QI stated she had reported this to the DON.

Interview with the DON, on 08/04/2021 at 8:28 AM, on 08/05/2021 at 12:35 PM, on 08/16/2021 at 11:35 AM, and again, on 08/18/2021 at 10:48 AM, revealed no one had reported to her any missing individual Percocet tablet belonging to Resident #17. She revealed the first she heard of missing Percocet was when pharmacy had determined a skid to be missing belonging to Resident #17 in an audit conducted on 07/09/2021. She revealed she had reported this to the Administrator and sent in a self-report to Police on 07/09/2021. She revealed when Police came to the facility, she never spoke with them, the Administrator did. She revealed pharmacy had delivered three (3) skids of thirty (30) tablets each of Percocet 5/325 mg for Resident #17, on 06/28/2021; however LPN #1 stated she only received two (2) skids. The DON stated she thought there was a "trigger call" (a call between management staff and corporate regarding facility concerns and reportable incidents) that day, but she was not on the trigger call. The DON stated neither LPN #1 nor LPN #2 were suspended or drug tested. The DON stated it was not policy to test someone due to an allegation of drug

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 610	Continued From page 144	F 610		

diversion. She stated she would have to suspect without a doubt someone was under the influence, and she had never suspected LPN #1, and staff had never reported to her LPN #1 was under the influence. She stated the decision was made as a team by corporate and administration to suspend or drug test an employee. She stated she agreed on the importance of suspending staff to prevent further potential drug diversion.

Interview with the Ombudsman, on 07/26/2021 at 3:15 PM, revealed she interviewed the DON following the 07/09/2021 incident with drug diversion and asked what the facility had done to address the issue. She stated the DON said they were unable to determine which of two (2) nurses was guilty of drug diversion. When asked why both were not suspended, the Ombudsman stated the DON shrugged her shoulders, indicating she did not know.

Review of the facility Drug Free Workplace Policy (DFWP), revised 12/2018, revealed the company recognized the need for a safe and healthy work environment free from the use of prohibited drugs and alcohol. The policy stated employees who abused drugs or alcohol posed a serious risk to the safety, security, and welfare of residents and the company. The policy revealed all applicants for Registered Nurse (RN), Licensed Practical Nurse (LPN), or Medication Aide were required to submit a urine sample as a condition of employment. The policy defined Prohibited Conduct as possessing or using any prohibited drug or alcohol while at the workplace, while at work, or during working hours. Further Prohibited Conduct, per the policy, included refusing to submit to a drug or alcohol test required by the policy, or failing a drug or alcohol test

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 610	Continued From page 145	F 610		

administered in accordance with the policy. The Drug and Alcohol Testing Policy, as documented in the DFWP, revealed employees could be asked to submit to various testing for drugs and alcohol, and included the company's right to test employees in situations such as, but not limited to, a workplace injury, following an incident that resulted in an investigation such as instances of resident abuse or medication diversion, or any time at the sole discretion of the company. The policy required employees consent to the Drug Free Workplace Policy (DFWP), by signing an acknowledgement of receipt of the policy.

Review of the employee file for LPN #1 revealed a DFWP Acknowledgement of Receipt of Policy, signed on 04/07/2021.

Review of the employee file for LPN #2 revealed a DFWP Acknowledgement of Receipt of Policy, signed on 04/25/2020.

4. Interview with the Facility Consultant, on 07/27/2021 at 1:15 PM, revealed, on 07/18/2021, the DON informed her that LPN #2 had discovered two (residents) with the same occurrence, Resident #32 and #84. She stated the DON informed her the occurrence was that LPN #2 found for each that two (2) pills were taped into an Roxicodone skid which were not Roxicodone, affecting a total of four (pills) for both residents. She stated the medication used to replace the Roxicodone tablets was Primidone, an anti-seizure medication. The Facility Consultant stated Police were present and had already detained LPN #1. She stated it was discovered LPN #1 had taken medications from skids but not signed them out for Residents #71, #56, #1, #47, #34, #60, #48, #65, #79, and #8.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 610	Continued From page 146	F 610		

Interview with LPN #2, on 07/29/2021 at 4:29 PM, revealed she was working the night of 07/18/2021, and was administering medications when she noted Resident #32's narcotic skid had tape on it, and the medications taped inside were thicker than the other medications in the skid. She revealed she contacted the DON and had SRNA #20 witness as she searched the rest of the medication cart and found two more medications taped in place of Resident #84's narcotics. She stated she contacted Adult Protective Services, and was advised by Social Services Clinician I (SSCI) to have other staff witness her medication administration involving any narcotics, which she did by having SRNA #8 and SRNA #20 witness every narcotic pulled.

Continued interview with LPN #2, on 07/29/2021 at 4:29 PM, revealed the DON and Administrator identified multiple narcotic skids with tape on them and were busy wasting medications on the night of 07/18/2021 through the morning of 07/19/2021. She stated some skids had tape all over them and had to be wasted, while others just had pills removed due to tape. She stated when individual pills were taken from her medication cart, both she and the removing staff signed on the narcotics sheet.

Continued interview with the DON, on 08/04/2021 at 8:28 AM, revealed she received a call from LPN #2, on the night of 07/18/2021 at 7:30 PM, who revealed she had found two (2) of Resident #32's narcotics had been replaced with other pills. She then stated she received a text, at 7:47 PM, from LPN #2 that she had found a second resident, #84, also had two (2) narcotics replaced with other pills. The DON stated she alerted the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 610	Continued From page 147	F 610		

Administrator, and the Administrator was on a trigger call, at 7:52 PM, with the Facility Consultant, the Clinical Director, and the Regional Vice President (RVP).

Continued interview with the DON, on 08/04/2021 at 8:28 AM, revealed she and the Administrator arrived at the facility, a little after 9:00 PM on 07/18/2021; the Police and SSCI were already present. She stated they did medication cart audits, and the Administrator made copies of everything that was missing that night, however the DON was unaware of where those copies were. She stated she and the Administrator went through the medication carts and were following corporate guidance to destroy any medications that were taped in skids. The DON stated she and the Administrator went through LPN #1's medication cart together. She stated she timed any medications she wasted. She stated all carts were audited by 2:00 AM on 07/19/2021, when she left the facility. The DON stated she did not have a full record of what was wasted, on the evening of 07/18/2021 through the morning of 07/19/2021.

Continued interview with the DON, on 08/04/2021 at 8:28 AM, and again, on 08/18/2021 at 10:48 AM, revealed she expected that abuse not occur, but if it did occur, it be reported immediately. In addition, she expected facility staff should act to protect residents from abuse, including removal of staff members from resident care if they were implicated in a situation that kept residents unsafe. She revealed, when she received a report, she reported it to the Administrator, who called corporate. At that point, she stated, the determination was made whether it was a reportable incident. If it was a reportable incident,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 610	Continued From page 148	F 610		

an investigation was started.

Interview with the Interim Administrator, on 08/20/2021 at 10:24 AM, revealed his expectation the facility would have a good investigation program, a good audit program, and a good count program for narcotics that started when they came to the facility, to limit the possibility of drug diversion occurring.

The previous Administrator was not available during the course of the survey and did not return calls, the last of which was attempted on 08/20/2021 at 9:48 AM.

Interview with the Regional Vice President (RVP), on 08/20/2021 at 3:03 PM, revealed he was part of the trigger call that occurred on 07/09/2021. He stated the facility reported the incident and also notified Police of the missing skid of thirty (30) tablets of Percocet. However, he stated, as they were unable to determine which specific nurse might have taken the medications, neither nurse was suspended at that time. He stated he had not been informed of any prior allegations that implicated LPN #1 in diverting medications, and as RVP he would have expected to be notified of those types of allegations.

The facility provided an acceptable Immediate Jeopardy Removal Plan, on 09/01/2021, that alleged removal of the Immediate Jeopardy (IJ) on 08/31/2021. The facility implemented the following:

1. On 07/09/2021, a Performance Improvement Plan (PIP) was initiated related to Missing Narcotics which was reported to the Office of Inspector General- Division of Health Care (State

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 610	Continued From page 149	F 610		

Survey Agency), at 4:30 PM on 07/09/2021.

2. On 07/09/2021, the Unit Manager and MDS Nurses audited narcotics in the remaining medication carts as the North back hall had a blister pack missing. All count sheets were found to match the number of skids. Staff signing in and out of a medication cart was expected on controlled substance check sheets.

3. On 07/09/2021, the Staff Development Coordinator (SDC) initiated staff education. The topics included narcotic count, counting sheets added and subtracted, signing packing slips, and logging narcotics into the narcotic books.

4. On 07/12/2021, 07/13/2021, 07/20/2021 to 07/22/2021, 07/24/2021 to 08/13/2021, and 08/22/2021 to 08/29/2021, an RN Corporate (Facility) Consultant worked in the facility. An RN Corporate Nurse would continue to be at the facility five (5) days a week through September 2021, ensuring residents remained free from abuse, neglect, and exploitation, and policy and procedures were followed, including the active plan of correction. An RN Corporate Nurse could complete any audit in place of the assigned auditor and would help ensure the facility followed policy and took immediate action to prevent further abuse, neglect, and exploitation.

5. On 07/12/2021, the DON initiated additional education which included signing as needed (PRN) medications on the back of themedication administration record (MAR), giving discontinued narcotics to the DON, and labeling declining count sheets.

6. On 07/18/2021, the Licensed Practical Nurse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 610	Continued From page 150	F 610		

(LPN) #1 was removed from the facility and arrested by Police. LPN #1 was automatically suspended.

7. On 07/18/2021, an Addendum was added to the PIP due to findings that Percocet tablets were replaced with Primidone on Resident #84 and Resident #32 medications.

8. On 07/18/2021, an ad hoc meeting was held to review the additional action steps with the interdisciplinary team (IDT). The IDT was comprised of the Administrator, DON, Quality Improvement Nurse/Staff Development Coordinator (SDC/QI), Minimum Data Set (MDS) Nurse, Unit Manager, Activity Director, Social Services Director, and Dietary Manager. The IDT agreed actions taken would include abuse/neglect education, abuse/neglect monitoring via progress note review, safe surveys with residents, and staff surveys regarding abuse/neglect.

9. On 07/19/2021, the DON, Unit Manager, Administrator, Corporate RN, or a support RN began reconciling the narcotic packing slips to the narcotics received. The reconciliation would be completed three (3) times per week to ensure the correct number of delivered narcotics were logged into the narcotic count book and the number of declining count sheets were updated. Any discrepancies would be reported immediately to the DON and/or administration.

10. On 07/19/2021, staff nurses performed assessments on all residents, including assessing pain. For residents with a BIMS of eight (8) or below, the assessment included observation of non-verbal signs of pain to include:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 610	Continued From page 151	F 610		

breathing, facial expression, body language, and consolability. No concerns were identified.

11. On 07/19/2021, the APRN assessed Residents #32 and #84.

12. On 07/20/2021, the Administrator suspended LPN #2.

13. On 07/20/2021, the DON, ADON, SDC, MDS Nurses, Weekend Supervisor, Social Services Director (SSD), Activities Director (AD), and/or support RN nurses began interviewing three (3) random residents, with a BIMS of nine (9) or above, weekly to ensure they had no concerns related to when or how their narcotic medications were administered. Any concern regarding narcotic administration would be reported to the DON or Administrator for review at the morning interdisciplinary team (IDT) meeting. The three (3) audits would continue five (5) times a week until the Quality Assurance Performance Improvement (QAPI) committee determined a reduction could be made. The results of these audits would be reviewed in the monthly QAPI meeting. The QAPI Committee consisted of the Administrator, DON, Infection Preventionist, Medical Director, Social Worker, Medical Records Director, Dietary Manager, and Housekeeping Supervisor, plus additional staff members as deemed necessary.

In addition, each off-going (leaving work, completed shift) licensed nurse/Kentucky Medication Aide (KMA) would report any concerns regarding narcotic administration and complete a concern form indicating a resident had expressed concern regarding their narcotic medication administration. The completed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 610	Continued From page 152	F 610		

concern would include who the concern was reported to. Any resident concern regarding narcotic medication administration would be reported to the DON or Administrator for review at the morning IDT meeting. The results of these audits would be reviewed in the monthly QAPI meeting.

14. On 07/20/2021, the DON audited the Shift Change Controlled Substance Count Check sheets and found Licensed Practical Nurse (LPN #2) had recorded on the log sheet a reduced number of sheets counted. The nurse documented four (4) less sheets than the previous shift. There was no documented explanation why there were four (4) less sheets than the previous shift. The facility suspended the nurse and reported the information to the OIG, APS (Adult Protective Services), and police.

15. On 07/20/2021 to 07/21/2021, the Social Worker and Admissions Coordinator completed interviews with all residents with a BIMS above 8. Residents were asked about concerns with how and when medications were administered. Any concerns, which included but was not limited to pain, were documented and reported to the Administrator.

16. On 07/21/2021, the DON, ADON, Unit Manager, SDC/QI, Weekend Supervisor, MDS Nurses, the Corporate RN, and/or a support RN would audit the storage and documentation of narcotics when checking medication carts to ensure narcotics were stored appropriately and documentation was correct. The audits included: locking carts, MAR's, shift change count sheets, signatures, declining count sheets, wasted narcotics, back side of narcotic medication skids,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 610	Continued From page 153	F 610		

skid cards in numerical order, no missing skids, all narcotics accounted for, and/or pharmacy packing slips. Audits would occur five (5) times per week until the QAPI committee determined frequency could be reduced. Any concern regarding documentation or storage of narcotic administration would be addressed at the time of the audit and reported to the DON or Administrator. All new concerns would be reviewed in the morning IDT meeting. Any concerns and trending would be reviewed and discussed weekly on Fridays.

17. On 07/21/2021, the Regional Vice President interviewed and suspended the facility's Administrator.

18. On 07/20/2021 through 07/25/2021, the RN Corporate Nurses provided education on Abuse, Neglect, and the Misappropriation of Resident Property Policy. The education included: screening of employees, training of employees, prevention, identification, investigation, protection, and reporting/response. One hundred five (105) of one hundred eight (108) employees completed the education at that time. The three (3) remaining employees have since received the education. This education has been added to the new employee orientation for all facility and agency staff.

19. On 07/22/2021, the DON and RN Consultants educated all nurses and Kentucky Medication Aides (KMA) on the Controlled Substance Policy which included the proper way to count narcotics and the correct record keeping for narcotics. As of 07/22/2021, twenty-nine (29) of thirty-one (31) nurses and KMA's were educated. One (1) nurse was on vacation and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 610	Continued From page 154	F 610		

had since returned. One (1) nurse was on Family Medical Leave Act (FMLA) and remained on FMLA. This education included the off-going nurse should have the record for comparison to actual narcotics seen by the on-coming staff member. Narcotics should be signed out at the time they were removed from the packet; a nurse must witness destruction of a dropped or refused narcotic before signing as a witness. KMA's could not be the second signature. (A KMA could not witness for a nurse.) Nurses and KMA's could not tape a medication to hold it in a card. If a narcotic came loose, it must be wasted, and two (2) signatures must be present. This education also included signing the Shift Change Controlled Substance Count Check sheet at the beginning and end of the shift. This education included that the signature was the nurse's affirmation that the count was correct and must be signed when counting. It could not be signed early or late. Nurses and KMA's were also educated regarding deliveries of multiple cards of narcotics. The nurse receiving the narcotics and the nurse whose medication cart would hold the narcotics must both sign for the receipt. If the same nurse was both receiving and had the medication cart, a second nurse must sign also.

20. On 07/26/2021, the DON, Unit Manager, SDC, Nurse Supervisor, MDS Nurse, and Corporate RN consultants began administering a medication administration post-test to all licensed nurses and KMA's. The quiz covered both medication administration and physician notification and validated the licensed nurses and the KMA's continued competency in a written form. Any licensed nurse or KMA not scoring one-hundred percent (100%) on the quiz would receive additional education.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 610	Continued From page 155	F 610		

21. On 07/27/2021, the DON and SDC began abuse/neglect monitoring via nursing progress note review. The past twenty-four (24) hours of nursing notes were printed off and read, looking for any indication of abuse/neglect/exploitation.

22. On 07/27/2021, the DON, SDC, Unit Manager, RN's, and Administrators from "sister facilities", and RN Corporate nurses continued safe surveys, with residents, and staff surveys regarding abuse/neglect.

23. On 07/29/2021, the DON facilitated a Medical Director Update telephone call.

24. On 08/01/2021, the DON e-mailed the narcotic abuse/neglect PIP to the Medical Director.

25. On 08/10/2021, the DON facilitated a QAPI Committee meeting with the Medical Director present. The committee discussed the facility's survey status, including the abuse/neglect PIP. Review of actions taken and audit results concluded in the recommendation for the facility to: 1) continue with the narcotics PIP; 2) provide on-going education; and, 3) continue auditing.

26. On 08/11/2021, the DON completed narcotic cart audits on each of the five (5) medication carts. Audit result: no issues were identified. The Corporate RN Consultant noted the front-north narcotic drawer had a screw sticking out that caused tears and punched holes in the back of multiple narcotic skids. The screw was covered.

27. On 08/12/2021, the DON completed narcotic

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 610	Continued From page 156	F 610		

cart audits on each of the five medication carts. Audit result: no issues.

28. On 08/13/2021, the SDC completed narcotic cart audits on each of the five (5) medication carts. Audit result: no issues.

29. On 08/18/2021, the SDC completed narcotic cart audits on each of the five medication carts. Audit result: no issues.

30. On 08/19/2021 the DON facilitated a Medical Director update telephone call.

31. On 08/20/2021, the DON notified the Medical Director of eight (8) IJ tags and the PIP's that were being worked on.

32. On 08/20/2021, the Administrator, DON, SDC, and Corporate Support staff began additional Code of Conduct in-servicing. The in-service included a quiz. The quiz questions included employees following laws, reporting systems, when to report, who to report to, and where to find more information. The employees were able to verbalize their role in protecting residents and preventing abuse, neglect, and exploitation.

33. On 08/20/2021, the facility verified the facility rebilled and/or paid for the misappropriated medications.

34. On 08/25/2021, the Regional Vice President announced the transition to the new Administrator. The Regional Vice President and Interim Administrator provided education to the new Administrator, including the requirements of the tags F-600 Abuse/Neglect/Exploitation and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 610	Continued From page 157 F-610 Investigate/Prevent/Correct Alleged Violation. 35. On 08/26/2021, the DON facilitated a Medical Director update telephone meeting, including the DON, Regional Vice President, Medical Director, Interim Administrator, new Administrator, and RN Consultant. The discussion included the facility's immediate jeopardy (IJ) status, including the tag F-610 Investigate/Prevent/Correct Alleged Violation. Review of actions taken and audit results concluded in the recommendation for the facility to: 1) provide continued education and 2) continue auditing. 36. On 08/28/2021, the SDC and RN Corporate Nurse provided education to three (3) new dietary employees, including abuse/ neglect, and Investigate/Prevent/Correct Alleged Violation if they saw abuse. 37. On 08/28/2021, the SDC monitored and audited the north-front medication cart and verbally quizzed the medication cart nurse related to preventing and protecting residents from further misappropriation of property (controlled medications). The medication cart nurse passed the quiz with one-hundred percent (100%) correct answers. 38. On 08/28/2021, the SDC, Support RN Nurse, and Corporate RN Consultant monitored medication carts, narcotic medication documentation, and the facility's progress. 39. On 08/28/2021, the RN Corporate Nurse worked with the new Administrator and reviewed the steps to take for a thorough investigation. The Administrator was assigned/responsible for	F 610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 610	Continued From page 158	F 610		

investigations, preventing, and correcting any alleged violations. Review of the Action Checklist for abuse/neglect was also included. This continued on 08/29/2021, at which time the Administrator was able to verbalize the importance of, and timeline for, reporting any allegation of misappropriation of property. The Administrator also articulated corrective actions to protect, thoroughly investigate, and resolve alleged violations.

40. On 08/29/2021, the DON, four (4) Support RN Nurses, and a Corporate RN Nurse interviewed staff and residents, inspected medication carts, and reviewed narcotic documentation. No new staff concerns were received. No new resident concerns were received, as residents stated they were receiving their medications. No narcotic medications were identified as missing.

41. Starting 08/29/2021, the facility's IDT would have a meeting five (5) times a week to review concerns. The Administrator or DON would identify an investigator to conduct the investigation. The Cardinal IDT tool would be utilized to track the investigation and ensure the investigation was completed timely and thoroughly.

42. The Pharmacy Consultant would visit the facility at least monthly to validate narcotics were being monitored and counted per standard of practice.

The State Survey Agency validated the implementation of the facility's Immediate Jeopardy Removal Plan as follows:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 610	Continued From page 159	F 610		

1. Review of a Quality Assurance (PIP), dated 07/09/2021, revealed, as a result of the missing blister pack of thirty (30) Percocet identified in a pharmacy audit, the facility identified only one (1) staff was signing for narcotics arriving at the facility, and initiated education on controlled substances, to include having a second person sign for controlled substances arriving at the facility.

Review of a Long Term Care Facility Self-Reported Incident Form, dated 07/09/2021, confirmed the facility reported the incident of misappropriation to all appropriate parties, to include the Office of Inspector General (State Survey Agency) on 07/09/2021.

2. Review of documentation confirmed facility staff audited narcotics in all medication carts on 07/09/2021. Review of audits revealed no other missing narcotics.

3. Review of a Complete In-Service Training Report with Staff Attending, dated 07/09/2021, confirmed the SDC initiated staff education, attended by licensed nursing staff and KMA's. Education covered the need for both the off going and on coming shift to sign the Shift Change Controlled Substance Count Check sheet at change of shift, the importance of completing an appropriate narcotic count at shift change, adding and subtracting sheets from the Shift Change Controlled Substance Count Check sheet, and the employee accepting delivery for narcotics must sign each individual sheet of the packing slips.

Interview with the SDC, on 09/02/2021 at 4:49 PM, revealed she provided all nurses and KMA's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 610	Continued From page 160	F 610		

a packet of education on medication administration as well as having each nurse sign for delivery of narcotics.

4. Interview, on 09/02/2021 at 9:10 AM, with the Clinical Director revealed that she, prior to her arrival, the Facility Consultant, had been in the facility on the dates documented in the IJ Removal Plan. She revealed her daily routine consisted of talking to residents on both the South and North halls of the building, observing staff providing care, and talking with staff. She revealed she assessed and interviewed for evidence of abuse. She revealed she also conducted chart reviews and validated the facility was continuing audits and doing everything they were supposed to be doing. The Clinical Director stated she had made surprise visits to the facility at 2:00 AM, as well as on weekends, to determine any resident concerns and ensure staff was following procedures they had been educated on.

5. Review of Complete In-Service Training Report with Staff Attending, dated 07/12/2021, confirmed the DON initiated staff education for licensed nursing staff and KMA's. Education covered (1) All PRN (as needed) medications must be signed on the back of the MAR, (2) all narcotics no longer in use must stay locked up in the medication cart until they could be given to the DON, and (3) declining count sheet must be labeled with room numbers at the top of the sheet.

Interview with the DON, on 09/02/2021 at 9:10 AM, revealed it had been determined not everything was signed out consistently on the back of the MAR, so the education initiated, on 07/12/2021, emphasized to staff the need to do

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 610	Continued From page 161	F 610		

this, including documenting the effectiveness of pain medication administered to residents.

6. Review of a Kentucky Incident Based Reporting System (KYIBRS) Report, dated 07/18/2021, revealed LPN #1 had been arrested and charged with thirteen (13) counts of Theft by Unlawful Taking, three (3) counts of Possession of Controlled Substances, two (2) counts of Wanton Endangerment, and two (2) counts of Abuse and Neglect of an Adult Person.

Review of LPN #1's employee file confirmed LPN #1 had been terminated from employment on 07/18/2021.

7. Review of the Narcotic PIP confirmed, as a result of the 07/18/2021 incident in which two (2) residents had narcotics replaced with non-prescribed medications, a PIP addendum was in place to identify the scope of residents affected, as well as further staff education on controlled substances and monitoring by management staff.

8. Review of meeting minutes, dated 07/18/2021, confirmed the IDT met and were in agreement to provide abuse/neglect education, abuse/neglect monitoring via progress note review, safe surveys with residents, and staff surveys regarding abuse and neglect.

9. Review of Packing Slips revealed two (2) staff nurses were consistently signing for incoming narcotics, with nursing staff additionally initialing the count slips for medications specifically received for their medication carts. The review confirmed all packing slips were being signed; however, there was not consistent documentation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 610	Continued From page 162	F 610		

indicating the slips had been reviewed by either the DON, Unit Manager, Administrator, a Corporate RN, or a Support RN.

One (1) packing slip, dated 07/22/2021, was signed for by one (1) nurse. Further review determined this nurse received consultation and reeducation by the Facility Consultant regarding the need for two (2) signatures always.

Interview with the DON, on 09/02/2021 at 9:10 AM, revealed when reviewing packing slips, she confirmed there were two (2) signatures and checked to ensure everything listed on the packing slips was on the medication cart; then she would initial the packing slips to show she reviewed them.

10. Review of Pain Assessments revealed Pain Assessments were completed for all facility residents on 07/19/2021. No concerns were identified. Additionally, Resident Interview Medication Administration papers were reviewed, with no concerns identified.

Interview with the DON, on 09/02/2021 at 9:10 AM, revealed no new or untreated pain was identified through the pain assessments conducted on 07/19/2021.

11. Review of Ambulatory Nursing Home Report confirmed APRN #1 assessed Resident #84 on 07/19/2021. No concerns were identified with the assessment of Resident #84.

Review of the physician visit by the Medical Director (MD) with Resident #32, on 07/20/2021, revealed possible indicators Resident #32's opiates had been replaced with Primidone. MD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 610	Continued From page 163	F 610		

documentation revealed Resident #32's condition improving at the time of documentation. MD documentation further revealed APRN #2 had visited with Resident #32 on 07/19/2021.

12. Review of a Long Term Care Facility - Self-Reported Incident Form, dated 07/20/2021, confirmed LPN #2 had been suspended from the facility.

13. Review of Resident Interview Medication Administration confirmed facility staff interviewed three (3) or more residents each week beginning on 07/20/2021 regarding any concerns with medication administration, and if so who they reported to and when. No concerns were noted in review of resident interviews.

Review of Shift Change Narcotic Review sheets, also used to document nurse and KMA concerns regarding narcotics administration, revealed no forms had been completed, indicating no concerns had been reported as of the review date of 09/02/2021.

Interview with the DON, on 09/02/2021 at 9:10 AM, revealed she frequently interviewed residents as part of the audit process, asking about any concerns regarding their medications. She revealed, if residents were to express a concern, she would educate them on reporting and share their concerns in QAPI meetings. To date, she revealed no residents or staff had expressed any concerns to her regarding narcotics administration.

14. Review of documentation confirmed the DON audited medication carts, on 07/20/20, and determined Resident #9 was missing skid two (2)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 610	Continued From page 164	F 610		

of two (2) for Percocet and Resident #76 was missing skid four (4) of four (4) for Norco (a narcotic pain medication). Review of Shift Change Controlled Substance Count Check sheets confirmed one (1) sheet ended at forty-six (46), while the following sheet started at forty-two (42).

15. Resident Interview Medication Administration documentation was reviewed. Residents were questioned the Regional Vice President by the Social Services Director or the Admissions Coordinator about whether or not they had concerns regarding administration of their medications. If residents indicated concerns, this was explored further, to include to whom the residents reported concerns and when. No issues were identified during documentation review.

16. Review of Narcotic Cart Audit forms, dated 07/21/2021 confirmed the DON audited the storage and documentation of all facility medication carts. Continued review of audits revealed audits were occurring five (5) or more times each week. Review of Narcotic Cart Audit forms revealed required education was given, on 07/22/2021, for a KMA who had pulled narcotics but did not sign at the time the narcotics were given.

17. Interview with the Regional Vice President, on 09/02/2021 at 7:07 PM, confirmed the previous Administrator had been suspended on 07/21/2021, as a result of concerns regarding the way the Administrator handled the drug diversion issue. The Regional Vice President stated he was present at the facility acting in the capacity of Administrator from 07/21/2021 through

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 610	Continued From page 165	F 610		

07/23/2021, with an Interim Administrator present at the facility, beginning 07/27/2021, until a new Administrator started on 08/26/2021.

18. Review of Complete In-Service Training Report with Staff Attending, with a start date of 07/20/2021, revealed staff was educated on the facility Abuse, Neglect, and Misappropriation of Resident Property Policy, revised 03/10/2017. The focus of the training appeared to be on reporting and following the chain of command in reporting if the situation had not been addressed. The chain of command consisted of the employee's supervisor, the DON, the Administrator, and followed by the Corporate Compliance line or the Regional Vice President. The training also noted calls to the Corporate Compliance line could be anonymous. Review of sign in sheets for training revealed the last employee completed the training, on 08/10/2021.

Interviews, on 09/02/2021, with Housekeeper #4, at 2:27 PM; the Admissions Coordinator, at 2:48 PM; RN #3, at 3:14 PM; and SRNA #23, at 3:21 PM, revealed they all had received education on abuse/neglect and misappropriation. In addition, each was able to identify their immediate supervision and that they would go up the chain of command if their concern was not addressed.

19. Review of a Complete In-Service Training Report with Staff Attending, initiated on 07/19/2021, revealed licensed nursing staff and KMA's were educated on the Controlled Substances policy, dated 09/2020. Although the policy itself did not cover damaged skids, documentation revealed the training covered not taping the backs of skids.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 610	Continued From page 166	F 610		

Interview with the DON, on 09/02/2021 at 9:10 AM, revealed education emphasized skids could not be taped, and discussed the proper way to waste narcotics. She revealed a nurse could sign for a KMA to waste narcotics, however, a KMA could not sign for a nurse. She stated drugs were all to be wasted in the Drug Buster, which was a chemical container that drugs were placed in for disposal. She stated staff was educated on the requirement for two (2) staff to sign for receipt of narcotics.

Interviews, on 09/02/2021 with LPN #11, at 3:03 PM, and RN #3 at 3:14 PM, revealed both had been educated on the proper way to do a narcotic count at shift change, counting skids, comparing to the number of controlled substance sheets, and wasting medications, with another nurse witnessing and signing, in the Drug Buster kept in the medication rooms. Both stated education also covered the importance of signing and completing pain assessments on the back of the MAR for PRN (as needed) medications and signing with another nurse when narcotics arrived. LPN #11 also stated, if a skid was damaged, to report it to the DON, and if a medication was in danger of falling out of a damaged skid, it was to be wasted with another nurse witnessing and signing. LPN #11 revealed she had seen and experienced management staff, including the DON, going around doing medication cart audits, and she stayed with her medication cart while was being audited.

Interview with SRNA #20, on 09/02/2021 at 3:39 PM, a KMA, revealed he received the same education nursing staff received. He revealed he had received multiple educations. The KMA stated the education included the importance of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 610	Continued From page 167	F 610		

signing out narcotics when he gave them and not waiting until the end of shift to sign them out. He revealed he signed them out right after they were given, and if a resident refused, he would mark it as a refusal and have a nurse witness and sign the medication as wasted. He stated, if a pill or skid was compromised, or if anything looked tampered with, he would alert the DON so she could assess and determine if medications needed to be wasted. He revealed corporate nurses had audited his drug cart recently.

20. Review of the facility's Narcotic Administration Quiz revealed licensed nurses and KMA's completed written quizzes, beginning on 07/26/2021. Quiz responses reviewed were appropriate, with no concerns identified during review of them.

21. Interview with the DON, on 09/02/2021 at 9:10 AM, revealed the DON and the SDC printed and reviewed all resident progress notes, highlighting anything potentially indicative of abuse or neglect. She revealed, in addition to reviewing any incidents and accidents, they looked for any documentation of resident injuries or behaviors. She stated this was an ongoing process and was reviewed in IDT meetings.

22. Review of Safe Surveys with residents, and untitled surveys with employees, revealed staff conducted surveys, on 07/27/2021, with no concerns identified.
Interview with Housekeeper #4, on 09/02/2021 at 2:27 PM, revealed she had completed a staff survey asking if she had any concerns.

23. Review of documentation confirmed the Medical Director was updated regarding the PIP's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 610	Continued From page 168	F 610		

for Abuse and Narcotics and ongoing audits on 07/29/2021.

24. Review of an email, with the Abuse PIP and Narcotic PIP attached, confirmed it was sent to the Medical Director, on 08/01/2021.

25. Review of a QAPI Committee meeting agenda, from 08/10/2021, revealed the Abuse PIP was in the monitoring phase, with monitoring continuing. Review of a sign in sheet, dated 08/10/2021, revealed the Medical Director was in attendance at the meeting.

Interview with the Medical Director, on 08/10/2021 at 4:11 PM, revealed the DON had been in contact with him two (2) to three (3) times a week and had provided him all the PIP's that had been planned out. The Medical Director revealed he was extremely pleased at the progress the facility had made addressing their problems.

26. Review of the Narcotic Cart Audit sheets used for facility narcotic cart audits revealed staff were auditing to ensure (1) All staff were signing the Controlled Substance Count Sheet (CSCS) at shift change, (2) All narcotic sheets had been counted, (3) the number of narcotic count sheets matched the number of skids on the cart, (4) Skids on the cart did not have tape on their backs, (5) Skids were checked to ensure there were no missing skids, (6) CSCS were being logged in and out of the cart on the Shift Change Controlled Substance Count Check form as the sheet count number changed (new skids arrived, skids were completed), and (6) All narcotics were signed out and accounted for.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 610	Continued From page 169	F 610		

Review of a Narcotic Cart Audit completed, on 08/11/2021 at 11:42 AM, by the DON revealed the audit was completed with no issues noted or corrective action required or taken. The Corporate RN Consultant noted the front-north narcotic drawer had a screw sticking out that caused tears/punched holes in the back of multiple narcotic skids: The screw was covered.

27. Review of Narcotic Cart Audit completed, on 08/12/2021 at 5:10 PM, by the DON revealed the audit was completed with no issues noted or corrective action required or taken.

28. Review of the Narcotic Cart Audit completed, on 08/13/2021 at 2:25 PM, by the DON revealed the audit was completed with no issues noted or corrective action required or taken.

29. Review of the Narcotic Cart Audit completed, on 08/18/2021 at 10:30 AM, by the SDC revealed the audit was completed with no issues noted or corrective action required or taken.

30. Documentation review confirmed the DON provided the Medical Director an update call on 08/19/2021.

31. Review of facility documentation confirmed the DON informed the Medical Director, on 08/20/2021 of the eight (8) IJ tags and the PIP's that were being worked on.

32. Review of Code of Conduct in-servicing, revealed the sign-in sheet documented all staff had completed training. Review of employee quiz information revealed employees were educated on reporting of fraud or abuse, as well as the availability of the Corporate Compliance line, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 610	Continued From page 170	F 610		

the ability to make anonymous reports if desired, with the goal of ensuring all potential violations were reported and addressed.

Interview with SRNA #24 and the Occupational Therapist, on 09/02/2021 at 3:30 PM, revealed both had received training on the Code of Conduct, which included abuse, neglect, misappropriation, what to report, who to report to, and when to report. Both revealed if they were to report an allegation to their supervisor and did not feel like it was being addressed, they could contact the DON and Administrator, as well as call or fax the Corporate Compliance line.

33. Review of facility documentation, not labeled or dated, revealed a total of one hundred and eight (108) narcotics were documented as missing, which included three (3) skids of thirty (30) medications each that were missing, and four (4) non-controlled medications that were documented as missing. The document listed residents by name, along with discrepancies noted, the cost for each individual dose, resident payors, and the total cost of all medications reimbursed, which was three hundred and four dollars and ninety-seven ($304.97) cents.

34. Review of an Appointment Letter as facility Administrator revealed appointment of a new Administrator, on 08/26/2021, with an Administrator job description, reporting to the Regional Vice President, who also signed the letter on 08/26/2021.

Interview with the Administrator, on 09/02/2021 at 6:32 PM, confirmed he spoke with the Interim Administrator and the Regional Vice President over the phone, on 08/25/2021, and they

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 610	Continued From page 171	F 610		

discussed with him the IJ tags the facility had been cited, to include abuse and misappropriation tags. He stated they wanted to make sure he was aware of the situation he would be coming into. He stated the Regional Vice President had stressed the importance of reporting allegations and keeping him informed.

35. Review of the document Communication with Medical Director, signed by the Medical Director on 08/28/2021, confirmed the Medical Director was provided an update by the DON on the Immediate Jeopardy (IJ) citations and corrective actions the facility was taking to address the citations.

Interview with the Administrator, on 09/02/2021 at 6:32 PM, revealed he was present for the phone call with the Medical Director, on 08/26/2021, in which the jeopardy citations were discussed, as well as the audits the facility had been doing and the education the facility had provided. He revealed they went down each one of the tags, discussing issues and what was being done to address issues.

36. Review of three (3) Employee Affirmation Statements, dated 08/28/2021, revealed three (3) new dietary employees had received and reviewed the Code of Conduct as part of their orientation. Further, review of In-Service Training Report, dated 08/28/2021, revealed new staff had received training on abuse, neglect, and misappropriation investigating and reporting.

37. Review of Shift Change Narcotic Review sheet completed by the SDC, on 08/28/2021, confirmed the north-front medication cart was audited, and LPN #6 was verbally quizzed, with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 610	Continued From page 172	F 610		

no concerns identified.

38. Review of Shift Change Narcotic Review sheets, completed by the SDC, support RN's, and corporate RN's, revealed medication carts and narcotic documentation were monitored on 08/28/2021, 08/29/2021, and 08/30/2021, with no issues identified.

Interview with the Clinical Director, on 09/02/2021 at 9:10 AM, revealed she, the SDC, and a sister facility nurse went to each medication cart, on 08/28/2021 at shift change with their audit tools, and went through the packet of audit tools with medication cart staff, asking questions about documentation and reporting. She revealed this process was repeated on 08/29/2021 with a nurse from a different sister facility. She revealed there had been no concerns with the audits.

39. Interview with the Administrator, on 09/02/2021 at 6:32 PM, confirmed the Clinical Director had thoroughly reviewed with him abuse reporting and investigating.

Interview with the Clinical Director, on 09/02/2021 at 9:10 AM, revealed she reviewed an investigation file with the Administrator on 08/29/2021. She revealed they went down the Action Checklist, reviewed the process, and the Administrator made notes to himself on what he needed to do and on what he could do at that time. The Clinical Director stated the Administrator had interviewed residents, called residents' representatives, and was very thorough in his investigation of misappropriation.

40. Review of the facility's Weekend Audits, dated 08/28/2021, confirmed the Administrator

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 610	Continued From page 173 and a support RN interviewed staff and residents regarding abuse, code of conduct, and medication administration. Staff members were able to answer questions accurately, and residents did not express any concerns during interviews. Further, nursing staff conducted an audit of narcotic documentation and did not determine any concerns. 41. Review of the Cardinal IDT Meeting minutes for 08/30/2021, 08/31/2021, and 09/01/2021 revealed evidence the facility had initiated five (5) times weekly IDT meetings. 42. Interview with the Consultant Pharmacist confirmed she visited the facility monthly and conducted a narcotics audit during her monthly visits. Interview with the DON, on 09/02/2021 at 9:10 AM, confirmed the Consultant Pharmacist conducted monthly visits, reviewed charts, and conducted a medication administration audit. She stated the only time the Consultant Pharmacist was not coming were times, during the last year, when the facility was in lock-down due to the pandemic.	F 610		
F 641 SS=G	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review,	F 641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 641	Continued From page 174	F 641		

and review of the Centers for Medicare and Medicaid Services, "Resident Assessment Instrument (RAI) Manual 3.0", it was determined the facility failed to ensure the Minimum Data Set (MDS) Assessment accurately reflected the resident's status for two (2) of forty-four (44) residents (Residents #13 and #245).

Observation of Resident #13, on 08/09/2021, 08/10/2021, and 08/12/2021 revealed the resident had functional limitations in bilateral lower extremities: hips and knees and his/her mobility was dependent on an "Evolution" chair (a chair that addressed mobility and positioning needs).

However, review of Resident #13's Quarterly Minimum Data Set (MDS) Assessment, dated 08/10/2021, revealed the resident did not have functional limitations in Range of Motion (ROM) for lower bilateral extremities and did not use a mobility device.

Review of Resident #245's fall assessment and Progress Notes revealed the resident had two (2) falls on 02/19/2021 and 02/23/2021, prior to the Quarterly MDS Assessment, dated 02/26/2021, which only reflected one (1) fall.

The findings include:

Interview with the MDS Coordinator, on 08/13/2021 at 2:51 PM, revealed the facility utilized the Resident Assessment Instrument (RAI) Manual 3.0, as a guideline for accuracy of assessments. Additionally, she stated the Assessment process included communication with licensed and non-licensed direct care staff members, face-to-face observations and assessment of residents, and review of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 641	Continued From page 175	F 641		

medical record.

Review of the Centers for Medicare and Medicaid Services, "Resident Assessment Instrument (RAI) Manual 3.0," dated October 2019, revealed the primary purpose of the MDS Assessment was to identify resident care problems; address resident problems in individualized care plans; and, monitor the quality of care provided to residents. Additional review revealed the Assessment should be an accurate reflection of the resident's status.

1. Review of Resident #13's medical record revealed the facility admitted the resident, on 07/28/2017, with diagnoses that included Dementia, Major Depressive Disorder, Arthritis, and Schizoaffective Disorder.

Rreview of Resident #13's most current comprehensive Significant Change MDS Assessment, dated 12/14/2020, Section C: Cognitive Pattern, revealed the resident had short and long term memory problems; moderately impaired cognitive skills for daily decision making. Additional review of Section G: Functional Status, revealed the resident ambulated in his/her room independently with setup help from staff and ambulated in the corridor independently with no setup or physical help from staff. Continued review revealed the resident had no functional limitations in ROM for upper or lower bilateral extremities.

Review of Resident #13's Comprehensive Care Plan (CCP), revised on 06/24/2021, revealed a focus for mobility: positioning and locomotion. The goal was for the resident to maintain mobility. The intervention revealed the resident was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 641	Continued From page 176	F 641		

dependent on an Evolution chair (a device that addressed mobility and positioning needs).

Review of Resident #13's most current Quarterly MDS Assessment, dated 08/10/2021, Section C: Cognitive Pattern, revealed the resident had short and long term memory problems; moderately impaired cognitive skills for daily decision making. Additional review of Section G: Functional Status, revealed ambulation did not occur, and the resident did not use a mobility device. Further, the resident required extensive assistance of two (2) staff with ADL's such as bed mobility, transfer, toileting, personal hygiene, dressing, and eating. Continued review revealed the resident had no functional limitations in ROM for upper or lower bilateral extremities.

Observation of Resident #13, on 08/09/2021 at 4:11 PM, revealed the resident lying in bed. It was noted that at rest, the resident's bilateral lower extremities were bent at the knees and the resident's left leg rested on the right leg. Further observation revealed an Evolution chair at the bedside.

Observation of Resident #13, on 08/10/2021 at 11:58 AM, revealed the resident was lying in bed. Additionally, at rest, the resident's left leg was bent greater than the right leg. The resident's left calf touched the left thigh. Continued observation revealed the resident's left leg fell over the resident's right leg.

Observation of Resident #13, on 08/12/2021 at 3:06 PM, with Registered Nurse (RN) #6, revealed the resident had functional limitations in his/her bilateral lower extremities: hips and knees. The resident's right knee was bent at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 641	Continued From page 177	F 641		

approximately a ninety (90) degree angle, and the resident was not able to flex or extend the right knee past the resting position. Further observation revealed the resident's left leg was bent greater than forty-five (45) degrees, and the resident was not able to flex or extend the left knee beyond the resting position. The resident's legs touched each other, and the left leg crossed the right leg. RN #6 stated the resident's bilateral quadriceps were tight, and there was resistance when trying to move the resident's knees and when trying to move the resident's legs apart. Further, when RN #6 attempted to move the resident's left leg off the right leg, the resident moaned and attempted to grab the nurse's hands. Additional observation revealed when the resident was at rest, the resident's left leg rolled to the right over the right leg, and the resident was not able to control normal alignment of his/her legs.

Interview with RN #6, on 08/12/2021 at 3:06 PM, revealed Resident #13's legs were severely contracted. Per the interview, the resident had a decline in December of 2020 and had not been ambulatory since then. Further, she stated it was important to provide care to residents to meet their needs and ensure quality care.

Continued observation of Resident #13, on 08/12/2021 at 3:41 PM, revealed the resident was sitting up in his/her Evolution chair at the bedside. The resident's right foot was resting on the floor; however, the resident's left leg was bent at the knee and the resident's foot was suspended in the air, at rest. The resident's left leg's was bent at the knee and was positioned above the resident's right knee.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 641	Continued From page 178	F 641		

Interview with State Registered Nurse Aide (SRNA) #19 (worked at the facility for twelve (12) years), on 08/12/2021 at 11:00 AM, revealed she was often assigned to provide care to Resident #13. Per the interview, the resident was not able to put his/her legs down and he/she held them bent at all times. In addition, she stated the resident's legs had been bent for several months. SRNA #19 stated she provided passive ROM to the resident's arms and legs for one (1) hour a day during care. Further, she stated Resident #13 had an Evolution chair that he/she was assisted to daily.

However, review of the Quarterly MDS assessment, dated 08/10/2021, revealed the assessment did not capture Resident #13's functional limitations in ROM, bilateral lower extremities, or the mobility device used daily.

Further, review of Resident #13's nurse aide care plan (Kardex), dated 08/13/2021, revealed the resident was dependent on an Evolution chair for mobility.

Interview with Licensed Practical Nurse (LPN) #13/MDS Coordinator and Registered Nurse (RN) #7/MDS Coordinator (at the facility for seven (7) years), on 08/13/2021 at 2:51 PM, revealed they used the RAI guidelines to ensure accurate MDS Assessments. Per the interview, when collecting data to complete MDS Assessments, they interviewed staff and the resident; completed a face-to-face assessment of the resident, and reviewed the medical record in its entirety. In addition, they stated it was important to ensure MDS Assessments were accurate and that they reflected the current status of the resident because the MDS Assessment helped develop

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 641	Continued From page 179	F 641		

and revise the Comprehensive Care Plan (CCP).

Continued interview with LPN #13/MDS Coordinator and RN #7/MDS Coordinator, on 08/13/2021 at 2:51 PM, revealed, after review of Resident #13's CCP, dated 06/24/2021, the Quarterly MDS Assessment, dated 08/10/2021, should have been coded to indicate the resident used an Evolution chair for mobility. They also stated, after review of the SSA Surveyor's observations, on 08/09/2021, 08/10/2021, and 08/12/2021, limitation in functional ROM to the bilateral lower extremities should have been coded for Resident #13's Quarterly MDS Assessment, dated 08/10/2021. Per the interview, LPN #13 stated she assessed Resident #13's bilateral lower extremity ROM, during the Assessment Reference Date (ARD) and determined the resident's legs were bent, and he/she could not straighten them. However, she failed to document that the resident's bilateral lower extremities had limitations in ROM/contractures.

Interview with the Director of Nursing (DON), on 08/13/2021 at 2:31 PM, revealed she had worked at the facility as the DON for one (1) year. Per the interview, she expected the MDS Assessments to be accurate, as per the RAI guidelines. In addition, she stated LPN #13/MDS Coordinator and RN #7/MDS Coordinator were responsible for section "G" Functional Status. After review of Resident #13's CCP and the SSA Surveyor's observations, on 08/09/2021, 08/10/2021, and 08/12/2021, she stated limitation in functional ROM to bilateral lower extremities and a mobility device should have been coded on the 08/10/2021 Quarterly MDS Assessment.

2. Review of Resident #245's medical record

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 641	Continued From page 180	F 641		

revealed the facility admitted the resident, on 01/18/2021, with diagnoses including Parkinson's Disease, Major Depression, Dementia, and Diabetes Mellitus Type 2.

Review of Resident #245's Quarterly Minimum Data Set (MDS) Assessment, dated 02/26/2021, revealed the facility assessed the resident with the Brief Interview for Mental Status (BIMS) examination. Resident #245 scored four (4) out of fifteen (15), which indicated severe cognitive impairment. Continued review revealed in Section G: the resident was a one (1) person assist for bed mobility and self-transfers. The resident used mobility devices, walker and wheelchair. Further review of Section G revealed the resident was not steady for moving from seated to standing position, walking, turning around, and surface-to-surface transfers between the bed and wheelchair. Further review of this MDS Assessment, revealed Resident #245's fall, on 02/23/2021, which occurred during the look back period, prior to the assessment, was not noted on the MDS.

Review of Resident #245's CCP, dated 01/18/2021, revealed the resident had an area of Focus for falls with interventions listed. Further review revealed the Focus area did not address the falls on 02/19/2021 or 02/23/2021 and revealed no revision of interventions after these falls. (see F-657)

Review of the incident reports for falls revealed Resident #245 had falls, on 02/19/2021 and 02/23/2021. Review of Resident #245's fall assessment and Progress Notes revealed the resident had two (2) falls, on 02/19/2021 and 02/23/2021, prior to the Quarterly MDS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 641	Continued From page 181	F 641		

Assessment, dated 02/26/2021, which only reflected one (1) fall.

Interview with LPN #13/MDS Coordinator, on 08/18/2021 at 11:02 AM, revealed she found out about the falls from the Interdisciplinary Team (IDT) meetings, Risk Management, and review of the Progress Notes. She stated Resident #245 had a history of two (2) falls, prior to 02/26/2021, and the Quarterly MDS Assessment, dated 02/26/2021, should have recorded the second fall.

Additional interview with the DON, on 08/18/2021 at 11:19 AM, revealed the MDS Assessment should have been updated and accurate to reflect Resident #245's current condition, with the second fall.

Interview with the DON, on 08/13/2021 at 2:31 PM, revealed the MDS Assessments guided the development or revision of the CCP. Further interview revealed the MDS Assessment was to be an accurate reflection of the resident's status in order for residents to receive appropriate services and individualized care.

Interview with the Administrator, on 08/16/2021 at 3:30 PM, revealed he had worked at the facility since 07/27/2021. Per the interview, the facility utilized the RAI Manual as a resource to ensure accuracy of the MDS Assessments. He stated it was important for the MDS Assessments to accurately reflect a resident's current status in order to ensure the CCP was developed or revised to address each resident's individual needs and to ensure resources were provided as necessary to meet the resident's care needs.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 656	Continued From page 182	F 656		
F 656 SS=G	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)	F 656		

§483.21(b) Comprehensive Care Plans
§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -
(i) 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 §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 656	Continued From page 183 entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the Centers for Medicare and Medicaid Services (CMS), "Resident Assessment Instrument (RAI) Manual 3.0", it was determined the facility failed to develop and/or implement a person centered Comprehensive Care Plan (CCP) for each resident that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for four (4) of forty-four (44) sampled residents (Residents #13, #77, #240, and #36). 1. The CCP for Resident #240 did not specify the assistance required for bed mobility, which contributed to an unlicensed staff member providing assistance to Resident #240 without a	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 656	Continued From page 184	F 656		

second, licensed staff member present. Resident #240 suffered a fall with serious injury on 01/27/2021.

2. The CCP for Resident #13 was not developed to include bilateral lower extremity contractures or Restorative Care with interventions, services, or treatment to maintain current functional status or prevent a decrease in function.

3. The CCP for Resident #77 was not implemented consistently related to Restorative Care interventions, services, or treatment (left palmar splint) to maintain current functional status or prevent a decrease in function.

4. The CCP for Resident #36 was not developed to include the air mattress that was purchased for the resident.

The findings include:

Review of the Centers for Medicare and Medicaid Services, "Resident Assessment Instrument (RAI) Manual 3.0", dated October 2019, revealed the Comprehensive Care Plan was an interdisciplinary communication tool and must include measurable objectives and time frames and must describe the services to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Additionally, the facility was responsible for assessing and addressing all care issues that were relevant to individual residents, regardless of whether or not they were covered by the RAI, including monitoring each resident's condition and responding with appropriate interventions. Further review revealed the services provided or arranged must be consistent

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 656	Continued From page 185	F 656		

with each resident's written Plan of Care.

1. Review of Resident #240's medical record revealed the resident was re-admitted to the facility, on 03/26/2020, with diagnoses to include Paraplegia Unspecified, Unspecified Atrial Fibrillation, and Morbid (Severe) Obesity due to Excess Calories.

Review of Resident #240's Quarterly Minimum Data Set (MDS) Assessment, dated 01/05/2021, as a fifteen (15) of fifteen (15) on the BIMS, indicating no cognitive impairment. Further, the facility assessed Resident #240 as an assist of two (2) with bed mobility, transfers, and dependent on two (2) staff for toileting. In additional, review of previous MDS Assessments, a Quarterly , dated 10/08/2020; a Quarterly, dated 07/01/2020, and an Annual, dated 05/29/2020, all revealed Resident #240 was assessed as an assist of two (2) with bed mobility, transfers, and toileting.

Review of the facility Fall Protocol, as referenced in the Quality Assurance and Performance Improvement Guidance Manual, revised 02/04/2021, revealed falls were to be investigated to determine the root cause of the fall and validate the investigation was completed.

Review of an Investigational Summary of a fall that occurred, on 01/27/2021 at 5:45 AM, revealed Resident #240, a paraplegic with no control over his/her lower extremities, was receiving care from a staff member when he/she rolled out of the bed approximately eighteen (18) inches onto the floor, resulting in multiple skin tears and bruising. The Investigation Summary further stated the Medical Director was notified,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 656	Continued From page 186	F 656		

and mobile x-ray was ordered of bilateral hips, pelvis, and left shoulder, which was completed on site that day. Further review revealed X-ray results were returned at 1:35 PM on 01/27/2021, with abnormal results, and Resident #240 was ordered to be transferred to the hospital. Resident #240 returned from the local hospital, on 01/27/2021 at 8:30 PM, with a diagnosis of left humeral fracture.

Review of Resident #240's CCP revealed the resident's mobility care plan, prior to 01/27/2021, had not been developed to indicate the assistance required for bed mobility, transfers, or toileting. However, all four (4) previous MDS Assessment, on 01/05/2021, 10/08/2020, 07/01/2020, and 05/29/2020, assessed the resident as requiring an assist of two (2) with bed mobility, transfers, and toileting. On 01/27/2021, the resident's CCP was updated for two (2) person assist with bed mobility.

Review of the Witness Statement from Personal Care Assistant (PCA) #2, dated 01/27/2021, revealed PCA #2 was providing incontinence care Resident #240 when the resident's hand slipped off the rail, resulting in a fall. PCA #2 revealed she notified the nurse to come and help as soon as possible.

Review of the Witness Statement from LPN #17 revealed she was called into Resident #240's room, on 01/27/2021, and noted Resident #240 on the floor on his/her back between the beds. LPN #17's statement revealed Resident #240 said "I couldn't hold on." LPN #17's statement revealed she completed a head-to-toe assessment of the resident and noted a skin tear to the right lower arm, a skin tear to the right inner

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 656	Continued From page 187	F 656		

knee, an abrasion to the left elbow, and a skin tear to the second toe on the left foot.

Review of the Witness Statement from State Registered Nurse Aide (SRNA) #11 revealed she was doing rounds, on 01/27/2021 with SRNA #12, and SRNA #12 yelled for her, and LPN #17 responded to the room to help because Resident #240 was in the floor. SRNA #11 stated PCA #2 was changing Resident #240 when Resident #240 slipped out of bed.

Interview with PCA #2, on 07/31/2021 at 9:32 AM, revealed she had been told she was not allowed to change residents without an SRNA present. She revealed SRNA #11 and SRNA #12 had stepped out of the room and told her to go ahead and change Resident #240. She revealed SRNA #11 had gone to the bathroom, and SRNA #12 had left the room as well. PCA #2 stated when she went to change Resident #240, the resident's foot slid off of the bed, and by the time she got down there to catch him/her, the resident had already fallen. She stated the incident had scarred her for life. PCA #2 revealed she had changed Resident #240 numerous times and never had a problem but knew she was not supposed to be changing a resident without an SRNA being present.

Interview with RN #7/MDS Coordinator, on 08/04/2021 at 3:29 PM, revealed, prior to 01/27/2021, Resident #240's care plan might not have indicated the assistance required for bed mobility. She revealed there had been an update to their system that occurred after Resident #240 had been admitted, and specific information on his/her bed mobility might have been erased. She stated the nurse aide care plans (Kardex)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 656	Continued From page 188	F 656		

were a reflection of the CCP, so this information would not have been reflected on the nurse aide care plan prior to 01/27/2021.

Interview with the DON, on 08/04/2021 at 8:28 AM, revealed care plans should match the MDS, which was a reflection of a resident's care needs. She stated she would expect staff to follow the care plan.

Additional interview with the DON, on 08/18/2021 at 10:48 AM, revealed MDS nurses followed the RAI manual in developing and revising care plans. She revealed the highest level of care required during the look back period was what was coded, and staff could always provide more care than the care plan specified, but could not provide less care.

2. Review of Resident #13's medical record revealed the facility admitted the resident, on 07/28/2017, with diagnoses including Dementia, Major Depressive Disorder, Arthritis, and Schizoaffective Disorder.

Review of Resident #13's Admission Minimum Data Set (MDS) Assessment, dated 08/04/2017, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of three (3) of fifteen (15), indicating severe cognitive impairment. Additional review revealed the resident had no functional limitations in Range of Motion (ROM) for upper or lower bilateral extremities. Per the Assessment, the resident was ambulatory and did not use a mobility device. Further, the resident required extensive assistance of one (1) staff with bed mobility, transfer, dressing, toileting, and personal hygiene.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 656	Continued From page 189	F 656		

Observation of Resident #13, on 08/09/2021 at 4:11 PM, revealed the resident lying in bed with a thin throw over his/her abdomen and lower extremities; bilateral lower extremities were bent at the knees, and the resident's left leg rested on the right leg.

Additional observation of Resident #13, on 08/10/2021 at 11:58 AM, revealed the resident was lying in bed uncovered from the waist down. The resident's bilateral lower extremities were bent at the knees. Further, at rest, the resident's left leg was bent greater than the right leg was bent at rest. His/her left calf touched the left thigh. The resident's left leg fell over the resident's right leg.

Review of Resident #13's Quarterly MDS Assessment, dated 08/10/2021, assessed the resident as having short and long term memory problems; moderately impaired cognitive skills for daily decision making. Additional review, revealed the resident did not ambulate or use a mobility device. Further, the resident required extensive assistance of two (2) staff for bed mobility, transfer, toileting, personal hygiene, and dressing. Continued review revealed the resident did not have functional limitations in Range of Motion (ROM) for upper or lower bilateral extremities. The resident had not received Occupational Therapy, Physical Therapy, or the Restorative Nursing Program (RNP).

Review of Resident #13's CCP, revealed no documented evidence the CCP was developed to include the resident's functional limitations in ROM to his/her bilateral lower extremities or a Restorative Care regimen with interventions, services, or treatment to maintain current

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 656	Continued From page 190	F 656		

functional status or to prevent a decrease in function.

Further observation of Resident #13, on 08/12/2021 at 3:06 PM, with Registered Nurse (RN) #6, revealed the resident had functional limitations in bilateral lower extremities: hips and knees. The resident's right knee was bent at approximately a ninety (90) degree angle, and the resident was not able to flex or extend the right knee past the resting position. The resident's left leg was bent less than forty-five (45) degrees, and the resident was not able to flex or extend the left knee beyond resting position. Per the observation, the resident's legs touched each other, and the left leg crossed the right leg. The nurse stated the bilateral quadriceps were tight and there was resistance when trying to move the resident's knees and when trying to move the resident's legs apart. Further, when RN #6 attempted to move the resident's left leg off the right leg, the resident moaned and attempted to grab the nurse's hands. When the resident was at rest, the residents left leg rolled to the right over the right leg, and Resident #13 was not able to control normal alignment of his/her legs.

Interview with RN #6, on 08/12/2021 at 3:06 PM, revealed Resident #13's legs were severely contracted. Per the interview, the resident had a decline in December of 2020 and had not been ambulatory since then. Additionally, RN #6 stated it was important to provide care to residents to meet their needs and ensure quality care. Further, RN #6 stated the CCP should have been developed to include the bilateral lower extremity contractures and appropriate interventions to assist the resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 656	Continued From page 191	F 656		

Continued observation of Resident #13, on 08/12/2021 at 3:41 PM, revealed the resident sitting up in his/her Evolution chair (addressed mobility and positioning issues) at the bedside. The resident's right foot was resting on the floor; however, the residents left leg was bent at the knee and the resident's foot was suspended in the air, at rest. The resident's left leg, bent at the knee, was resting above the resident's right knee.

Interview with State Registered Nurse Aide (SRNA) #19 (worked at facility for twelve (12) years), on 08/12/2021 at 11:00 AM, revealed she was often assigned to provide care to Resident #13. Per the interview, the resident was not able to put his/her legs down and held them bent at all times. Further, she stated the resident's legs had been bent for several months. Additionally, she stated she used the CCP to know how to provide care to each resident. Further, she stated Resident #13 required staff to provide total care for all activities of daily living (ADL), and it was important for staff to know if the resident needed additional care for his/her legs.

3. Review of Resident #77's medical record revealed the facility admitted the resident, on 08/31/2001, with diagnoses including Schizophrenia, Hemiplegia Affecting the Left Non-dominant Side, Alzheimer's Disease, and Contracture Unspecified Hand.

Review of Resident #77's CCP, initiated on 03/18/2020 revealed the resident required assistance and had potential to restore or maintain function of mobility by opening and closing of the left hand. The goal was the resident would not have worsening ROM in the upper extremity (left hand). Further review

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 656	Continued From page 192	F 656		

revealed interventions included to encourage the resident to participate in passive ROM, dated 05/20/2020. Additional interventions included hand hygiene for the resident, prior to donning the left palmar orthotic (splint); donning of the splint for the resident to wear three (3) to four (4) hours before removing; and checking skin prior to and after removing the splint, for six (6) days a week for twelve (12) weeks, dated 03/18/2020. Further interventions included, if the resident did not participate in the splint/brace program, document the reason, dated 03/18/2020.

However, there was no documented evidence the facility consistently implemented the Restorative Care regimen with interventions, services, or treatment to maintain current functional status or to prevent a decrease in function for Resident #77.

Review of Resident #77's RNP Restorative Aide task, dated 05/23/2021 through 08/18/2021, revealed no documented evidence the resident received his/her splint three (3) to four (4) hours a day, six (6) days a week, for six (6) of the twelve (12) weeks. Additional review revealed no documented evidence passive ROM had been provided since 01/26/2021. Further review revealed no documented evidence the resident received splint skin integrity checks before and after donning of the left palmar hand splint for twelve (12) of the twelve (12) weeks.

Review of Resident #77's Annual MDS Assessment, dated 07/14/2021, revealed the facility assessed the resident to have a BIMS score of seven (7) of fifteen (15), indicating severe cognitive impairment. Additional review revealed the resident had functional limitations in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 656	Continued From page 193	F 656		

ROM on one (1) side, for upper and lower bilateral extremities. Further, the resident required extensive assistance of two (2) staff for bed mobility, transfer, and toileting; extensive assistance of one (1) staff for dressing and personal hygiene; and total assistance of one (1) staff for eating. The resident did receive occupational therapy, ending on 03/09/2020, and splint and brace assistance seven (7) days for at least fifteen (15) minutes in the last seven (7) calendar days.

However, observations of Resident #77, on 08/09/2021 at 4:28 PM; on 08/10/2021 at 12:20 PM; on 08/11/2021 at 9:50 AM; and on 08/12/2021 at 10:57 AM, revealed the resident's left hand was edematous and his/her fingers were folded down onto the palm at rest. The resident was not wearing any device on his/her left hand.

Interview with SRNA #19, on 08/12/2021 at 11:00 AM, revealed she was assigned to Resident #77 often. Per the interview, she used the Kardex/the CCP to know what care each resident needed. Additionally, Resident #77 required total assistance with all ADL's. Continued interview revealed the resident required a splint daily, on his/her left hand because it was contracted. She stated the RNP aide assisted the resident each day with putting on and taking off the splint; however, she was not aware who was responsible to ensure the splint was on if the RNP aide was not at the facility. Further, she stated she was not aware the resident received passive ROM or required skin integrity checks with his/her splint. Resident #77's Kardex was reviewed with SRNA #19 which showed the resident required a left palmar orthotic three (3) to four (4) hours a day, six (6) days a week for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 656	Continued From page 194	F 656		

twelve (12) weeks; however, there was no documented evidence of passive ROM, or skin integrity checks with the splint.

Interview with SRNA #5 (had worked at the facility for thirty-four (34) years), on 08/12/2021 at 11:24 AM, revealed she had been a RNP aide for eight (8) years. Per the interview, she used the CCP as a guide to know how to care for residents. Also, she stated Resident # 77 required a brace to his/her left hand for four (4) to five (5) hours a day. She stated the resident also needed his/her hand washed and his/her fingers moved around before applying the brace. SRNA #5 stated further care should be provided to residents per their CCP to ensure safe care and to ensure their needs were met. However, she revealed she did not always work as a RNP aide, and all aides were responsible to implement the Restorative care per the CCP.

Interview with RN #4, on 08/12/2021 at 3:45 PM, revealed nursing staff followed the CCP to ensure care was provided appropriately to individualized residents. Per the interview, Resident #77's Restorative interventions should be applied per his/her RNP Care Plan. In addition, she stated it was important to encourage passive ROM, provide skin integrity checks, and to apply the brace per the RNP Care Plan to decrease risk for worsening contracture, pain, and skin impairment. Additionally, she stated nurses should spot check the resident and ensure aides had provided those interventions. Further, RN #4 reported she had not identified any issues with the resident not receiving his/her Restorative interventions as care planned.

Interview with the Occupational Therapist (OT),

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 656	Continued From page 195	F 656		

(worked at facility for eight (8) years), on 08/13/2021 at 2:10 PM, revealed the CCP was a communication tool for the Interdisciplinary Team (IDT) to ensure resident specific care was consistently provided to meet each resident's needs. Additionally, the CCP should include specific functional limitations for each resident and include ROM and devices as necessary. The OT stated she expected therapy recommendations to be followed up by nursing staff, post OT program discharge, to ensure the resident's best well-being and to refer residents back to therapy when a change in the resident's functioning occurred. Further, she stated the therapy department communicated therapy discharge recommendations during the Morning Clinical Meeting, Monday through Friday, as well as utilization of referrals on the Electronic Health Record (EHR) with nursing staff as necessary.

Interview with Licensed Practical Nurse (LPN) #13/MDS Nurse (at the facility for seven (7) years), on 08/13/2021 at 2:51 PM, revealed she met daily with the Clinical team, Monday through Friday, to discuss changes in residents and to ensure the CCP was accurate to meet the resident's needs. However, unless a change in a resident was documented in the medical record, it would not be discussed in the Clinical Morning meeting. Additionally, she stated the CCP should be developed to include functional limitations in ROM, including contractures and interventions, services, or treatment to maintain current functional status or to prevent a decrease in function. Further, she stated it was important for the CCP to be developed and implemented to include appropriate services, equipment, and assistance to maintain or improve mobility with independence to ensure each resident's care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 656	Continued From page 196	F 656		

needs were met and a decline in functionality was avoided. Further, she revealed Resident #13's CCP should have been developed to include his/her contractures to bilateral lower extremities, and Resident #77's CCP should have been consistently implemented related to his/her Restorative interventions to ensure safe quality care to meet the needs of the individual resident.

Interview with the Director of Nursing (DON), on 08/13/2021 at 2:31 PM, revealed she had worked at the facility as the DON for one (1) year, and she expected the RAI Manual Guidelines to be followed related to development of the CCP for functional limitations in ROM. Per the interview, she also expected the CCP for Restorative care intervention to be implemented consistently. Additionally, she stated, if a resident had a functional limitation in ROM, the CCP should be developed to include the limitations and interventions, services, or treatment to maintain current functional status or to prevent a decrease in function of ROM. Further, she stated it was important for the CCP to be developed and implemented to ensure the IDT provided necessary care to residents to prevent complications and maintain quality of care.

Interview with the Administrator, on 08/16/2021 at 3:30 PM, revealed he had worked at the facility since July 27, 2021. Per interview, he expected the CCP to be developed per the RAI guidelines and the facility's policy. Additionally, he expected residents who had functional limitations in ROM, to have a CCP developed to include interventions, services, or treatment to maintain current functional status or to prevent a decrease in function of ROM. Continued interview revealed he expected the CCP to be implemented

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 656	Continued From page 197	F 656		

consistently by the IDT. Further, he stated it was important for residents to receive treatment and services to prevent decreased ROM or contractures to ensure comfort, quality care, and to decrease the risk for complications.

4. Review of Resident #36's medical record revealed the facility admitted the resident on 06/11/2020, with diagnoses to include Chronic Respiratory Failure with Hypoxia, Dementia in Other Diseases Classified Elsewhere without Behavioral Disturbance, and Specified Anxiety Disorders. The facility assessed Resident #36, in a Quarterly MDS Assessment, dated 06/08/2021, as an eight (8) of fifteen (15) on the BIMS, indicating moderate cognitive impairment.

Review of Resident #36's CCP revealed a fall care plan for a winged/deep dish mattress, dated 01/05/2020, with the CCP last revised on 09/30/2020. Continued review revealed there had been no indication the care plan had been revised or updated for an air mattress or that Resident #36 had even been assessed for an air mattress.

Interview with LPN #7, on 08/13/2021 at 10:21 AM, and again, on 08/14/2021 at 10:29 AM, revealed Resident #36 had never complained to her that his/her winged mattress was uncomfortable. She stated staff were confused about why Resident #36 would need an air mattress, as the resident tended to slide out of bed a lot. She stated it did not make sense to take him/her from a winged mattress (which the resident had) to an air mattress because the air mattress was easier to slide off of.

Interview with Resident #36, on 08/17/2021 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 656	Continued From page 198	F 656		

8:48 AM, revealed he/she had told staff he/she did not need an air mattress when they brought it in the room. Resident #36 shared that the winged mattress he/she was currently using was comfortable, and he/she had never had an issue with his/her bed being uncomfortable.

Interview with RN #7/MDS Coordinator, on 08/17/2021 at 9:20 AM, revealed that typically, resident mattresses were fall interventions. She stated if a resident were to have a new intervention with a mattress, the previous mattress intervention would be resolved. She revealed in the case of Resident #36, the mattress had been replaced for not even a day, prior to returning the resident to his/her winged/deep dish mattress. She stated the decision to change mattresses had been entirely the decision of the previous Administrator, and she was uncertain why the previous Administrator had made the change.

Interview with the SDC/QI, on 08/17/2021 at 10:25 AM, revealed the previous Administrator had ordered the air mattress for Resident #36 for comfort, as she thought it would benefit Resident #36. The SDC/QI stated, when she came to work the following morning, Resident #36 had slid out of bed, so she had staff remove the air mattress and place the deep dish/winged mattress back on Resident #36's bed. The SDC stated she was unaware whether or not Resident #36 was assessed by therapy for needing an air mattress.

Continued interview with the DON, on 08/18/2021 at 10:48 AM, revealed residents should be assessed prior to changing mattresses, and care plans should be updated whenever there was a change.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 656	Continued From page 199 Additional interview with the Administrator, on 08/20/2021 at 10:24 AM, revealed his expectation would be that care plans be timely, accurate, and updated as the resident's condition changed. In addition, he stated he expected residents to be cared for appropriately by trained staff.	F 656		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 657	Continued From page 200	F 657		

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review, and review of the Centers for Medicare and Medicaid Services (CMS), "Resident Assessment Instrument (RAI) Manual 3.0," it was determined the facility failed to ensure the Comprehensive Care Plan (CCP) was reviewed and revised by an interdisciplinary team composed of individuals who had knowledge of the resident and his/her needs for four (4) of forty-four (44) sampled residents (Resident #13, #22, #80, and #245).

1. Resident #13 had a fall, on 07/22/2021, and the Fall Incident Report noted the resident required a high low bed to prevent further falls of the same nature; however, the Comprehensive Care Plan (CCP) was not revised to reflect the resident's fall intervention of the high low bed to prevent further falls until 08/11/2021 (twenty (20) days after the fall).

Additionally, Resident #13 had a fall, on 07/23/2021, and the Fall Incident Report noted the resident required a winged mattress to prevent further falls of the same nature. However, the CCP was not revised to reflect the resident's fall intervention of the winged mattress

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 657	Continued From page 201	F 657		

to prevent further falls until 07/29/2021 (six (6) days after the fall).

Further, Resident #13 had a fall, on 07/24/2021, and the Fall Incident Report noted the resident required dycem to his/her wheelchair seat to prevent further falls. However, there was no documented evidence the CCP was revised to reflect the resident's fall intervention of the dycem status post the 07/24/2021 fall.

2. Resident #22 had a fall, on 03/04/2021, and the Fall Incident Report noted the resident required dycem to his/her wheelchair to prevent further falls of the same nature. However, the CCP was not revised to include the fall intervention of dycem to the wheelchair until 03/17/2021 (thirteen (13) days after the fall).

3. Resident #80 had a fall, on 06/29/2021, and the Fall Incident Report noted the resident required ice chips in between meals and at bedtime to prevent further falls of the same nature. However, the CCP was not revised to include the fall intervention of ice chips between meals and at bedtime until 07/15/2021 (sixteen (16) days after the fall).

4. Resident #245 had falls on 02/19/2021, 02/23/2021, and 03/13/2021. Review of the Fall Investigation Reports revealed fall interventions were not updated on the CCP in a timely manner.

The findings include:

Review of the CMS, "Resident Assessment Instrument (RAI) Manual 3.0," dated October 2016, revealed the CCP must be reviewed and revised periodically, and the services provided or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 657	Continued From page 202	F 657		

arranged should be consistent with each resident's written plan of care. Continued review revealed the CCP was driven not only by identified resident issues and/or conditions, but also by a resident's unique characteristics, strengths, and needs. Furthermore, a CCP based on a thorough assessment and effective clinical decision making, was compatible with current standards of clinical practice that provided a strong basis for optimal approaches to quality of care and quality of life needs of individual residents. A well developed and executed assessment and CCP re-evaluated the resident's status at prescribed intervals (quarterly, annually, or if a significant change in status occurred) using the RAI, and then, the individualized CCP was modified as appropriate and necessary.

1. Review of Resident #13's medical record revealed the facility admitted the resident, on 07/28/2017, with diagnoses including Dementia, Major Depressive Disorder, Arthritis, and Schizoaffective Disorder.

Review of Resident #13's CCP, revised on 10/02/2020, revealed the resident had a history of falls with injury, and had multiple risk factors such as impaired cognition and an actual fall on 10/02/2020. The goal was the resident would be free of serious injury from falls. Further review revealed interventions, which included encourage the resident to wear glasses (07/14/2020); attempt to distract the resident with candy and/or snack (10/02/2020); have commonly used articles within easy reach (07/14/2020); keep call light within reach and answer timely (07/14/2020); winged mattress (07/29/2021); and high low bed (08/11/2021).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 657	Continued From page 203	F 657		

Review of Resident #13's Quarterly Minimum Data Set (MDS) Assessment, dated 05/10/2021, revealed the facility assessed the resident as having short and long term memory problems; moderately impaired cognitive skills for daily decision making. Continued review of the assessment revealed the resident required extensive assistance of two (2) staff with bed mobility, transfers, and dressing; extensive assistance of one (1) staff with personal hygiene; and total assistance of two (2) staff for toilet use. Per the Assessment, the resident did not ambulate, had impaired balance during transitions between surfaces, and could only stabilize with staff assistance. Further review revealed the resident had not fallen since the prior Assessment.

A) Review of Resident #13's Fall Incident Report Form, dated 07/22/2021, signed by Licensed Practical Nurse (LPN) #9 revealed, on 07/22/2021 at 5:22 PM, the resident had a fall occurrence in his/her room from bed to floor. The resident was found sitting on the floor between the two (2) beds. Additionally, the resident was unable to give a description of the event. Further, the report stated the immediate action taken was the resident was assisted back to a high low bed.

However, Resident #13's CCP was not revised to include high low bed, until 08/11/2021, twenty (20) days after the fall occurrence, on 07/22/2021 at 5:22 PM.

B) Review of Resident #13's Fall Investigation Summary, dated 07/27/2021, signed by the Quality Indicator (QI) nurse, revealed, on 07/23/2021, the resident was noted sitting on his/her buttocks with the bed blanket and sheet

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 657	Continued From page 204	F 657		

on the floor. Additionally, the resident was provided perineal care by staff and was assisted by two (2) staff back to bed; a winged mattress was placed on the bed to prevent further falls from the bed.

However, Resident #13's CCP was not revised to include a winged mattress, until 07/29/2021, six (6) days after the fall occurrence, on 07/23/2021 at 5:15 AM.

C) Review of Resident #13's Fall Incident Report Form, dated 07/24/2021, signed by LPN #3, revealed on 07/24/2021 at 5:40 PM, the resident had a fall occurrence in his/her room from the Evolution chair to the floor. The resident was sitting on the floor, the lights were off, and his/her back was resting against the dresser; the Evolution chair was to the resident's right side. Additionally, the resident was unable to give a description of the event related to his/her cognitive status. Further, the report stated the immediate action taken was the resident was assisted by two (2) staff, back to his/her Evolution chair, and dycem was placed on the seat to prevent the resident from sliding out of the chair.

However, there was no documented evidence Resident #13's CCP was revised to include dycem to the chair after the fall occurrence, on 07/24/2021 at 5:40 PM.

Interview with LPN # 3, on 08/15/2021 at 3:15 PM, revealed she had worked at the facility for eleven (11) years. Per the interview, after a fall event, it was the nurse's responsibility to implement an intervention immediately to decrease the risk of another fall of the same nature. Additionally, she stated the CCP should

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 657	Continued From page 205	F 657		

be revised to include the immediate intervention to ensure continuity of care. Further, she stated Resident #13 should have had dycem consistently placed on his/her Evolution chair seat after the 07/24/2021 fall event. Per the interview, she forgot to revise the CCP to include dycem after the fall.

Observations of Resident #13, on 08/09/2021 at 4:11 PM, on 08/10/2021 at 9:35 AM, and on 08/12/2021 at 3:06 PM, revealed the resident's Evolution chair was on the left side of the bed in front of the dresser; however, there was no dycem in the chair seat, which was the immediate intervention status post fall, on 07/24/2021 at 5:40 PM. Further observation, on 08/12/2021 at 3:41 PM, revealed the resident sitting up in his/her Evolution chair at the bedside.

Interview with Registered Nurse (RN) #6, on 08/12/2021 at 3:06 PM, revealed Resident #13 required total assistance with Activities of Daily Living (ADL), had poor safety awareness, and was a risk for falls. Additionally, she stated it was the nurse's responsibility to implement immediate fall interventions after a fall event and to ensure the CCP was revised to include the intervention for safety. Per the interview, dycem should be care planned as a fall prevention. Further interview revealed she was not aware dycem was a fall intervention to be added to the seat to prevent sliding out. RN #6 stated direct care staff needed to know interventions were accurately listed on the CCP to ensure safe quality care.

Interview with State Registered Nurse Aide (SRNA) #19 (worked at facility for twelve (12) years), on 08/12/2021 at 3:45 PM, revealed she always reviewed Resident #13's Kardex (CCP)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 657	Continued From page 206	F 657		

before providing care, was aware the resident required the assistance of two (2) staff for mobility, and was a fall risk. Additional interview revealed she was aware Resident #13 had poor safety awareness and had a history of falling from bed and his/her Evolution chair. SRNA #19 stated it was the responsibility of the staff to ensure residents were provided a safe environment to keep the resident safe and to meet their needs. Further, she stated she was not aware the resident required dycem to the chair seat to prevent him/her from sliding out of the chair.

2. Review of Resident #22's medical record revealed the facility admitted the resident, on 04/17/2019, with diagnoses including Dementia, Anxiety Disorder, Atrial Fibrillation, Sick Sinus Syndrome, Pseudobulbar Affect, Overactive Bladder, and Hypertension.

Review of Resident #22's Significant Change MDS Assessment, dated 02/22/2021, revealed the facility assessed the resident as having short and long term memory problems; and severely impaired cognitive skills for daily decision making. Continued review of the Assessment revealed the resident required extensive assistance of two (2) staff with bed mobility and transfers; extensive assistance of one (1) staff with eating; and total assistance of two (2) staff for personal hygiene, dressing, and toilet use. Per the Assessment, the resident did not ambulate. Further review revealed the resident had two (2) non-injury falls and one (1) fall with injury since the prior Assessment.

Review of Resident #22's Fall Incident Report Form, dated 03/04/2021, signed by LPN #3,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 657	Continued From page 207	F 657		

revealed, on 03/04/2021 at 4:30 PM, the resident had a fall occurrence in his/her room from wheelchair to floor. Additionally the resident was sitting on the floor at the end of the bed, and the wheelchair was behind the resident. Continued review revealed the resident was unable to give a description of the event. Further, the report stated the immediate action taken was the resident was assisted by two (2) staff back to the wheelchair and dycem was placed in the wheelchair seat.

Review of Resident #22's CCP, revised on 03/17/2021, revealed the resident had a history of falls and actual falls (03/04/2021), and had multiple risk factors such as Dementia, altered perception of awareness/surroundings, and cardiovascular medications. The CCP stated the resident had a tendency to sit on the floor when tired and lie back. The goal was the resident would be free of serious injury from falls. Further review revealed interventions included encourage the resident to take rest periods as needed when ambulating (11/28/2020); lay the resident down after meals for rest periods (11/09/2020); commonly used articles within easy reach (dated 04/18/2019); take the resident to the nurses station for close observation (dated 11/30/2020); and allow the resident to ambulate as desired, use wheelchair for long distance, dycem to wheelchair (dated 03/17/2021).

However, Resident #22's CCP was not revised to include dycem to the wheelchair, until 03/17/2021, thirteen (13) days after the fall occurrence, on 03/04/2021 at 4:30 PM.

Continued interview with LPN #3, on 08/15/2021 at 3:15 PM, revealed Resident #22's CCP should

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 657	Continued From page 208	F 657		

have been revised to include the use of dycem on the wheelchair seat. Per the interview, she did not recall why she failed to complete the evaluation or revise the CCP to include dycem, after the fall on 03/04/2021.

3. Review of Resident #80's medical record revealed the facility admitted the resident, on 11/28/2019, with diagnoses including Type II Diabetes Mellitus, Osteoarthritis, General Anxiety Disorder, Morbid Obesity, Major Depressive Disorder, Hypertension, Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, and Chondrocalcinosis of the Right Knee and Hip.

Review of Resident #80's Quarterly MDS Assessment, dated 04/21/2021, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of ten (10) of fifteen (15), indicating moderately impaired cognition. Continued review of the assessment revealed the resident required extensive assistance of two (2) staff with bed mobility, transfers, and dressing; extensive assistance of one (1) staff with personal hygiene; and total assistance of two (2) staff for toilet use. Per the Assessment, the resident did not ambulate, had impaired balance during transitions between surfaces, and could only stabilize with staff assistance. Further review revealed the resident had not fallen since the prior Assessment.

Review of Resident #80's CCP, revised on 06/24/2021, revealed the resident had a history of falls, and had multiple risk factors such as depression, medication (antidepressant, cardiovascular, and a diuretic), and an actual fall. The goal was the resident would be free of serious injury from falls. Further review revealed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 657	Continued From page 209	F 657		

interventions, which included anti-roll back on wheelchair, wheelchair to properly fit the resident (02/02/2021); encourage resident to wear non-skid footwear (06/08/2021); commonly used articles within easy reach (08/26/2020); and give the resident a glass of ice chips between meals and at bed time (07/15/2021).

Review of Resident #80's Fall Incident Report Form, dated 06/29/2021, signed by the QI nurse, revealed, on 06/29/2021 at 2:00 PM, the resident had a fall occurrence in his/her room and was noted lying on his/her right side in the floor with regular socks on. Additionally, the resident stated he/she was trying to get some water, lost his/her balance, spilled the water, took a step and fell. Further, the immediate action taken was the resident was provided first aid and assisted by two (2) staff into a wheelchair.

However, Resident #80's CCP was not revised to include giving the resident a cup of ice between meals and at bedtime, until 07/15/2021, sixteen (16) days after the fall occurrence on 06/29/2021 at 2:00 PM.

Interview with the LPN #13/MDS Coordinator and RN #7/ MDS Coordinator, on 08/13/2021 at 2:51 PM, revealed the facility utilized the CMS Resident Assessment Instrument (RAI) Manual 3.0, as a guideline for CCP's. She stated at the morning clinical meetings, staff discussed any fall events. Per the interview, any staff nurse had access to revise the care plan. Further, both stated it was important to have a current, accurately revised CCP to ensure direct care staff would know how to provide care to residents to meet their needs.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 657	Continued From page 210	F 657		

Interview with the DON (worked as the DON for one (1) year), on 08/31/2021 at 2:31 PM, revealed Resident #13's, Resident #22's and Resident #80's CCP's should have been revised to include interventions status post fall events more timely. In addition, the DON stated the CCP's should be revised as necessary to ensure residents received appropriate services and individualized care.

4. Review of Resident #245's medical record revealed the facility admitted the resident, on 01/18/2021, with diagnoses including Parkinson's Disease, Major Depression, Dementia, and Diabetes Mellitus Type II.

Review of Resident #245's Quarterly MDS Assessment, dated 02/26/2021, revealed the facility assessed the resident as having a BIMS of four (4) of fifteen (15), indicating severe cognitive impairment. Continued review revealed the resident was a one (1) person assist for bed mobility and self-transfers; used mobility devices, a walker and wheelchair. Further review revealed the resident was not steady for moving from seated to standing position, walking, turning around, and surface-to-surface transfers between bed and wheelchair; however was able to stabilize without staff.

Review of Resident #245's CCP, dated 01/18/2021, revealed the Focus area of falls did not address the falls on 02/19/2021, 02/23/2021, and 03/13/2021. Continued review of the Interventions dated 01/18/2021 revealed no timely revision of the CCP with interventions for falls which occurred on 02/19/2021, 02/23/2021, and 03/13/2021.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 657	Continued From page 211	F 657		

A) Review of Resident #245's Fall Incident Report Form, dated 02/19/2021, revealed an added intervention to take the resident to the bathroom after supper. The intervention was not updated on the CCP until 03/01/2021, after the report was completed and ten (10) days after the fall.

B) Review of Resident #245's Fall Incident Report Form, dated 02/23/2021, revealed the intervention was to place a sign to remind the residents it was a shared bathroom. The intervention was not updated on the care plan until 03/11/2021, after the report was completed and sixteen (16) days after the fall.

C) Review of Resident #245's Fall Incident Report Form, dated 03/13/2021, revealed the intervention was to make sure no pillows were in the wheelchair seat and that dycem was in place. The intervention was not updated on the care plan until 03/25/2021, after the report was completed and twelve (12) days after the fall.

Interview with LPN #7, on 08/14/2021 at 10:37 AM, revealed Resident #245 did not remember the 03/13/2021 fall, did not report the fall to staff, and only expressed pain on 03/25/2021, but did not appear injured. LPN #7 stated she did not always remember to update the CCP.

Additional interview with LPN #13/MDS Coordinator, on 08/18/2021 at 11:02 AM, revealed she found out about falls from Interdisciplinary Team (IDT, the DON, Unit Managers, MDS Nurses, Therapy, Activities etc.) meetings, risk management, and review of progress notes. She stated she was responsible to update the CCP quarterly, annually, and with significant changes. She stated the staff nurse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 657	Continued From page 212 was responsible to update the CCP as needed. Additional interview with the DON, on 08/31/2021 at 2:31 PM, revealed she expected the CCP's to be revised accurately, per the RAI manual. Per the interview, nurses were responsible for revision of the CCP, including any changes related to fall events to prevent future falls. Additionally, she stated the current process in place was, during the facility's Morning Clinical Meeting, held on Monday through Friday, to review the CCP's after fall events to ensure revisions were made as necessary and for the IDT to ensure the CCP was revised with the most appropriate intervention. Interview with the Administrator, on 08/16/2021 at 3:30 PM, revealed the facility was to utilize the RAI Manual and facility policies as resources to ensure the CCP was revised as necessary. He stated it was important for the CCP to be revised accurately to reflect a resident's current status and ensure the CCP addressed each resident's individual needs.	F 657		
F 658 SS=J	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality.	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 658	Continued From page 213	F 658		

This REQUIREMENT is not met as evidenced by:
Based on interview, record review, review of the Emergency Medical Services (EMS) Run Sheet, American Heart Association Cardiopulmonary Resuscitation (CPR) guidelines, and the facility's policy, it was determined the facility failed to ensure licensed nursing staff met professional standards of practice in providing CPR for one (1) of thirty-two (32) residents, Resident #242, that had a full code status.

On 01/26/2021 at 6:30 PM, Licensed Practical Nurse (LPN) #15 was notified of an emergent situation in Resident #242's room, and she called a Code Blue for CPR to be given to the resident. LPN #15 assessed Resident #242 to have a pulse after two (2) minutes of CPR and stated to stop CPR. However, the previous Administrator directed the Staff Development Coordinator/Quality Improvement (SDC/QI) nurse to continue chest compressions until the resident had a pulse of sixty (60) beats per minute (bpm) or there was a physician's order to stop. The previous Administrator placed her hands over the SDC/QI nurse's hands and forced chest compressions for approximately one (1) more minute until Emergency Medical Service (EMS) arrived on site and transported the resident to the local hospital.

The facility's failure to ensure the CPR provided to Resident #242 met professional standards of quality has caused or is likely to cause serious injury, serious harm or death to other residents in the facility. Immediate Jeopardy (IJ) was identified on 08/20/2021 and was determined to exist on 01/26/2021, in the area of 42 CFR 483.21 Comprehensive Care Plans, F-658,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 658	Continued From page 214	F 658		

Services Provided Meet Professional Standards. The facility was notified of the IJ on 08/20/2021.

The facility provided an acceptable Immediate Jeopardy Removal Plan on 09/01/2021, with the facility alleging removal of the Immediate Jeopardy, on 08/31/2021. The State Survey Agency validated removal of the Immediate Jeopardy, as alleged on 08/31/2021, prior to exit on 09/02/2021. The facility's remaining non-compliance was at a Scope and Severity of a "D" while the facility develops and implements a Plan of Correction and the facility's Quality Assurance (QA) monitors to ensure compliance with systemic changes.

The findings include:

Review of the facility's policy titled, "Cardiopulmonary Resuscitation, Nursing Procedure Manual," Version Date: April 2013, revealed the objective was to ventilate the resident until adequate circulation to the brain was re-established. The policy stated if the resident was not breathing to call 911 and begin CPR. The policy also instructed staff on how to do chest compressions and administer rescue breathing at a rate of thirty to two (30/2) compressions/breaths. Further review revealed CPR would continue for two (2) minutes, then stop, check for breathing; if the resident was not breathing, repeat the process, checking for breath every (2) minutes. The policy stated the CPR process was to continue until there were signs of life, another rescuer took over, EMS arrived and took over, or a physician gave an order to discontinue CPR.

Review of the American Heart Association 2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 658	Continued From page 215	F 658		

CPR guidelines (updated every five (5) years) revealed if the victim was breathing and had a pulse, to monitor until emergency responders were on the scene. Therefore, a resident would not need a heart rate of sixty (60) bpm to discontinue CPR as was stated by the former Administrator.

Review of Resident #242's medical record revealed the facility admitted the resident, on 07/26/2017, with diagnoses that included Presence of Cardiac Pacemaker, Benign Prostatic Hyperplasia, Chronic Obstructive Pulmonary Disease, Atherosclerotic Heart Disease, Ischemic Cardiomyopathy, and Presence of Coronary Angioplasty Implant and Graft.

Review of the facility's resuscitative level communication sheet revealed Resident #242 was a Full Code. Resident #242 signed the documentation on 05/24/2019.

Review of Resident #242's physician's orders, dated 07/26/2017, on admission, and the Comprehensive Care Plan, dated 07/28/2017, revealed Resident #242 was a Full Code.

Review of Resident #242's Nursing Progress note, dated 01/26/2021, revealed LPN #15 documented that she was called to Resident #242's room, and the resident was noted to be in respiratory distress, mouth breathing, not responding to verbal/tactile stimulation. He/she had a faint pulse. She stated the resident was repositioned to the head of the bed and a sternal rub was initiated. Per the note, Resident #242 started vomiting, and staff was unable to obtain a blood pressure (B/P) or oxygen saturation level

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 658	Continued From page 216	F 658		

(determined how much oxygen was circulating through the body). Oxygen was applied via mask for labored breathing. Further review of the progress note revealed staff were unable to obtain a pulse for Resident #242, and CPR was initiated. Per the note, EMS and the physician were notified, and Resident #242 was transported to a local hospital by EMS.

Review of the EMS run sheet, dated 01/26/2021, revealed they were dispatched at 6:06 PM and arrived on scene at 6:11 PM. Resident #242 was alert and moaning. The run sheet stated the facility reported the resident had been pulseless and apneic (without breath), was given CPR, and pulse/breath was regained. Documentation showed that a 12-lead electrocardiogram (EKG) indicated Resident #242 was throwing premature ventricular contractions (extra heart beats which could be dangerous with underlying heart conditions, with which Resident #242 had been diagnosed).

Review of the Hospital Emergency Department (ED) History and Physical (H&P) revealed Resident #242 arrived in the ED on 01/26/2021, status post respiratory arrest and CPR at the facility. Resident #242 met Sepsis criteria and was admitted for treatment. Additional review of the ED records indicated EMS staff had performed a 12-lead EKG during transport, which showed Resident #242 had sustained a ST-Segment Elevation Myocardial Infarction (STEMI), the most severe type of heart attack.

Review of the Hospital Death Discharge Summary revealed Resident #242 received broad-spectrum intravenous (IV) antibiotics, fluid boluses and appropriate sepsis protocols were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 658	Continued From page 217	F 658		

initiated, and he/she initially responded well. However, nursing staff found him/her pulseless and unresponsive on the afternoon of 01/27/2021.

Telephone interview with LPN #15, on 08/19/2021 at 1:28 PM, revealed she remembered the night Resident #242 coded, right after supper. Further interview revealed she went to the resident's room and sat Resident #242 up; he/she was gasping and vomiting. She stated she called a code blue; he/she did not have a pulse. Then, she stated the SDC/QI nurse came in the room and started compressions while staff were looking for a mask. She stated, when the former Administrator came in the room, she was informed the resident had coded and gave breaths through paper towels until the resident grunted. At that time, LPN #15 stated the resident had a pulse, and she told the others to stop compressions. She stated the former Administrator said staff could not stop compressions until they had a doctor's order to stop compressions or the resident's pulse was sixty (60) bpm. LPN #15 stated she immediately texted the Advanced Practice Registered Nurse (APRN) who responded that if a resident had a pulse, to stop compressions. She stated compressions had continued for approximately a minute after the resident got his/her pulse back. LPN #15 stated she was glad the APRN responded when she did because if she had not, who knows what would have happened. She stated the former Administrator was convinced that was how to do CPR in a nursing home.

Continued interview with LPN #15, on 08/19/2021 at 1:28 PM, revealed she was unaware of how to document the Code Blue. She stated the former

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 658	Continued From page 218	F 658		

Administrator instructed her to document the code in the Progress Notes and not to do an incident report. She stated staff got annual training, from the SDC/QI nurse on what to do in case of a code. However, she stated the SDC/QI nurse did not tell the former Administrator to stop, she just smirked. LPN #15 stated she reported what had occurred in the code to the DON because she could not believe the Administrator did not know how to do CPR. She stated Physician #1 and the APRN both called her later that evening, and she told them what had happened. She stated nobody investigated the event or asked staff to write a statement. Additionally, LPN #15 stated it was the worst experience she had ever been in and was so traumatized by the events of 01/26/2021 that she did not work for a month.

Interview with the SDC/QI nurse, on 08/19/2021 at 1:50 PM, revealed she assessed Resident #242 before beginning CPR. She stated that when he/she regained a pulse, she also told the previous Administrator to stop CPR. Then, she demonstrated to the State Survey Agency (SSA) Surveyor how the previous Administrator put her hands over the SDC/QI nurse's hands and forced CPR for approximately another minute, until EMS arrived on the scene. She stated she was unable to remember if she reported the incident to the Corporate Clinical Nurse Consultant. Additionally, the SDC/QI nurse stated the American Heart Association (AHA) guidelines were the facility education resource.

Review of nursing staff CPR cards validated that the SDC/QI nurse and the former Administrator were certified to perform CPR on 01/26/2021.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 658	Continued From page 219	F 658		

However, the facility's Cardiopulmonary Resuscitation policy revealed education on CPR was not from the AHA guidelines as stated by the SDC/QI nurse, but was from an unnamed Nursing Procedure Manual (Version Date: April 2013).

Interview with the Unit Manager, on 08/17/2021 at 10:41 AM, revealed she was not present at the code with the Resident #242. Additionally, she stated on the following day, the interdisciplinary team (IDT) would have discussed the resident's code. However, she did not recall what exactly was discussed. Per the interview, there should be documents of the IDT meetings. Further, she stated she was not aware of who was present for the code, and no concerns were brought to her from nurses about the code being unusual. She stated she was not aware the previous Administrator had directed compressions to continue after the resident had a pulse.

Review of the IDT tool, dated 01/27/2021, only had Resident #242's name listed, no other documentation.

Telephone interview with Physician #1, on 08/17/2021 at 4:11 PM, revealed the previous administration was not as good as he would have hoped. However, he stated, since the change, the DON was in contact with him at least twice a week. He stated he was familiar with the situation with Resident #242. Physician #1 stated the resident was significantly impaired, but the code was somewhat unexpected. He stated he had seen Resident #242, on 01/25/2021, and he/she had increased confusion and was not acting like him/herself. He stated he had started some Remeron for weight loss and lab work to be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 658	Continued From page 220	F 658		

done immediately. He stated he was not too shocked when the resident passed away two (2) days later. He stated the previous Administrator had overstepped her bounds in ordering continued chest compressions, and resuscitation was not handled in an appropriate way. Physician #1 reported continuing CPR, on someone with a pulse, could harm them drastically.

Interview with the DON, on 08/19/2021, at 2:00 PM, revealed she had not been present for the code. She stated she met with the former Administrator the next day and told her it was wrong to continue CPR if there was a pulse. She stated the former Administrator again stated a resident needed a pulse of at least sixty (60) bpm to stop CPR. Additionally, the DON stated she sought guidance from the APRN who stated to stop CPR if there was a pulse. She stated an email was received from the APRN, about a week after the incident that included a current AHA algorithm for CPR and revealed if a resident had a pulse, chest compressions were no longer indicated.

Interview with the Regional Vice President (RVP), on 08/20/2021 at 3:03 PM, revealed he had no knowledge of the incident regarding Resident #242 and the fact that CPR continued after a pulse was obtained. He stated he was aware that CPR should be discontinued if there was a pulse. He stated he was not aware Physician #1 had concerns when he was notified of this situation. He stated his expectation was the Administrator would have reported the incident to him; others could have reported it to him as well. They could have reported through the compliance line or called him specifically. He had no thoughts on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 658	Continued From page 221	F 658		

why it was not reported. He stated, as the Regional VP, the Administrator did report to him. The RVP stated the previous Administrator no longer worked with the company.

The facility provided an acceptable Immediate Jeopardy Removal Plan, on 09/01/2021, that alleged removal of the Immediate Jeopardy (IJ) on 08/31/2021. The facility implemented the following:

1. On 8/19/2021 through 8/20/2021, the DON and SDC/QI nurse conducted a one-hundred (100%) percent audit. The audit reviewed all discharge charts, over the last thirty (30) days, to identify any resident who had coded in the center. No other residents had coded in the center within the past thirty (30) days, and no issues where identified.

2. On 8/18/2021, the SDC/QI nurse completed an audit of one-hundred (100%) percent of nurses' CPR certifications to ensure all current licensed nurses on all shifts were certified in CPR and possessed a copy of a CPR certification card. There were no concerns identified during the audit. The facility did not require nursing assistants, Kentucky Medication Aides (KMA), or therapy staff to be CPR certified because they did not perform CPR. Non-certified staff acted as runners to gather equipment and greet EMS.

3. On 8/19/2021, the DON in-serviced the SDC/QI nurse, which included that CPR should not continue after a pulse was detected. The previous Administrator was no longer at the facility. The DON, SDC/QI nurse, and Nurse Supervisor initiated an in-service with all nurses. The in-service was about the Adult Basic Life

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 658	Continued From page 222	F 658		

Support Algorithm for Healthcare providers, the CPR policy, and Code Blue. The in-service instructed nurses that: 1) if a resident was found without a pulse, blood pressure (BP), respirations or with insufficient respirations, a Code Blue must be called immediately, 2) the chart must always be checked for the resident's code status, 3) always make sure you had the correct resident's chart, 4) if a resident was a full code, then CPR must be started immediately, 5) if a resident was a Do Not Resuscitate (DNR), then CPR must not be initiated, 6) if a resident was a full-code to call 911, 7) the medical doctor (MD) must be notified as soon as possible of the resident's condition, and 8) the nursing staff must follow the Adult Basic Life Support Algorithm for Healthcare Providers.

4. On 8/19/2021, the DON, SDC/QI nurse, and Nurse Supervisor initiated a Questionnaire with all licensed nurses for validation of understanding their role in CPR. The passing score was one-hundred percent (100%). The questions included: 1) how do you know if a resident was a full code or DNR? 2) If a resident was a full code when do you initiate CPR? 3) what was the code to overhead page if a resident was found not breathing and/or no pulse? 4) when should the MD be notified if a resident was found not breathing and/or no pulse? 5) when a resident was found not breathing and/or no pulse, what were the nurse's responsibilities? and 6) do you continue CPR when heart rate and breathing had returned?
As of 8/30/2021, any nurse who was unable to answer the questions on the questionnaire after two attempts would be removed from working with residents until they were able to validate knowledge. Nurses unable to validate knowledge

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 658	Continued From page 223	F 658		

would not be allowed to work in the facility. After 8/30/2021, no facility or agency nurse would be allowed to work without completing the questionnaire. Nurses who were not working would be mailed a copy of the in-service and questionnaire. Upon returning to work, a review of the questionnaire would be completed with the DON, SDC/QI nurse, Nurse Supervisor, or RN Corporate nurse.

5. The DON, SDC/QI nurse, and/or Nurse Supervisor would facilitate CPR Drills weekly for four (4) weeks. The facility had a CPR drill on 1) 8/20/2021 with first shift, 2) 8/24/2021 with second shift, 3) 8/29/2021 with the weekend staff, and 4) 8/31/2021 with first shift staff. The purpose of the drills were to ensure licensed and unlicensed staff understood their responsibilities during a Code Blue. Responsibilities included checking the resident for responsiveness, checking for pulse and respirations, summoning for assistance, checking code status, paging Code Blue, initiating CPR, ensuring adequate staff responded, nurse(s) designated staff to call 911, nurse(s) designated staff to obtain crash cart, crash cart brought to scene, CPR continued until EMS arrived, physician discontinued code, or until the resident's pulse and respirations had returned. Additional responsibilities included checking if crash carts were stocked appropriately and ensuring the correct chart was pulled/reviewed. Retraining would be conducted during the drill by the DON, SDC/QI nurse, and/or Nurse Supervisor for any identified areas of concern. There had been no issues identified.

6. On 8/20/2021, the DON, SDC/QI nurse, and the Unit Manager facilitated a CPR Drill for first shift staff. During and after the drill, the DON

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 658	Continued From page 224	F 658		

offered feedback and suggestions to the staff. The staff were able to demonstrate and answer questions correctly, establishing staff were familiar with facility policies related to CPR, in accordance with standards of practice.

7. On 8/24/2021, the DON, SDC/QI nurse, and the Unit Manager facilitated a CPR Drill for second shift staff. During and after the drill, the DON offered feedback and suggestions to the staff. The staff was able to demonstrate and answer questions correctly, establishing staff was familiar with facility policies related to CPR, in accordance with standards of practice.

8. On 8/25/2021, the DON facilitated the morning interdisciplinary team (IDT) meeting. Members of the IDT included the Administrator, DON, Quality Improvement Nurse/Staff Development Coordinator (SDC/QI), Minimum Data Set (MDS) Nurse, Unit Manager, Activity Director, Social Services Director, and Dietary Manager. At the meeting, the RN Corporate nurse reviewed residents' medical charts, during which resident code status was reviewed. Approximately twenty-five (25%) percent of resident records were reviewed and code status was noted to be up-to-date.

9. On 8/26/2021, the DON reviewed and updated the CPR plan of correction with the Medical Director via telephone.

10. On 8/29/2021, the DON facilitated a CPR Drill for the weekend staff. The DON was assisted by three (3) RN's from a sister facility. During and after the drill, the DON and RN's offered feedback and suggestions to the staff. The staff were able to demonstrate and answer

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 658	Continued From page 225	F 658		

questions correctly, establishing staff were familiar with facility policies related to CPR, in accordance with standards of practice.

11. On 8/29/2021, the RN Corporate nurse audited twenty-five percent (25%) of the residents' electronic health records (EHR) to determine if the physical chart, residents' plans of care, and electronic face sheets all matched. No issues were identified.

12. The RN Corporate nurse would continue working at the facility five (5) days a week through September 2021 to help ensure the facility staff were familiar with facility policies related to CPR, in accordance with standards of practice.

13. The DON would continue forwarding the results of the CPR Drills to the Quality Assurance Performance Improvement (QAPI) Committee monthly for one (1) month. The QAPI Committee would meet monthly for one (1) month and review the CPR Drill results to determine trends and/or issues that might need further interventions put into place and to determine the need for further and/or frequency of monitoring. The QAPI Committee consisted of the Administrator, DON, Infection Preventionist, Medical Director, Social Worker, Medical Records Director, Dietary Manager, and Housekeeping Supervisor, plus additional staff members as deemed necessary.

The State Survey Agency validated the implementation of the facility's Immediate Jeopardy Removal Plan as follows:

1. Review of documentation dated 08/19/2021 through 08/20/2021 revealed the DON and SDC/QI nurse audited one-hundred (100%)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 658	Continued From page 226	F 658		

percent of discharged charts to identify if any residents had coded in the last thirty days. There were no residents identified.

2. Review of CPR cards revealed the SDC/QI nurse audited one-hundred (100%) percent of licensed nurses for current CPR education.

Interviews with LPN #11, RN #3, LPN #10, and LPN #6, on 09/02/2021 at 3:03 PM, 3:14 PM, 4:16 PM, and 4:26 PM respectively, revealed they were all currently CPR certified.

3. Review of signed in-service documentation sheet, dated 08/19/2021, revealed the DON in-serviced the SDC/QI nurse regarding that CPR should not be continued if there was a pulse. Continued review revealed the DON and SDC/QI nurse educated all licensed nursing staff on Adult Basic Life Support Algorithm for Healthcare Providers, CPR Policy, and Code Blue.

Interviews with LPN #11, RN #3, LPN #10, and LPN #6, on 09/02/2021 at 3:03 PM, 3:14 PM, 4:16 PM, and 4:26 PM respectively, revealed they did receive CPR education and had Code Blue drills and quizzes across every shift and on weekends.

4. Review of CPR quizzes revealed one-hundred (100%) percent of licensed nursing staff took the quizzes and passed. An employee roster was used to ensure no one was missed in receiving the education.

5. Review of CPR drill documentation revealed the facility held drills on 08/20/2021, 08/24/2021, 08/29/2021, and on 08/31/2021. Continued review revealed they were held across all shifts

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 658	Continued From page 227	F 658		

and on the weekend. No concerns were identified.

Interview with the Corporate RN, on 09/02/2021 at 1:18 PM, revealed she was present for the Code Blue drill on 08/29/2021 (a weekend). She stated she also quizzed staff on what their various responsibilities might be in a Code Blue situation.

6. Review of documentation, dated 08/20/2021, revealed the DON and SDC/QI nurse facilitated a CPR drill for first shift staff.

7. Review of documentation, dated 08/20/2021, revealed the DON and SDC/QI nurse facilitated a CPR drill for second shift staff.

8. Review of the IDT meeting agenda, dated 08/25/2021, revealed the Corporate RN reviewed approximately twenty-five (25%) percent of residents' charts to ensure code status was documented and up-to-date.

9. Review of facility documentation, dated 08/26/2021, revealed the DON updated the Medical Director via telephone call.

10. Review of CPR Drill documentation, dated 08/29/2021, revealed the DON held the drill for weekend staff.

11. Review of documentation, dated 08/29/2021, revealed the Corporate RN audited twenty-five (25%) percent of residents' charts to ensure the electronic face sheets, physical charts, and residents' plans of care contained updated code status.

12. Interview with the Corporate RN, on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 658	Continued From page 228 09/02/2021 at 1:18 PM, revealed she was assigned to be at the facility until the end of September 2021. She stated she would assist facility management in ensuring staff were familiar with facility policies related to CPR, in accordance with standards of practice. 13. Interview with the DON, on 09/02/2021 at 1:18 PM, revealed she had sent the CPR Drills analysis from 08/20/2021, 08/24/2021, 08/29/2021, and on 08/31/2021 to the QAPI Committee to be discussed at the next meeting.	F 658		
F 678 SS=J	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: Based on interview, record review, review of the American Heart Association's Cardiopulmonary Resuscitation (CPR) guidelines, and review of the facility's policy, it was determined the facility failed to have an effective system to ensure staff were familiar with facility policies related to CPR for one (1) of thirty-two (32) residents with Full Code Status, Resident #242. On 01/26/2021 at 6:30 PM, Resident #242 suffered a cardiopulmonary arrest and Licensed Practical Nurse (LPN) #15 called a Code Blue for full CPR to be given. The Staff Development	F 678		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 678	Continued From page 229	F 678		

Coordinator/Quality Improvement (SDC/QI) nurse initiated CPR for approximately two (2) minutes. Then, LPN #15 assessed Resident #242 to have a pulse and stated to stop CPR. However, the previous Administrator directed the SDC/QI nurse to continue chest compressions until the resident had a pulse of sixty (60) beats per minute or there was a physician's order to stop. The previous Administrator placed her hands over the SDC/QI nurse's hands and forced chest compressions for approximately one (1) more minute until Emergency Medical Service (EMS) arrived on site and transported the resident to the local hospital.

The facility's failure to ensure appropriate cardiopulmonary resuscitation (CPR) was provided to Resident #242, who required such care prior to the arrival of emergency medical personnel, has caused or is likely to cause serious injury, serious harm or death to other residents in the facility. Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) were identified on 08/20/2021, and were determined to exist on 01/26/2021, in the area of 42 CFR 483.24 Quality of Life, F-678, Cardio-Pulmonary Resuscitation. The facility was notified of the IJ and SQC on 08/20/2021.

The facility provided an acceptable Immediate Jeopardy Removal Plan on 09/01/2021, with the facility alleging removal of the Immediate Jeopardy, on 08/31/2021. The State Survey Agency validated removal of the Immediate Jeopardy, as alleged on 08/31/2021, prior to exit on 09/02/2021. The facility's remaining non-compliance was at a Scope and Severity of a "D" while the facility develops and implements a Plan of Correction and the facility's Quality Assurance (QA) monitors to ensure compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 678	Continued From page 230	F 678		

with systemic changes.

The findings include:

Review of the American Heart Association (AHA) 2020 CPR guidelines revealed if the victim was breathing and had a pulse, to monitor until emergency responders were on the scene. A resident would not need a heartrate of sixty (60) beats per minutes (bpm) to discontinue CPR.

Review of the facility's CPR policy, titled "Cardiopulmonary Resuscitation, Nursing Procedure Manual," Version Date: April 2013, revealed the objective was to ventilate the resident until adequate circulation to the brain was re-established. Procedure steps included to call 911 if the resident was not breathing and to begin CPR. The policy instructed that CPR would continue for two (2) minutes, then stop, check for breathing; if the resident was not breathing, repeat the process, checking for breath every (2) minutes. The policy stated the CPR process was to continue until there were signs of life, another rescuer took over, EMS arrived and took over, or a Physician gave an order to discontinue CPR.

Review of Resident #242's medical record revealed the facility admitted the resident, on 07/26/2017, with diagnoses that included Presence of Cardiac Pacemaker, Benign Prostatic Hyperplasia, Chronic Obstructive Pulmonary Disease, Atherosclerotic Heart Disease, Ischemic Cardiomyopathy, and Presence of Coronary Angioplasty Implant and Graft.

Review of the facility's resuscitative level communication sheet revealed Resident #242

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 678	Continued From page 231	F 678		

was a Full Code. Resident #242 signed the documentation on 05/24/2019.

Review of Resident #242's Physician orders, dated 07/26/2017, on admission, revealed Resident #242 was a Full Code.

Review of Resident #242's Comprehensive Care Plan, dated 07/28/2017, revealed Resident #242 was a Full Code.

Review of Resident #242's Nursing Progress note, dated 01/26/2021, revealed LPN #15 documented that she was called to Resident #242's room by an unknown State Registered Nurse Aide (SRNA). Resident #242 was noted to be in respiratory distress, mouth breathing, and not responding to verbal/tactile stimulation. He/she had a faint pulse. The resident was repositioned to the head of the bed, and a sternal rub was initiated. Per the note, he/she started vomiting and staff were not able to obtain a blood pressure (B/P) or oxygen saturation level (determined how much oxygen was circulating through the body). Oxygen was applied via mask for labored breathing. Further review of the progress note revealed staff were not able to obtain a pulse for Resident #242, and CPR was initiated. Emergency Medical Service (EMS) and the Medical Provider was notified, and Resident #242 was transported to a local hospital.

Interview with the Unit Manager, on 08/17/2021 at 10:41 AM, revealed she was not working when Resident #242 coded. She stated staff received annual Code education and on hire. Additionally, she stated nursing staff were to have basic life support (BLS) training every two (2) years. Review of the Unit Manager's CPR card revealed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 678	Continued From page 232	F 678		

she was current on CPR training through the American Heart Association.

Interview with the SDC/QI, on 08/19/2021 at 1:50 PM, revealed the American Heart Association (AHA) guideline was the facility education resource. Additionally, she stated nursing staff had Code training on hire and annually. She stated CPR certification occurred every two (2) years by a certified AHA Instructor.

However, the facility's CPR policy stated education was not from the AHA guidelines, as stated by the SDC/QI nurse, but the education was from a Nursing Procedure Manual (Version Date: April 2013).

Review of nursing staff CPR cards validated that the SDC/QI nurse and the former Administrator were certified to perform CPR on 01/26/2021.

Telephone interview with LPN #15, on 08/19/2021 at 1:28 PM, revealed she remembered the night Resident #242 coded, around 6:30 PM, right after supper. She stated a SRNA notified her Resident #242 was having trouble breathing. She stated she sat Resident #242 up, and he/she was gasping and vomiting. She stated she called a Code Blue because the resident did not have a pulse, and the SDC/QI nurse came in the room started compressions while staff were looking for mask. LPN #15 stated, when the former Administrator came in the room and discovered the resident had coded, she administered breaths through paper towels. Then, LPN #15 stated Resident #242 grunted, and the resident had a pulse, so she told staff to stop compressions. However, she stated the former Administrator told staff to not stop with compressions because they

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 678	Continued From page 233	F 678		

had to have a doctor's order to stop compressions or the resident's pulse was sixty (60) bpm. LPN #15 stated she immediately texted the Advanced Practice Registered Nurse (APRN) who responded that if a resident had a pulse, to stop compressions. LPN #15 stated compressions continued for another minute after the resident's pulse returned. LPN #15 stated she was so glad the APRN responded when she did because, if she had not, who knows what would have happened. She stated the former Administrator was convinced that was how to do CPR in nursing homes. LPN #15 stated she was unaware of how to document the Code Blue. She stated the former Administrator instructed her to just document in the Progress Notes and not do an incident report.

Continued interview with LPN #15, on 08/19/2021 at 1:28 PM, revealed staff did get annual training on what to do in case of a code, and the SDC/QI nurse did the training. She stated the SDC/QI nurse did not tell the former Administrator to stop; she wanted her to tell the former Administrator to stop, but the SDC/QI nurse just smirked. LPN #15 stated she reported to the Director of Nursing (DON) what had occurred because she just could not believe the Administrator did not know how to do CPR. She stated Physician #1 and the APRN both called LPN #15 later that evening, and she told them what had happened. LPN #15 stated nobody investigated the event or asked staff to write a statement. Additionally, LPN #15 stated it was the worst experience she had ever been in and was so traumatized by the events of 01/26/2021 that she did not work for a month. Further, LPN #15 stated she was CPR certified every two (2) years.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 678	Continued From page 234	F 678		

Interview with the DON, on 08/19/2021, at 2:00 PM, revealed she had not been present for the code. She stated she met with the former Administrator the next day and told her it was wrong to continue CPR if there was a pulse. She stated the former Administrator again stated a resident needed a pulse of at least sixty (60) bpm to stop CPR. Additionally, the DON stated she sought guidance from the APRN who stated to stop CPR if there was a pulse. The DON stated staff received Code training annually and were CPR certified every two (2) years.

Observation, on 08/20/2021 at 9:27 AM, of the North dining room revealed the Automated External Defibrillator (AED) and pads on their crash cart. However, there was no log of checking the AED.

Interviews with LPN #6, LPN #7, and Registered Nurse (RN) #3, on 08/20/2021 at 9:35 AM, revealed they were not aware where the AED was in the facility but knew where crash carts were located in facility. The Interim Administrator stated there was not an AED in the facility.

Interview with the DON, on 08/20/2021 at 9:40 AM, revealed the logs should be audited to ensure the AED was working; however, she did not audit the AED log. The DON stated the facility received the AED in April 2021. However, review of provided AED education and sign-in sheets revealed the facility received AED training on 02/22/2021 by the SDC/QI nurse. The DON stated the facility's policy should have been updated to include the AED.

Interview with the DON and SDC/QI nurse, on 08/20/2021 at 11:20 AM, revealed the facility did

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 678	Continued From page 235	F 678		

mock code audits to ensure staff knew what to do for a code and how to do CPR correctly. However, they stated it had been a really long time, since their 2016 Plan Of Correction (POC) related to codes, that they had completed a mock code. They stated they did not have any documentation of a mock code audit. They stated they should have continued mock code audits after the POC to ensure staff would perform codes and CPR per standards of practice/care. Further, they stated it was important to ensure audits were completed for resident safety and quality of care.

Interview with the Regional Vice President (RVP), on 08/20/2021 at 3:03 PM, revealed he had no knowledge of the incident regarding Resident #242 and the fact that CPR continued after a pulse was obtained. He stated he was aware that CPR should be discontinued if there was a pulse. He stated he was not aware Physician #1 had concerns when he was notified of this situation. His expectation was the Administrator would have reported the incident to him; others could report that as well. They could have reported through the compliance line, or called him specifically, and he had no thoughts on why it was not reported.

The facility provided an acceptable Immediate Jeopardy Removal Plan, on 09/01/2021, that alleged removal of the Immediate Jeopardy (IJ) on 08/31/2021. The facility implemented the following:

1. On 8/19/2021 through 8/20/2021, the DON and SDC/QI nurse conducted a one-hundred (100%) percent audit. The audit reviewed all discharge charts, over the last thirty (30) days, to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 678	Continued From page 236	F 678		

identify any resident who had coded in the center. No other residents had coded in the center within the past thirty (30) days, and no issues where identified.

2. On 8/18/2021, the SDC/QI nurse completed an audit of one-hundred (100%) percent of nurses' CPR certifications to ensure all current licensed nurses on all shifts were certified in CPR and possessed a copy of a CPR certification card. There were no concerns identified during the audit. The facility did not require nursing assistants, Kentucky Medication Aides (KMA), or therapy staff to be CPR certified because they did not perform CPR. Non-certified staff acted as runners to gather equipment and greet EMS.

3. On 8/19/2021, the DON in-serviced the SDC/QI nurse, which included that CPR should not continue after a pulse was detected. The previous Administrator was no longer at the facility. The DON, SDC/QI nurse, and Nurse Supervisor initiated an in-service with all nurses. The in-service was about the Adult Basic Life Support Algorithm for Healthcare providers, the CPR policy, and Code Blue. The in-service instructed nurses that: 1) if a resident was found without a pulse, blood pressure (BP), respirations or with insufficient respirations, a Code Blue must be called immediately, 2) the chart must always be checked for the resident's code status, 3) always make sure you had the correct resident's chart, 4) if a resident was a full code, then CPR must be started immediately, 5) if a resident was a Do Not Resuscitate (DNR), then CPR must not be initiated, 6) if a resident was a full-code to call 911, 7) the medical doctor (MD) must be notified as soon as possible of the resident's condition, and 8) the nursing staff must follow the Adult

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 678	Continued From page 237 Basic Life Support Algorithm for Healthcare Providers. 4. On 8/19/2021, the DON, SDC/QI nurse, and Nurse Supervisor initiated a Questionnaire with all licensed nurses for validation of understanding their role in CPR. The passing score was one-hundred percent (100%). The questions included: 1) how do you know if a resident was a full code or DNR? 2) If a resident was a full code when do you initiate CPR? 3) what was the code to overhead page if a resident was found not breathing and/or no pulse? 4) when should the MD be notified if a resident was found not breathing and/or no pulse? 5) when a resident was found not breathing and/or no pulse, what were the nurse's responsibilities? and 6) do you continue CPR when heart rate and breathing had returned? As of 8/30/2021, any nurse who was unable to answer the questions on the questionnaire after two attempts would be removed from working with residents until they were able to validate knowledge. Nurses unable to validate knowledge would not be allowed to work in the facility. After 8/30/2021, no facility or agency nurse would be allowed to work without completing the questionnaire. Nurses who were not working would be mailed a copy of the in-service and questionnaire. Upon returning to work, a review of the questionnaire would be completed with the DON, SDC/QI nurse, Nurse Supervisor, or RN Corporate nurse. 5. The DON, SDC/QI nurse, and/or Nurse Supervisor would facilitate CPR Drills weekly for four (4) weeks. The facility had a CPR drill on 1) 8/20/2021 with first shift, 2) 8/24/2021 with second shift, 3) 8/29/2021 with the weekend staff,	F 678		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 678	Continued From page 238	F 678		

and 4) 8/31/2021 with first shift staff. The purpose of the drills were to ensure licensed and unlicensed staff understood their responsibilities during a Code Blue. Responsibilities included checking the resident for responsiveness, checking for pulse and respirations, summoning for assistance, checking code status, paging Code Blue, initiating CPR, ensuring adequate staff responded, nurse(s) designated staff to call 911, nurse(s) designated staff to obtain crash cart, crash cart brought to scene, CPR continued until EMS arrived, physician discontinued code, or until the resident's pulse and respirations had returned. Additional responsibilities included checking if crash carts were stocked appropriately and ensuring the correct chart was pulled/reviewed. Retraining would be conducted during the drill by the DON, SDC/QI nurse, and/or Nurse Supervisor for any identified areas of concern. There had been no issues identified.

6. On 8/20/2021, the DON, SDC/QI nurse, and the Unit Manager facilitated a CPR Drill for first shift staff. During and after the drill, the DON offered feedback and suggestions to the staff. The staff were able to demonstrate and answer questions correctly, establishing staff were familiar with facility policies related to CPR, in accordance with standards of practice.

7. On 8/24/2021, the DON, SDC/QI nurse, and the Unit Manager facilitated a CPR Drill for second shift staff. During and after the drill, the DON offered feedback and suggestions to the staff. The staff was able to demonstrate and answer questions correctly, establishing staff was familiar with facility policies related to CPR, in accordance with standards of practice.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 678	Continued From page 239	F 678		

8. On 8/25/2021, the DON facilitated the morning interdisciplinary team (IDT) meeting. Members of the IDT included the Administrator, DON, Quality Improvement Nurse/Staff Development Coordinator (SDC/QI), Minimum Data Set (MDS) Nurse, Unit Manager, Activity Director, Social Services Director, and Dietary Manager. At the meeting, the RN Corporate nurse reviewed residents' medical charts, during which resident code status was reviewed. Approximately twenty-five (25%) percent of resident records were reviewed and code status was noted to be up-to-date.

9. On 8/26/2021, the DON reviewed and updated the CPR plan of correction with the Medical Director via telephone.

10. On 8/29/2021, the DON facilitated a CPR Drill for the weekend staff. The DON was assisted by three (3) RN's from a sister facility. During and after the drill, the DON and RN's offered feedback and suggestions to the staff. The staff were able to demonstrate and answer questions correctly, establishing staff were familiar with facility policies related to CPR, in accordance with standards of practice.

11. On 8/29/2021, the RN Corporate nurse audited twenty-five percent (25%) of the residents' electronic health records (EHR) to determine if the physical chart, residents' plans of care, and electronic face sheets all matched. No issues were identified.

12. The RN Corporate nurse would continue working at the facility five (5) days a week through September 2021 to help ensure the facility staff were familiar with facility policies related to CPR,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 678	Continued From page 240	F 678		

in accordance with standards of practice.

13. The DON would continue forwarding the results of the CPR Drills to the Quality Assurance Performance Improvement (QAPI) Committee monthly for one (1) month. The QAPI Committee would meet monthly for one (1) month and review the CPR Drill results to determine trends and/or issues that might need further interventions put into place and to determine the need for further and/or frequency of monitoring. The QAPI Committee consisted of the Administrator, DON, Infection Preventionist, Medical Director, Social Worker, Medical Records Director, Dietary Manager, and Housekeeping Supervisor, plus additional staff members as deemed necessary.

The State Survey Agency validated the implementation of the facility's Immediate Jeopardy Removal Plan as follows:

1. Review of documentation dated 08/19/2021 through 08/20/2021 revealed the DON and SDC/QI nurse audited one-hundred (100%) percent of discharged charts to identify if any residents had coded in the last thirty days. There were no residents identified.

2. Review of CPR cards revealed the SDC/QI nurse audited one-hundred (100%) percent of licensed nurses for current CPR education.

Interviews with LPN #11, RN #3, LPN #10, and LPN #6, on 09/02/2021 at 3:03 PM, 3:14 PM, 4:16 PM, and 4:26 PM respectively, revealed they were all currently CPR certified.

3. Review of signed in-service documentation sheet, dated 08/19/2021, revealed the DON

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 678	Continued From page 241	F 678		

in-serviced the SDC/QI nurse regarding that CPR should not be continued if there was a pulse. Continued review revealed the DON and SDC/QI nurse educated all licensed nursing staff on Adult Basic Life Support Algorithm for Healthcare Providers, CPR Policy, and Code Blue.

Interviews with LPN #11, RN #3, LPN #10, and LPN #6, on 09/02/2021 at 3:03 PM, 3:14 PM, 4:16 PM, and 4:26 PM respectively, revealed they did receive CPR education and had Code Blue drills and quizzes across every shift and on weekends.

4. Review of CPR quizzes revealed one-hundred (100%) percent of licensed nursing staff took the quizzes and passed. An employee roster was used to ensure no one was missed in receiving the education.

5. Review of CPR drill documentation revealed the facility held drills on 08/20/2021, 08/24/2021, 08/29/2021, and on 08/31/2021. Continued review revealed they were held across all shifts and on the weekend. No concerns were identified.

Interview with the Corporate RN, on 09/02/2021 at 1:18 PM, revealed she was present for the Code Blue drill on 08/29/2021 (a weekend). She stated she also quizzed staff on what their various responsibilities might be in a Code Blue situation.

6. Review of documentation, dated 08/20/2021, revealed the DON and SDC/QI nurse facilitated a CPR drill for first shift staff.

7. Review of documentation, dated 08/20/2021, revealed the DON and SDC/QI nurse facilitated a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 678	Continued From page 242 CPR drill for second shift staff. 8. Review of the IDT meeting agenda, dated 08/25/2021, revealed the Corporate RN reviewed approximately twenty-five (25%) percent of residents' charts to ensure code status was documented and up-to-date. 9. Review of facility documentation, dated 08/26/2021, revealed the DON updated the Medical Director via telephone call. 10. Review of CPR Drill documentation, dated 08/29/2021, revealed the DON held the drill for weekend staff. 11. Review of documentation, dated 08/29/2021, revealed the Corporate RN audited twenty-five (25%) percent of residents' charts to ensure the electronic face sheets, physical charts, and residents' plans of care contained updated code status. 12. Interview with the Corporate RN, on 09/02/2021 at 1:18 PM, revealed she was assigned to be at the facility until the end of September 2021. She stated she would assist facility management in ensuring staff were familiar with facility policies related to CPR, in accordance with standards of practice. 13. Interview with the DON, on 09/02/2021 at 1:18 PM, revealed she had sent the CPR Drills analysis from 08/20/2021, 08/24/2021, 08/29/2021, and on 08/31/2021 to the QAPI Committee to be discussed at the next meeting.	F 678		
F 688 SS=G	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3)	F 688		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 688	Continued From page 243	F 688		

§483.25(c) Mobility.
§483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and

§483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.

§483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to ensure a resident who entered the facility without limited range of motion (ROM) did not experience a reduction in ROM and a resident with limited ROM received appropriate treatment and services to increase ROM and/or to prevent further decrease in ROM for two (2) of forty-four (44) sampled residents (Resident #13 and #77). The facility failed to ensure a resident with limited mobility received appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence, unless a reduction in mobility was demonstrably unavoidable.

1. Resident #13's Admission Minimum Data Set (MDS) Assessment, dated 08/04/2017;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 688	Continued From page 244	F 688		

Significant Change MDS Assessment, dated 12/14/2020; and Quarterly MDS Assessment, dated 08/10/2021, in Section G: Functional Status, revealed the resident had no functional limitations in ROM for upper or lower bilateral extremities.

However, observation of Resident #13, on 08/09/2021, revealed he/she had contractures to his/her bilateral lower extremities. Further, review of the medical record revealed no documented evidence the facility developed or implemented a Restorative Care regimen with interventions, services, or treatment to maintain current functional status or to prevent a decrease in function.

2. Resident #77's most recent Annual MDS Assessment, dated 07/14/2021, Section G: Functional Status, revealed the resident had functional limitations in ROM on one (1) side upper and lower extremity. Additional review Section I: Diagnosis, revealed the resident had a diagnosis of Contracture; unspecified hand. Continued review of Section O: Special Treatment, Procedures and Programs, revealed the resident received seven (7) days of Restorative Nursing Programs, for brace or splint assistance.

However, observations of Resident #77, on 08/09/2021; 08/10/2021; 08/11/2021; and 08/12/2021 revealed his/her right hand was contracted with no brace or splint. Further review of the medical record revealed documented evidence the facility inconsistently implemented a Restorative Care regimen with interventions, services, or treatment to maintain current functional status or to prevent a decrease in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 688	Continued From page 245	F 688		

function.

Substandard Quality of Care (SQC) was identified related to the facility's systemic failure to provide the nursing care needed to prevent a decline in functional status.

The findings include:

Review of the facility's policy titled, "Restorative Nursing Program (RNP)," dated 01/07/2019, revealed RNP's were an integral part of resident care which enabled residents to maintain their highest practicable physical, mental, and psychological functional level and well-being. Additionally, RNP's helped promote optimal functioning by enabling residents to obtain or maintain independence, establish life patterns within existing limitations, and utilize skills to improve the overall quality of life for the resident(s). Per the policy, restorative nursing care consisted of nursing interventions that could or could not be accompanied by formalized rehabilitative services; nurses, State Registered Nurse Aides (SRNA), and the Quality Assurance Committee could at any time identify a resident need and make referrals for the RNP. Continued review revealed RNP management consisted of three (3) phases; Phase 1: Step down from skilled therapy, which included a therapist to provide a resident specific treatment plan to the RNP; Phase 2: the restorative nurse evaluated the resident's progress toward his/her goals quarterly and met with the RNP SRNA monthly to review the progress of residents receiving RNP services; modification to the RNP Plan and referrals should be made as appropriate; and Phase 3: Functional Maintenance Program, which included incorporation of restorative activities into

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 688	Continued From page 246	F 688		

the residents daily care and services. Continued review revealed the resident's Care Plan would outline restorative goals with expected outcomes, and objectives, which were individualized and resident-centered. Further, a decline in functional ability required an assessment by the licensed RNP nurse and/or a therapy referral for evaluation and treatment. The RNP SRNA should notify the RNP nurse immediately when a decline occurred in functional abilities (i.e.) mobility to ensure appropriate action in a timely manner.

1. Review of Resident #13's medical record revealed the facility admitted the resident, on 07/28/2017, with diagnoses including Dementia, Major Depressive Disorder, Arthritis, and Schizoaffective Disorder.

Review of Resident #13's Admission MDS Assessment, dated 08/04/2017, Section C: Cognitive Patterns, revealed the resident was assessed to have a Brief Interview for Mental Status (BIMS) score of three (3) of fifteen (15), indicating severe cognitive impairment. Additional review of Section G: Functional Status, revealed the resident had no functional limitations in ROM for upper or lower bilateral extremities. Per the Assessment, the resident was ambulatory and did not use a mobility device. Further, the resident required extensive assistance of one (1) staff with Activities of Daily Living (ADL) such as bed mobility, transfer, dressing, toileting, personal hygiene, and eating. The resident did receive physical and occupational therapy minutes, starting on 07/28/2017.

Review of Resident #13' Physical Therapy Progress and Discharge Summary, dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 688	Continued From page 247	F 688		

08/07/2017, revealed the resident was able to achieve all goals. The resident ambulated independently within his/her environment without assistive devices. Additionally, the resident had full ROM of bilateral lower extremities hips and knees. Further, the resident was discharged to Long Term Care (LTC).

Additional review of Resident #13's most current comprehensive Significant Change MDS Assessment, dated 12/14/2020, Section C: Cognitive Pattern, revealed the resident had short and long term memory problems; moderately impaired cognitive skills for daily decision making. Additional review of Section G: Functional Status, revealed the resident ambulated in his/her room independently with setup help from staff and ambulated in the corridor independently with no setup or physical help from staff. Per the Assessment, the resident did not use a mobility device. Further, the resident required extensive assistance of two (2) staff with ADL's such as bed mobility, transfer, toileting, personal hygiene, and eating; and total assistance with dressing. Continued review revealed the resident had no functional limitations in ROM for upper or lower bilateral extremities. The resident had not receive therapies since 07/31/2017 and did not receive RNP.

Review of Resident #13's Occupational Therapist (OT) Plan of Care, dated 01/08/2021, revealed the resident was referred to OT for wheelchair seating and positioning assessment. Additionally, nursing reported the resident had a significant decline in function over the last several weeks resulting in the resident being bed ridden. Per the plan, nursing reported the resident was now more alert, wanting to get out of bed; however, was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 688	Continued From page 248	F 688		

unable to transfer or ambulate without assistance. Continued review revealed no documented evidence of an assessment of the resident's ROM of the bilateral lower extremities; hips and knees. Further, the goal for the resident was to demonstrate optimal positioning in the most appropriate seating system while maintaining proper positioning up to two (2) hours a day to promote optimal positioning for ADL's and increase out of bed time to improve functional status.

Review of Resident #13's OT Progress and Discharge Summary, dated 01/17/2021, revealed the resident progressed to using an Evolution chair (addressed mobility and positioning issues)up to one (1) to two (2) hours a day out of bed with supervision and assistance. Further, the resident was discharged to LTC with the Evolution chair as a device to promote comfort and proper positioning. However, there was no documented evidence of an assessment of the resident's ROM of the bilateral lower extremities; hips and knees.

Observation of Resident #13, on 08/09/2021 at 4:11 PM, revealed the resident lying in bed with a thin throw over his/her abdomen and lower extremities; bilateral lower extremities were bent at the knees and the residents left leg rested on the right leg.

Additional observation, on 08/10/2021 at 11:58 AM, revealed the resident was lying in bed uncovered from the waist down. The resident's bilateral lower extremities were bent at the knees. Further, at rest, the resident's left leg was bent greater than the right leg was bent at rest. His/her left calf touched the left thigh. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 688	Continued From page 249	F 688		

resident's left leg fell over the resident's right leg.

Continued review of Resident #13's most current Quarterly MDS Assessment, dated 08/10/2021, Section C: Cognitive Pattern, revealed the resident had short and long term memory problems; moderately impaired cognitive skills for daily decision making. Additional review of Section G: Functional Status, revealed ambulation did not occur, and the resident did not use a mobility device. Further, the resident required extensive assistance of two (2) staff with ADL's such as bed mobility, transfer, toileting, personal hygiene, dressing, and eating. Continued review revealed the resident had no functional limitations in ROM for upper or lower bilateral extremities. The resident had not receive Occupational Therapy, Physical Therapy, or RNP.

Review of Resident #13's Comprehensive Care Plan (CCP), revealed no documented evidence the CCP was developed to include the resident's functional limitations in ROM to his/her bilateral lower extremities or appropriate services, equipment, and assistance to maintain or improve mobility.

Further observations of Resident #13, on 08/12/2021 at 3:06 PM, with Registered Nurse (RN) #6, revealed the resident had functional limitations in bilateral lower extremities: hips and knees. The resident's right knee was bent at approximately a ninety (90) degree angle, and the resident was not able to flex or extend the right knee past the resting position. The resident's left leg was bent less than forty-five (45) degrees, and the resident was not able to flex or extend the left knee beyond the resting position. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 688	Continued From page 250	F 688		

resident's legs touched each other, and the left leg crossed the right leg. The nurse stated the bilateral quadriceps were tight, and there was resistance when trying to move the resident's knees and when trying to move the resident's legs apart. Further, when RN #6 attempted to move the resident's left leg off the right leg, the resident moaned and attempted to grab the nurse's hands. When the resident was at rest, the resident's left leg rolled to the right over the right leg, and the resident was not able to control normal alignment of his/her legs.

Interview with RN #6, on 08/12/2021 at 3:06 PM, revealed Resident #13's legs were severely contracted. Per the interview, the resident had a decline in December of 2020 and had not been ambulatory since then. Additionally, RN #6 stated the SRNA's provided ROM to residents with limitations in ROM. Further, RN #6 stated it was important to provide care to residents to meet their needs and ensure quality care.

Continued observation of Resident #13, on 08/12/2021 at 3:41 PM, revealed the resident sitting up in his/her Evolution chair at the bedside. The resident's right foot was resting on the floor; however, the resident's left leg was bent at the knee and the resident's foot was suspended in the air, at rest. The resident's left leg bent at the knee was resting above the resident's right knee.

Interview with State Registered Nurse Aide (SRNA) #19 (worked at the facility for twelve (12) years), on 08/12/2021 at 11:00 AM, revealed she was often assigned to provide care to Resident #13. Per the interview, the resident did have contractures to his/her lower extremities, but the resident was not able to put his/her legs down

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 688	Continued From page 251	F 688		

and held them bent at all times. Continued interview revealed the resident's legs had been bent for several months. Additionally, she provided passive ROM to the resident's arms and legs for one (1) hour a day during care. Further, she stated Resident #13 required staff to provide total care for all ADL's.

However, there was no documented evidence the facility developed or implemented a Restorative Care regimen with interventions, services, or treatment to maintain current functional status or to prevent a decrease in function for Resident #13.

Review of Resident #13's Physician Orders, dated May 2021 through August 2021, revealed no documented evidence of orders related to appropriate services, equipment or assistance to maintain or improve mobility.

Review of Resident #13's Progress Notes, dated May 2021 through August 2021, revealed no documented evidence of Restorative Care interventions.

Review of Resident #13's Treatment Administration Record (TAR), dated May 2021 through August 2021, revealed no documented evidence of treatment to the resident's bilateral lower extremities.

Review of Resident #13's nurse aide care plan (Kardex), dated 08/13/2021, revealed no documented evidence of Restorative Care interventions.

Interview with the Occupational Therapist/Director of Therapy (worked at facility for eight (8) years),

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 688	Continued From page 252	F 688		

on 08/13/2021 at 2:10 PM, revealed Resident #13 was not on the therapy caseload currently and had not been seen in therapy for a very long time. Per the interview, she was not aware if Resident #13 had limitations in ROM to his/her bilateral lower extremities; the resident was ambulatory on admission. She stated all residents' ROM was assessed on admission, but unless nursing staff noted a decline in a resident's functional status, therapy would not reassess routinely. The therapy department relied on nursing staff to identify and communicate declines/changes in the functional status of residents to therapy via a referral on the Electronic Health Record (EHR); then a reassessment of functional status, including ROM, would be completed. Further, she stated it was important to provide appropriate services, equipment, and assistance to maintain or improve contractures to prevent skin integrity issues, maintain joint alignment, manage pain, and to prevent/maintain further developing of contractures.

Interview with Licensed Practical Nurse (LPN) #13/Minimum Data Set (MDS) Coordinator (at the facility for seven (7) years), on 08/13/2021 at 2:51 PM, revealed during the Assessment Reference Date (ARD), she would make observations of resident care and complete assessments of residents, which should be documented in a general Progress Note. Additionally, she stated, if a decline was noted in a resident's functional status, a referral should be made to the therapy department to ensure appropriate and timely action was taken to ensure the needs of the resident were met. Further, she stated Resident #13 had a significant change in December of 2020; was palliative care and had a decline in functional status. She stated the resident was no

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 688	Continued From page 253	F 688		

longer ambulatory and was bed ridden. Additionally, she stated, during the ARD, she assessed Resident #13's bilateral lower extremity ROM and determined the resident's legs were bent. However, she failed to document her assessment in a Progress Note and did not document that the resident's bilateral lower extremities had limitations in ROM/contractures. Per the interview, Resident #13 could not straighten out his/her knees and the resident's legs were contracted. She stated she failed to make a referral to therapy for the decline in functional status after her assessment of the resident's ROM.

2. Review of Resident #77's medical record revealed the facility admitted the resident, on 08/31/2001, with diagnoses including Schizophrenia, Hemiplegia Affecting the Left Non-dominant Side, Alzheimer's Disease, and Contracture Unspecified Hand.

Review of Resident #77's OT Plan of Care, dated 02/14/2020, revealed the resident was referred to OT after RNP staff reported concerns of increasing contracture to the left hand; increased difficulty stretching the resident's left hand and donning the left hand orthotic due to increased tightness and resistance from the resident due to pain. Further, the goals included tolerating the most appropriate orthotic to the left hand for up to one (1) hour a day; decreased pain in the left hand; and improved ROM to the left hand joints.

Review of Resident #77's OT Progress and Discharge Summary, dated 03/09/2020, revealed the resident was able to achieve all goals. The resident tolerated the left palmar orthotic up to two (2) hours a day to protect the skin integrity of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 688	Continued From page 254	F 688		

the left palm; decreased pain to the left hand during stretching; and improvement of ten (10) degrees in ROM in the left hand joints. Additionally, the resident was discharged to the RNP for orthotic management. Further, OT provided caregiver training focused on decreasing increased contracture to the left hand and ensuring completion of the RNP plan, to decrease the resident's risk for potential skin breakdown and further development of the left hand contracture.

Review of Resident #77's CCP, initiated on 03/18/2020, revealed the resident required assistance and had potential to restore or maintain function of mobility by opening and closing of the left hand. The goal was the resident would not have worsening ROM in the upper extremity (left hand). Interventions included encourage the resident to participate in passive ROM, dated 05/20/2020. Additional interventions included hand hygiene prior to donning the left palmar orthotic; donning of the splint three (3) to four (4) hours; check skin prior to and after removing the splint six (6) days a week for twelve (12) weeks, dated 03/18/2020. Further interventions included, if the resident did not participate in the splint/brace program, document the reason, dated 03/18/2020.

However, there was no documented evidence the facility consistently implemented the Restorative Care regimen with interventions, services, or treatment to maintain current functional status or to prevent a decrease in function.

Review of Resident #77's RNP Restorative Aide task, dated 05/23/2021 through 08/18/2021, revealed no documented evidence the resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 688	Continued From page 255	F 688		

received his/her splint three (3) to four (4) hours a day, six (6) days a week, for six (6) of the twelve (12) weeks. During the weeks of 06/06/2021 through 06/12/2021; 06/27/2021 through 07/03/2021; and 08/01/2021 through 08/07/2021, the resident's splint was applied four (4) days each week. Additionally, during the weeks of 07/18/2021 through 07/24/2021 and 07/25/2021 through 07/31/2021, the resident's splint was applied for five (5) days each week. Further, during the week of 08/08/2021 through 08/14/2021, the resident's splint was applied for three (3) days.

Continued review of Resident #77's RNP Restorative Aide task, dated 05/23/2021 through 08/18/2021, revealed no documented evidence passive ROM since 01/26/2021. Further review revealed documented evidence the resident received inconsistent splint skin integrity checks before and after donning of the left palmar hand splint for twelve (12) of the twelve (12) weeks. During the weeks 05/23/2021 through 05/29/2021; 05/30/2021 through 06/05/2021; 06/27/2021 through 07/03/2021; and 07/04/2021 through 07/10/2021, skin integrity checks were provided three (3) times each week. During the weeks of 06/06/2021 through 06/13/2021; and 07/18/2021 through 07/24/2021, skin integrity checks were provided two (2) times each week. During the weeks of 06/14/2021 through 06/19/2021; 06/20/2021 through 06/26/2021; and 07/11/2021 through 07/17/2021, skin integrity checks were provided five (5) times each week. During the weeks of 07/25/2021 through 07/31/2021; and 08/01/2021 through 08/07/2021, skin integrity checks were provided one (1) time each week. During the week of 08/08/2021 through 08/14/2021, skin integrity check were not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 688	Continued From page 256	F 688		

provided.

Review of Resident #77's Annual MDS Assessment, dated 07/14/2021, Section C: Cognitive Patterns, revealed the resident was assessed to have a Brief Interview for Mental Status (BIMS) score of seven (7) of fifteen (15), indicating severe cognitive impairment. Additional review of Section G: Functional Status, revealed the resident had functional limitations in ROM on one (1) side, for upper and lower bilateral extremities. Further, the resident required extensive assistance of two (2) staff with Activities of Daily Living (ADL) such as bed mobility, transfer, and toileting; extensive assistance of one (1) staff for dressing and personal hygiene; and total assistance of one (1) staff for eating. The resident did receive occupational therapy, ending on 03/09/2020 and splint and brace assistance seven (7) days for at least fifteen (15) minutes in the last seven (7) calendar days.

However, observation of Resident #77, on 08/09/2021 at 4:28 PM, revealed the resident's left hand was edematous and his/her fingers were folded down onto the palm at rest. The resident was not wearing any device on his/her left hand.

Additional observation of Resident #77, on 08/10/2021 at 12:20 PM, revealed the resident's left hand was closed in a fist. The resident was not wearing any device on his/her left hand.

Continued observation of Resident #77, on 08/11/2021 at 9:50 AM, revealed the resident's left hand was closed in a fist at rest with his/her fingers folded onto the palm. The resident was not wearing any device on his/her left hand.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 688	Continued From page 257	F 688		

Further observation of Resident #77, on 08/12/2021 at 10:57 AM, revealed the resident's left hand was closed in a fist at rest. The resident was not wearing any device of his/her left hand.

Interview with SRNA #19 (had worked at facility for twelve (12) years), on 08/12/2021 at 11:00 AM, revealed she was assigned to Resident #77 often. Per the interview, the resident required total assistance with ADL's. Additionally, the resident required a splint on his/her left hand because it was contracted. Continued interview revealed SRNA #5 assisted the resident each day with putting on and taking off the splint. Further, Resident #77's Kardex was reviewed with SRNA #19; the resident required a left palmar orthotic three (3) to four (4) hours a day, six (6) days a week for twelve (12) weeks.

Continued observation of Resident #77, on 08/12/2021 at 11:15 AM, revealed SRNA #5 entered Resident #77's room and closed the door. Additionally, on 08/12/2021 at 11:20 AM, SRNA #5 exited the resident's room. Resident #77 now had a palmar brace to his/her left hand.

Interview with SRNA #5 (had worked at the facility for thirty-four (34) years), on 08/12/2021 at 11:24 AM, revealed she had been a restorative aide for eight (8) years. Per the interview, each resident that received RNP services had a Care Plan for their specific needs, and she would provide the care to the resident per the Plan and document the minutes on the Care Plan task after providing the care/service. Additionally, she stated Resident #77's RNP Plan included a brace to his/her left hand after washing the hand and moving the fingers. Per the interview, the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 688	Continued From page 258	F 688		

resident wore the left hand brace for four (4) to five (5) hours a day. Further interview revealed when she was out of the facility or had other duties, such as working on the floor due to short staffing, the RNP services should be completed by other aides on the hallway. Continued interview revealed SRNA #5 had been out of the facility on 08/10/2021 and 08/11/2021.

Observations of Resident #77, on 08/12/2021 at 3:36 PM, with RN #4, revealed the resident was wearing a palmar brace to his/her left hand. Additionally, the nurse attempted to remove the palmar brace, the resident's fingers snuggly laid on the brace, and when the nurse lifted the resident's fingers, the resident pulled his/her hand away, mumbled and grimaced.

Interview with RN #4, on 08/12/2021 at 3:45 PM, revealed nursing staff was responsible to ensure Resident #77's left hand brace was applied per his/her RNP Plan. Per the interview, it was important to apply the brace per the RNP Plan to decrease risk for worsening contracture, pain, and skin impairment. Additionally, nurses should spot check the resident and ensure aides had applied the brace. Further, she stated she had not identified any issues with the resident not receiving his/her brace as care planned.

Interview with the Director of Nursing (DON), on 08/13/2021 at 2:31 PM, revealed she had worked at the facility as the DON for one (1) year. Per the interview, the facility had a RNP, she was the RNP nurse, and there were two (2) RNP aides; however, one (1) was off on medical leave. Per the interview, services, treatment, equipment, and assistance to maintain or improve a resident's mobility was also the responsibility of all aides in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 688	Continued From page 259	F 688		

the facility, and the ultimate goal was for residents to remain at baseline status without decline. She stated she ensured residents received appropriate treatment and services to maintain mobility through utilizing therapy and by referring residents for functional status changes, which was discussed in the Morning Clinical Meeting. She also stated she relied on completed quarterly evaluations of resident's progress in the RNP. However, she stated she was not aware Residents #13 had contractures to his/her bilateral lower extremities or that Resident #77 had not consistently been provided his/her device for contractures. She also stated she was aware Resident #13 had experienced a decline in functional ability since admission to the facility. Continued interview revealed services and treatment should have been provided to prevent a decline and maintain the baseline status. Further, the DON stated treatment and services to maintain mobility was very important to maintain functional status, prevent a decline in ADL's, maintain skin integrity, reduce pain, and improve or maintain psychosocial well-being.

Interview with the Administrator, on 08/16/2021 at 3:30 PM, revealed he had worked at the facility since July 27, 2021. Per the interview, he expected the rehabilitation department and nursing department to ensure residents were as mobile as possible and provide treatment/services to assist with reduction in mobility. Additionally, he expected the Restorative Nursing Program policy to be maintained and followed to ensure the highest functional ability for each resident. The Administrator stated he ensured this was done by follow-up during the Monday through Friday Clinical Meeting. Further, the Administrator

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 688	Continued From page 260 stated it was important to provide services and treatments to residents to keep their highest functioning level and to ensure those residents, without functional limitations, remained at baseline, and those with limitations did not decline.	F 688		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policies, it was determined the facility failed to ensure each resident's environment was free from accident hazards over which the facility had control; and failed to provide supervision and assistive devices to each resident to prevent avoidable accidents for five (5) of forty-four (44)	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 689	Continued From page 261	F 689		

residents (Resident #13, Resident #22, Resident #80, Resident #240, and Resident #245).

1. Resident #240 was provided care on 01/27/2021 by unlicensed staff acting beyond the scope of her job, resulting in Resident #240 suffering a fall with serious injury. Resident #240's CCP revealed the resident's Mobility Care Plan, prior to 01/27/2021, did not indicate the assistance required for bed mobility, transfers, or toileting.

2. Resident #13 had falls, on 07/22/2021, 07/23/2021, and 07/24/2021; however, the facility failed to implement corrective interventions and revise the Comprehensive Care Plan (CCP) immediately after each fall.

3. Resident #22 had a fall, on 03/04/2021, and the Initial Fall Incident Report noted the resident required dycem to his/her wheelchair to prevent further falls of the same nature. However, the CCP was not revised to include the fall intervention of dycem to the wheelchair until 03/17/2021 (thirteen (13) days after the fall). Additionally, there was no documented evidence the facility evaluated the resident's risk for falls, per the facility's Fall Protocol policy, until 05/24/2021, eighty-two (82) days after the fall on 03/04/2021

4. Resident #80 had a fall on 06/29/2021 and the Initial Fall Incident Report noted the resident required ice chips in between meals and at bedtime to prevent further falls of the same nature. However, the CCP was not revised to include the fall intervention of ice chips between meals and at bedtime until 07/15/2021.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 689	Continued From page 262	F 689		

5. Review of the Initial Fall Incident Reports revealed Resident #245 had falls on 02/19/2021, 02/23/2021, 03/13/2021, and 03/19/202. Review of the fall investigations revealed fall interventions were not updated on the CCP in a timely manner with interventions to help prevent future falls.

The findings include:

Review of the facility's policy titled, "Falls Protocol," dated 02/04/2021, revealed residents would be assessed for fall risk on admission, re-admission, quarterly and with a significant change. Continued review revealed residents with falls who were not identified as a fall risk would be assessed for fall risk. Additionally, residents at risk for falls would have a care plan initiated related to falls with multiple interventions. Per the policy, falls would be investigated to determine the root cause and validate that an investigation was completed. Further, trends with falls should be reviewed through the Interdisciplinary Team (IDT); and findings should be brought to the Quality Assurance Performance Improvement (QAPI) meeting.

1. Review of a Personal Care Assistant (PCA) Job Description and Training Form for PCA #2, updated on 11/23/2020, revealed "for anything beyond a one-person transfer, the PCA may only assist and must be directed by a certified/licensed staff member." The form was signed by PCA #2 and the DON on 12/31/2020.

Review of Resident #240's medical record revealed the resident was re-admitted to the facility, on 03/26/2020, with diagnoses to include Paraplegia Unspecified, Unspecified Atrial Fibrillation, and Morbid (Severe) Obesity due to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 689	Continued From page 263	F 689		

Excess Calories. The facility assessed Resident #240, in a 01/05/2021 Quarterly MDS Assessment, on the BIMS as fifteen (15) of fifteen (15), indicating no cognitive impairment. Further, the facility assessed Resident #240 as an assist of two (2) with bed mobility, transfers, and dependent on two (2) staff for toileting. Continued review of Resident #240's medical record revealed he/she was discharged from the facility on 03/22/2021 to another facility.

Review of an Investigational Summary of a fall that occurred on 01/27/2021 at 5:45 AM revealed Resident #240, paraplegic with no control over his/her lower extremities, was receiving care from a staff member when he/she rolled out of the bed approximately eighteen (18) inches onto the floor, resulting in multiple skin tears and bruising. The Investigation Summary goes on to reveal Medical Director was notified, and mobile x-ray was ordered of bilateral hips, pelvis, and left shoulder, which was completed on site that day. X-ray results were returned at 1:35 PM on 01/27/2021 with abnormal results, and Resident #240 was ordered to transfer to the hospital. The resident returned from the local hospital, on 01/27/2021 at 8:30 PM, with a diagnosis of Left Humeral Fracture.

Review of Resident #240's Comprehensive Care Plan revealed resident Mobility care plan prior to 01/27/2021 did not indicate the assistance required for bed mobility, transfers, or toileting. On 01/27/2021, resident care plan updated for two (2) person assist with bed mobility.

Review of Witness Statement from PCA #2 on 01/27/2021 revealed PCA #2 was changing Resident #240 when resident's hand slipped off

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 689	Continued From page 264	F 689		

the rail, resulting in a fall. PCA #2 revealed she notified the nurse to come help as soon as possible.

Review of a Witness Statement from LPN #17 revealed she was called into Resident #240's room on 01/27/2021, and noted resident on the floor on his/her back between the beds. LPN #17 statement revealed Resident #240 said "I couldn't hold on." LPN #17 statement revealed she completed a head to toe assessment of resident, and noted skin tear to right lower arm, skin tear to right inner knee, abrasion to left elbow, and skin tear to 2nd toe on left foot.

Review of a Witness Statement from SRNA #11 revealed she was doing rounds on 01/27/2021 with SRNA #12 and SRNA #12 yelled for her and LPN #2 to help because Resident #240 was in the floor. SRNA #11 stated PCA #2 was changing Resident #240 when Resident #240 slipped out of bed.

Review of a Witness Statement from SRNA #12 revealed she was in the hallway when someone yelled help and upon arrival at room Resident #240 was in the floor.

Interview with the Social Services Director (SSD) on 07/27/2021 at 10:29 AM revealed PCA's were not allowed to change residents. She revealed PCA's take a class and had a sheet that covered everything they were allowed to do.

Interview with Facility Consultant #1 on 07/27/2021 at 1:15 PM revealed the facility had begun utilizing PCA during the pandemic. She went on to reveal PCA's were allowed to assist SRNA's in changing residents, but were not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 689	Continued From page 265	F 689		

allowed to do so themselves.

Interview with PCA #2 on 07/31/2021 at 9:32 AM revealed she had been told she wasn't allowed to change residents without an SRNA present. She revealed SRNA #11 and SRNA #12 had stepped out of the room and stated she could go ahead and change Resident #240. She revealed SRNA #11 had gone to the bathroom, and SRNA #12 had left the room as well. PCA #2 revealed when she went to change Resident #240, the resident's foot slid off of the bed, and by the time she got down there to catch him/her, the resident had already fallen. She revealed the incident scarred her for life. PCA #2 revealed she had changed Resident #240 numerous times and never had a problem, but knew she wasn't supposed to be changing a resident without an SRNA being present.

Interview with RN #1 on 08/02/2021 at 3:52 PM revealed PCA #2 came to her on the morning of 01/27/2021 "tore up," and stated she had gone in to change Resident #240, though the resident had hold of the rail, but resident lost his/her grip and fell. RN #1 stated she asked PCA #2 if she had taken an SRNA with her, and PCA #2 stated no, she didn't have anyone to help her. RN #1 stated PCA's weren't supposed to be changing residents or providing resident care without a licensed staff member present. RN #1 went on to reveal Resident #240 had always been a two assist with transfers, changing, and bed mobility, as Resident #240 was a large lady.

Interview with SRNA #11, on 08/03/2021 at 1:02 PM, revealed when PCA's were first introduced to the facility, staff weren't sure what they were and were not allowed to do. She revealed on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 689	Continued From page 266	F 689		

01/27/2021, she and SRNA #12 had informed PCA #2 not to do anything on her own, not to provide any resident care without one of them present, but that she and SRNA #12 were down the hall, and the next thing they knew PCA #2 was yelling that Resident #240 was in the floor.

Interview with PCA #3, on 08/03/2021 at 3:02 PM, revealed as a PCA she assisted the SRNA's, and when she was done assisting the SRNA's, she assisted the Courtesy Aides. She revealed she sat with residents one-on-one (1:1) when asked to do so by nursing staff. She revealed she never did any changing or transferring of residents on her own.

Attempts to reach LPN #17 during the course of the survey were unsuccessful.

Interview with the DON, on 08/04/2021 at 8:28 AM, revealed PCA's could not provide resident care on their own. She revealed PCA's could assist aides. She revealed after Resident #240 fell out of bed, while a PCA was changing him/her, all staff were reeducated on what PCA's could and could not do.

Interview with the SDC, on 08/04/2021 at 2:58 PM, revealed PCA #2 should not have been trying to change Resident #240, as PCA's were not allowed to provide resident care without a licensed staff member present, and PCA #2 had received training and knew that. She revealed Resident #240 was a one (1) person assist, as he/she could help turn and reposition.

Interview with RN #7, the MDS Coordinator, on 08/04/2021 at 3:29 PM, revealed prior to 01/27/2021, Resident #240's care plan might not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 689	Continued From page 267	F 689		

have indicated the assistance required for bed mobility. She revealed there had been an update to their system that occurred after Resident #240 had been admitted, and specific information on his/her bed mobility might have been erased. She stated the nurse aide care plans were a reflection of the comprehensive care plan, so this information would not have been reflected on the nurse aide care plan prior to 01/27/2021.

Interview with the Interim Administrator, on 08/20/2021 at 10:24 AM, revealed he was not familiar with the PCA program, but his expectation would be residents be cared for appropriately by trained staff.

2. Review of Resident #13's medical record revealed the facility admitted the resident, on 07/28/2017, with diagnoses including Dementia, Major Depressive Disorder, Arthritis, and Schizoaffective Disorder.

Review of Resident #13's Monthly July 2021 Physician's Orders, revealed no documented evidence of fall intervention devices.

Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 05/10/2021, revealed the facility assessed Resident #13 as usually makes himself/herself understood and understands others. Additional review revealed the facility assessed the resident as having short and long term memory problems; and, moderately impaired cognitive skills for daily decision making. Continued review of the Assessment revealed the resident had no behaviors present and required extensive assistance of two (2) staff with bed mobility, transfers, and dressing; extensive assistance of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 689	Continued From page 268	F 689		

one (1) staff with personal hygiene; and total assistance of two (2) staff for toilet use. Per the Assessment, the resident did not ambulate, had impaired balance during transitions between surfaces, and could only stabilize with staff assistance. Further review revealed the resident had not fallen since the prior Assessment.

Review of Resident #13's CCP, revised on 10/02/2020, revealed the resident had a history of falls with injury and had multiple risk factors, such as impaired cognition and an actual fall on 10/02/2020. The goal was the resident would be free of serious injury from falls. Further review revealed interventions which included encourage the resident to wear glasses (07/14/2020); attempt to distract the resident with candy and/or snack (10/02/2020); have commonly used articles within easy reach (07/14/2020); keep call light within reach and answer timely (07/14/2020); winged mattress (07/29/2021); and high low bed (08/11/2021).

Review of Resident #13's Fall Risk Evaluation, dated 05/10/2021, revealed the facility assessed the resident to have a score of ten (10). Per the Evaluation, a total score of ten (10) or higher indicated the resident was at risk for falls and follow up was required.

A) Review of Resident #13's Fall Incident Report Form, dated 07/22/2021, signed by Licensed Practical Nurse (LPN) #9, revealed on 07/22/2021 at 5:22 PM, the resident had a fall occurrence in his/her room, falling from the bed to the floor. The resident was sitting on the floor between the two (2) beds. Per the report, the resident had no injuries or pain. Continued review revealed the resident was unable to give a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 689	Continued From page 269	F 689		

description of the event. Further, the immediate action taken was the resident was assisted back to bed.

Review of Resident #13's Fall Risk Evaluation, dated 07/22/2021, revealed the facility assessed the resident to have a score of twelve (12), indicating the resident was at risk for falls and follow up was required.

The State Survey Agency (SSA) Surveyor, on 08/15/2021 at 3:22 PM, attempted to contact LPN #9 related to the Fall Incident on 07/22/2021. LPN #9 was not available, and a message was left to return the call.

Review of Resident #13's Fall Investigation Summary, dated 07/26/2021 (four (4) days after the fall event), signed by the Quality Indicator (QI) Nurse, revealed, on 07/22/2021, the resident was noted sitting on the floor on his/her buttocks. Additionally, the actions taken during the investigation included a head to toe assessment for injuries, which revealed no injury or pain. Per the Summary, the resident's bed was changed to a high/low bed, and the resident was assisted by two (2) staff back to bed. Further, the root cause was related to safety awareness secondary to Dementia. Continued review revealed the resident moved in bed often and preferred to lie on the right edge which consequently caused the fall out of the bed.

However, the CCP was not revised to include the high/low bed, until 08/11/2021, twenty (20) days after the fall occurrence, on 07/22/2021 at 5:22 PM.

B) Review of Resident #13's Fall Incident Report

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 689	Continued From page 270	F 689		

Form, dated 07/23/2021, signed by LPN #16, revealed, on 07/23/2021 at 5:15 AM, the resident had a fall occurrence in his/her room, falling from the bed to the floor. The resident was sitting on the floor between the two (2) beds with the bed blanket and sheet. Per the report, the resident was soiled with a bowel movement and his/her buttocks were red; however, incontinence care had been provided at 3:00 AM. Continued review revealed the resident was unable to give a description of the event, and the resident had no injury. Continued review revealed there was no further immediate action taken.

Review of Resident #13's Fall Risk Evaluation, dated 07/23/2021, revealed the facility assessed the resident to have a score of fifteen (15), indicating the resident was at risk for falls and follow up was required.

The State Survey Agency (SSA) Surveyor, on 08/15/2021 at 3:25 PM, attempted to contact LPN #16 related to the Fall Incident on 07/23/2021. LPN #16 was not available, and a message was left to return the call.

Review of Resident #13's Fall Investigation Summary, dated 07/27/2021 (four (4) days after the fall event), signed by the Quality Indicator Nurse, revealed on 07/23/2021, the resident was noted sitting his/her buttocks wrapped in the bed blanket and sheet on the floor. Additionally, the actions taken during the investigation included a head to toe assessment for injuries, which revealed no injury. Per the Summary, staff provided the resident perineal care and he/she was assisted by two (2) staff back to bed; a winged mattress was placed on the bed to prevent further falls from the bed. Further, the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 689	Continued From page 271	F 689		

root cause was related to safety awareness secondary to Dementia. Continued review revealed the resident was incontinent and was not able to tell staff. However, he/she would attempt to go to the bathroom, even though he/she was unable to ambulate, which consequently caused the fall out of the bed.

However, the CCP was not revised to include a winged mattress, until 07/29/2021, six (6) days after the fall occurrence, on 07/23/2021 at 5:15 AM.

C) Review of Resident #13's Fall Incident Report Form, dated 07/24/2021, signed by LPN #3, revealed, on 07/24/2021 at 5:40 PM, the resident had a fall occurrence in his/her room from the Evolution chair (mobility and positioning device) to the floor. The resident was sitting on the floor, the lights were off, and his/her back was resting against the dresser; the Evolution chair was to the resident's right side. Per the report, the resident had no injuries or pain. Continued review revealed the resident was unable to give a description of the event related to his/her cognitive status. Further, the immediate action taken was the resident was assisted by two (2) staff, back to his/her Evolution chair, and dycem was placed on the seat to prevent the resident from sliding out of the chair.

Review of Resident #13's Fall Risk Evaluation, dated 07/24/2021 revealed the facility assessed the resident to have a score of thirteen (13), indicating the resident was at risk for falls and follow up was required.

Review of Resident #13's Fall Investigation Summary, dated 07/28/2021 (four (4) days after

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 689	Continued From page 272	F 689		

the fall event), signed by the Quality Indicator Nurse, revealed, on 07/24/2021, the resident was noted sitting on the floor on his/her buttocks with his/her back resting against the dresser. Additionally, the actions taken during the investigation included a head to toe assessment for injuries, which revealed no injury. Per the Summary, dycem was placed in the chair, and the resident was assisted by two (2) staff back to the Evolution chair. Further, the root cause was related to safety awareness secondary to Dementia. Continued review revealed the resident believed he/she could still ambulate independently but was unsteady, weak, and unable to do so. The resident attempted to get out of the Evolution chair and go to the bathroom alone, which consequently caused the fall out of the chair.

However, there was no documented evidence the CCP was revised to include dycem to the chair after the fall occurrence, on 07/24/2021 at 5:40 PM.

Interview with LPN #3, on 08/15/2021 at 3:15 PM, revealed, after a fall event, it was the nurse's responsibility to implement an intervention immediately to decrease the risk of another fall of the same nature. Additionally, the CCP should be revised to include the immediate intervention to ensure continuity of care. Further, Resident #13 should have had dycem consistently placed on his/her Evolution chair seat after the 07/24/2021 fall event. Per the interview, she forgot to revise the CCP to include dycem after the fall.

Observations of Resident #13, on 08/09/2021 at 4:11 PM; 08/10/2021 at 9:35 AM; and 08/12/2021 at 3:06 PM, revealed there was no dycem in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 689	Continued From page 273	F 689		

Evolution chair seat, which was the immediate intervention status post fall, on 07/24/2021 at 5:40 AM.

Interview with Registered Nurse (RN) #6, on 08/12/2021 at 3:06 PM, revealed Resident #13, required total assistance with Activities of Daily Living (ADL). RN #6 stated Resident #13 had poor safety awareness, was a risk for falls, and had a history of falling from the bed. Additionally, it was the nurses' responsibility to implement immediate fall interventions after a fall event and to ensure the CCP was revised to include the intervention, for safety. Per the interview, she stated devices such as dycem did not require a Physician's Order; however, they should be care planned as fall preventions. She stated she was not aware the fall investigation for Resident #13, dated 07/24/2021 at 5:40 PM, identified the Root Cause was the resident attempted to self-transfer and slid out of the Evolution chair and noted dycem would be added to the seat to prevent the resident from sliding out. RN #6 stated direct care staff needed to know interventions were accurately listed on the CCP to ensure safe quality care.

Interview with State Registered Nurse Aide (SRNA) #19, on 08/12/2021 at 3:45 PM, revealed she was often assigned to provide care to Resident #13. Per the interview, she stated she always reviewed Resident #13's Kardex (CCP) before providing care and was aware the resident required the assistance of two (2) staff for mobility and was a fall's risk. She stated she was aware Resident #13 had poor safety awareness and had a history of falling from the bed and his/her Evolution chair. SRNA #19 stated it was the responsibility of the staff to ensure residents were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 689	Continued From page 274	F 689		

provided a safe environment to keep the resident safe and to meet their needs. Further, she stated she was not aware the resident required dycem to the chair seat to prevent him/her from sliding out of the chair.

3. Review of Resident #22's medical record revealed the facility admitted the resident, on 04/17/2019, with diagnoses that included Dementia, Anxiety Disorder, Atrial Fibrillation, Sick Sinus Syndrome, Pseudobulbar Affect, Overactive Bladder, and Hypertension.

Review of Resident #22's Monthly March 2021 Physician's Orders, revealed no documented evidence of fall intervention devices.

Review of the Significant Change MDS Assessment, dated 02/22/2021, revealed the facility assessed Resident #22 as having short and long term memory problems and severely impaired cognitive skills for daily decision making. Continued review of the Assessment revealed the resident required extensive assistance of two (2) staff with bed mobility and transfers; extensive assistance of one (1) staff with eating; and total assistance of two (2) staff for personal hygiene, dressing and toilet use. Per the Assessment, the resident did not ambulate. Further review revealed the resident had two (2) non-injury falls and one (1) fall with injury since the prior Assessment.

Review of Resident #22's CCP, revised on 03/17/2021, revealed the resident had a history of falls and actual falls (03/04/2021) and had multiple risk factors such as Dementia, altered perception of awareness/surroundings, and cardiovascular medications. The resident had a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 689	Continued From page 275	F 689		

tendency to sit himself/herself down on the floor when tired and lie back. The goal was the resident would be free of serious injury from falls. Further review revealed interventions which included encourage the resident to take rest periods as needed when ambulating (11/28/2020); lay the resident down after meals for rest periods (11/09/2020); commonly used articles within easy reach (04/18/2019); take the resident to the nurse's station for close observation (11/30/2020); and allow the resident to ambulate as desired, use wheelchair for long distance, dycem to wheelchair (dated 03/17/2021).

Review of Resident #22's Fall Risk Evaluation, dated 03/04/2021, revealed the facility assessed the resident to have a score of nine (9). Per the Evaluation, a total score of ten (10) or higher indicated the resident was at risk for falls and follow up was required.

Review of Resident #22's Fall Incident Report Form, dated 03/04/2021, signed by LPN #3, revealed, on 03/04/2021 at 4:30 PM, the resident had a fall occurrence in his/her room from the wheelchair to the floor. Per the report, the resident's roommate witnessed the fall event and stated Resident #22 was attempting to stand from the wheelchair and sat on the floor. Continued review revealed the resident had no injuries or pain. Continued review revealed the resident was unable to give a description of the event. Further, the immediate action taken was the resident was assisted by two (2) staff back to the wheelchair, and dycem was placed on the wheelchair.

Review of Resident #22's Electronic Medical Record (EMR) revealed no evidence of a Fall

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 689	Continued From page 276	F 689		

Risk Evaluation on 03/04/2021. However, review of the facility's policy, "Fall Protocol" revealed residents with falls, who were not identified as a fall risk would be assessed for fall risk.

Additional review of Resident #22's Fall Risk Evaluation, dated 05/24/2021, eighty-two (82) days after the fall on 03/04/2021, revealed the facility assessed the resident to have a score of eleven (11), indicating the resident was at risk for falls and follow up was required.

Continued interview with LPN #3, on 08/15/2021 at 3:15 PM, revealed after a fall event, it was the nurse's responsibility to evaluate the fall risk of residents who were not previously at risk for falls. Further, Resident #22 should have had a Fall Risk Evaluation completed after his/her fall, on 03/04/2021. LPN #3 stated Resident #2's CCP should have been revised to include the use of dycem on the wheelchair seat. Per the interview, she did not recall why she failed to complete the evaluation or revise the CCP to include dycem after the fall.

Review of Resident #22's Fall Investigation Summary, dated 03/16/2021 (twelve (12) days after the fall event), signed by the QI Nurse, revealed, on 03/04/2021, the resident was noted sitting on the floor on his/her buttocks at the end of the bed; the resident's wheelchair was behind him/her. Additionally, the actions taken during the investigation included a head to toe assessment for injuries. Per the Summary, the resident was assisted back into the wheelchair by two (2) staff, and dycem was added to the wheelchair. Further, the root cause was related to safety awareness secondary to Dementia. Continued review revealed the resident had generalized

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 689	Continued From page 277	F 689		

weakness and impaired balance, which consequently caused the fall.

However, the CCP was not revised to include dycem to the wheelchair, until 03/17/2021, thirteen (13) days after the fall occurrence, on 03/04/2021 at 4:30 PM.

4. Review of Resident #80's medical record revealed the facility admitted the resident, on 11/28/2019, with diagnoses including Type II Diabetes Mellitus, Osteoarthritis, General Anxiety Disorder, Morbid Obesity, Major Depressive Disorder, Hypertension, Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, and Chondrocalcinosis of the Right Knee and Hip.

Review of Resident #80's Monthly June 2021 Physician's Orders, revealed no documented evidence of fall intervention devices.

Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 04/21/2021, revealed the facility assessed Resident #80 as having a Brief Interview for Mental Status (BIMS) score of ten (10) of fifteen (15), indicating moderately impaired cognition. Continued review of the Assessment revealed the resident required extensive assistance of two (2) staff with bed mobility, transfers, and dressing; extensive assistance of one (1) staff with personal hygiene; and total assistance of two (2) staff for toilet use. Per the Assessment, the resident did not ambulate, had impaired balance during transitions between surfaces, and could only stabilize with staff assistance. Further review revealed the resident had not fallen since the prior Assessment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 689	Continued From page 278	F 689		

Review of Resident #80's CCP, revised on 06/24/2021 revealed the resident had a history of falls and had multiple risk factors such as Depression, medication (antidepressant, cardiovascular, and a diuretic), and an actual fall. The goal was the resident would be free of serious injury from falls. Further review revealed interventions which included anti roll back on the wheelchair, wheelchair properly fit for resident (02/02/2021); encourage resident to wear non-skid footwear (06/08/2021); commonly used articles within easy reach (08/26/2020); and give the resident a glass of ice chips between meals and at bed time (07/15/2021).

Review of Resident #80's Fall Risk Evaluation, dated 06/08/2021, revealed the facility assessed the resident to have a score of fourteen (14). Per the Evaluation, a total score of ten (10) or higher indicated the resident was at risk for falls and follow up was required.

Review of Resident #80's Fall Incident Report Form, dated 06/29/2021, signed by the QI Nurse, revealed, on 06/29/2021 at 2:00 PM, the resident had a fall occurrence in his/her room. The resident was lying on his/her right side in the floor with regular socks on. Per the report, the resident suffered skin tears to bilateral elbows and his/her right knee. Continued review revealed the resident stated he/she was trying to get some water, lost his/her balance, spilled the water, took a step and fell. Further, the immediate action taken was the resident was provided first aid and assisted by two (2) staff into a wheelchair.

Review of Resident #80's Fall Risk Evaluation, dated 07/01/2021, two (2) days after the fall on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 689	Continued From page 279	F 689		

06/29/2021, revealed the facility assessed the resident to have a score of sixteen (16), indicating the resident was at risk for falls and follow up was required.

Review of Resident #80's Fall Investigation Summary, dated 07/12/2021 (thirteen (13) days after the fall event), signed by the QI Nurse, revealed, on 06/29/2021, the resident was noted lying in the floor on his/her right side. Additionally, the actions taken during the investigation included a head to toe assessment for injuries, which revealed skin tears to bilateral elbows and the right knee. Per the Summary, the resident's skin tears were cleaned and treatment was applied; then, the resident was assisted to his/her wheelchair. Further, the root cause was related to safety awareness secondary to Dementia. Continued review revealed the resident was on fluid restrictions and was attempting to get water from the sink, spilled the water in the floor, and slipped which consequently caused the fall. It was determined that staff would give the resident a glass of ice chips between meals and at bedtime.

However, the CCP was not revised to include giving the resident a cup of ice between meals and at bedtime, until 07/15/2021, sixteen (16) days after the fall occurrence on 06/29/2021 at 2:00 PM.

Interview with the QI nurse, on 08/16/2021 at 2:45 PM, revealed Resident #13, Resident #22, and Resident #80's Fall Incident Reports should have noted immediate interventions and Fall Investigation Summaries should have been more timely. Continued interview revealed the CCP should have been revised more timely too. It was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 689	Continued From page 280	F 689		

important to ensure the Fall Protocol policy and facility practices were maintained to ensure residents were provided safe care and to reduce their risk for injury.

Interview with the DON, on 08/31/2021 at 2:31 PM, revealed Resident #13's CCP should have been revised more timely with interventions for the 07/22/2021, 07/23/2021, and 07/24/2021 fall events, and the Fall Investigation Summary(ies) for those falls should have been more timely. The DON stated Resident #22's Fall Risk Evaluation and CCP revisions should have been more timely for the 03/04/2021 fall event. The DON stated Resident #80's Fall Investigation Summary and CCP revision should have been more timely for the 06/29/2021 fall event.

5. Review of Resident #245's medical record revealed the facility admitted the resident, on 01/18/2021, with diagnoses including Parkinson's Disease, Major Depression, Dementia, and Diabetes Mellitus Type 2. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 02/26/2021, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) of four (4) out of fifteen (15),indicating severe cognitive impairment. Continued review revealed in Section G the resident was a one (1) person assist for bed mobility and self-transfers. The resident used mobility devices, a walker and wheelchair. Further review of section G revealed the resident was not steady for moving from seated to standing position, walking, turning around and surface-to-surface transfers between bed and wheelchair; however, the resident was able to stabilize without staff. Review of section J revealed the resident had not expressed pain

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 689	Continued From page 281	F 689		

during the quarterly review.

Review Resident #245's Comprehensive Care Plan, dated 01/18/2021, revealed the area of Focus for falls/Goals was revised on 03/28/2021 with a target date of 05/05/2021. The Focus area did not address the falls on 02/19/2021, 02/23/2021, 03/13/2021, and 03/19/2021; however, it listed a fall on 03/24/2021. Continued review ofthe Interventions, dated 01/18/2021, revealed no revision of interventions for falls which occurred on 02/19/2021 and 02/23/2021.

Review of Resident #245's pain assessments revealed no pain expressed by the resident on 01/18/2021, 02/24/2021, 02/25/2021, 03/14/2021, and 03/19/2021. However, review of the pain assessment on 03/25/2021, revealed pain was four (4) out of ten (10).

Review of Resident #245's Health Status Notes, dated 03/25/2021 at 11:27 PM, revealed Resident #245 reported increased pain to the left hip and femur. There was no appearance of swelling or bruising.

Review of Resident #245 fall risk evaluations (the higher the score, the higher the risk), dated 01/18/2021, with an admission score of fourteen (14); 02/19/2021, a score of seven (7); 02/24/2021, a score of sixteen (16); 03/14/2021, a score of twenty (20); and 03/19/2021, a score of twenty (20).

Review of Resident #245's Fall investigation, on 02/19/2021, revealed the intervention to take the resident to use the bathroom after supper. The intervention was not updated on the care plan, until 03/01/2021, after the report was completed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 689	Continued From page 282	F 689		

Review of Resident #245's Fall investigation, on 02/23/2021, revealed the intervention to place a sign to remind the residents it was a shared bathroom. The intervention was not updated on the care plan, until 03/11/2021, after the report was completed.

Review of Resident #245's Fall investigation, on 03/13/2021, revealed the intervention to make sure no pillows were in the wheelchair seat and that dycem was in place was not updated on the care plan, until 03/25/2021, after the report was completed.

Review of Resident #245's Fall investigation, on 03/19/2021, revealed an intervention to obtain orders from the physician for blood work to determine if there was an underlying cause of the falls, after the report was completed on 03/24/2021. However, review of the Physician's orders revealed there was no blood work ordered.

Review of the Resident #245's Fall investigation, dated 03/24/2021, revealed the resident had fallen and notified staff that he/she had gotten himself/herself back up. Continued review of the fall investigation showed the resident was assessed, but it was not until he/she complained of leg pain that an x-ray was obtained, and he/she was sent to the Emergency Department (ED) for evaluation.

Review of Resident #245's ED medical record, dated 03/26/2021, revealed Resident #245 was not a good historian and could not state if he/she had a fall. The facility reported there might have been a fall the day before. Continued review of the ED note revealed Resident #245 was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 689	Continued From page 283	F 689		

diagnosed with a Closed Displaced Intertrochanteric Fracture of the Left Femur.

Interview with Licensed Practical Nurse (LPN) #7, on 08/14/2021 at 10:37 AM, revealed Resident #245 had experienced prior falls and had not expressed any prior pain with these falls.

Interview with LPN #12, North Unit, on 08/16/2021 at 7:05 AM, revealed Resident #245 did not remember falling, did not report fall to staff, and only expressed pain on 03/25/2021. She stated, after the resident expressed pain, he/she was assessed for pain, and the physician was called and ordered a Mobile x-ray. She stated Resident #245 received Tylenol (non-narcotic pain reliever) to relieve his/her pain until the results of the x-ray showed a fracture in the left leg. She stated the resident was sent out immediately to the ED. She stated Resident #245 had been able to put himself/herself to bed, get up by himself/herself, and ambulate short distances. She stated the resident had experienced prior falls, was assessed, and did not express any pain after each fall. She further revealed she did not always remember to update the care plan after every fall.

Interview with the QI nurse, on 08/16/2021 at 2:45 PM, revealed direct care nurses were responsible to determine the root cause of fall events and to implement an immediate intervention based on the root cause of the fall to ensure residents received the best care and their individual care needs were met. Additionally, she stated when a resident had a fall event, the direct care nurses were also responsible to change the CCP with the immediate intervention. Per the interview, during the Monday through Friday Morning Clinical

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 689	Continued From page 284	F 689		

Meeting, participants (DON, Unit Managers, QI Nurse, Activities, Therapy, Minimum Data Set (MDS) Nurse) reviewed Fall incident reports and ensured the documentation was thorough and that the CCP was revised to include the most appropriate intervention. Further, after each fall event, she stated the CCP should be revised to include an intervention to assist the resident with reducing the risk of further falls and injury. The QI Nurse stated she then was responsible to type up the Fall Investigation Summary with the Interdisciplinary Team (IDT) discussion. She stated the facility's practice was for the Fall Investigation Summary to be completed within three (3) days of the fall event, to ensure a timely investigation and actions. The QI Nurse stated when she was out of the facility she did not have a backup staff member who was responsible for her job duties and that was the reason the fall follow-up was not completed timely.

Interview with the LPN #13/MDS Coordinator and RN #7/MDS Coordinator, on 08/13/2021 at 2:51 PM, revealed Monday through Friday they met with the daily Clinical Morning Meeting and reviewed fall events. Additionally, she stated, during the meeting, the IDT would ensure the CCP was accurate to meet the resident's needs based on the fall documentation and meeting discussions. Further interview revealed there should be new interventions developed with each fall event. However, she stated she had not identified there was a failure to ensure falls were care planned with appropriate interventions timely. However, she stated all nurses were responsible to revise the CCP as necessary.

Interview with the DON, on 08/31/2021 at 2:31 PM, revealed after a resident fall event, the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 689	Continued From page 285	F 689		

assigned direct care nurse was responsible to complete a Progress Note, Fall Risk Evaluation, and a Fall Incident Report to include determining the root cause of the fall and implementing a corrective action intervention immediately. Per the interview, the assigned nurse revised the CCP at that time of the fall with the intervention. Additionally, she stated falls from the previous day were investigated during the Monday through Friday Clinical Morning Meeting, of which she was a participant, to ensure action was taken status post falls and interventions were put into place to reduce the risk for future occurrence of falls of the same nature.

Continued interview with the DON, on 08/31/2021 at 2:31 PM, revealed the CCP was revised with an appropriate intervention during the Morning Clinical Meeting after the fall event was reviewed by the IDT. Further, the Clinical Meeting IDT reviewed the Fall Incident Reports, Progress Notes, and Fall Risk Evaluations, to ensure appropriate interventions had been put into place timely to reduce the risk of resident falls/accidents and that care plans had been updated to reflect the intervention. Per the interview, the DON stated the QI Nurse summarized the IDT's fall discussion on a Fall Investigation Summary within three (3) days of the fall events.

Interview with the Administrator, on 08/16/2021 at 3:30 PM, revealed he had worked at the facility since July 27, 2021. Per the interview, he expected the facility's policy and fall process to be maintained through the investigation of each fall event, during the Monday through Friday Morning Clinical Meeting. Additionally, he stated, the DON was responsible to review fall event

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 689	Continued From page 286 documentation and ensure there were appropriate interventions implemented timely to reduce the risk for falls, that Fall Risk Evaluations were completely timely, and that the CCP was updated timely. Further interview revealed the audit process of review in Morning Clinical Meetings should have identified the noncompliance.	F 689		
F 755 SS=K	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and	F 755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 755	Continued From page 287	F 755		

§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

This REQUIREMENT is not met as evidenced by:
Based on interview, record review, and review of the facility's policy, it was determined the facility failed to ensure an effective system was in place to obtain pharmaceutical services to meet the needs of each resident. The facility failed to maintain a system to ensure controlled medications received from the pharmacy were accounted for; with only one (1) nurse required to sign for incoming controlled substances. In addition, the facility failed to have an effective system in place for reconciliation of each controlled narcotic medication, and there was no documented evidence that causes of the discrepancies were thoroughly investigated. These failures affected sixteen (16) of forty-four (44) sampled residents: Resident #1, #8, #9, #17, #32, #34, #47, #48, #56, #60, #65, #69, #71, #79, #82, and #84.

1. Prior to 07/09/2021, three (3) residents (Resident #9, #69, and #82) had indicated to staff, verbally and written, that Licensed Practical Nurse (LPN #1) had either signed out their requested narcotic pain medication and not given it to them, or she had signed out their narcotic pain medication, which the residents had not requested, and not given it to them.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 755	Continued From page 288	F 755		

2. On 07/09/2021, a pharmacy audit determined a skid of thirty (30) tablets of Percocet (Scheduled II narcotic pain reliever) was missing for Resident #17. Licensed Practical Nurse (LPN) #2 signed the pharmacy packing slip without another licensed staff to witness, for the three (3) skids of thirty (30) tablets of Percocet each, on 06/28/2021. However, LPN #1 stated she only received two (2) skids of thirty (30) tablets of Percocet each.

3. On 07/18/2021, LPN #1 was found by Police to have in her possession controlled medications that included Oxycodone (Scheduled II narcotic), Tramadol (opiate narcotic analgesic), Hydrocodone (Scheduled II narcotic), and Gabapentin (Scheduled III anticonvulsant). Additionally, LPN #1 was found to have Primidone (non-controlled anticonvulsive) on her person, which she admitted she used to replace Resident #32's and Resident #84's controlled narcotic medications, which she had misappropriated.

Ten (10) additional residents had a total of fourteen (14) controlled medications missing and not signed out properly, on 07/18/2021, some of which were the same type of medications found on LPN #1 by the Police: Resident #71, #8, #56, #1, #79, #47, #34, #60, #48, and #65.

Additionally, staff did not adhere to proper disposal of controlled medications. Only one (1) licensed staff was documented to witness disposal, which also led to opportunities for misappropriation of controlled medications.

4. On 07/20/2021, the Director of Nursing (DON)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 755	Continued From page 289	F 755		

determined, in an audit, the Shift Change Count Sheet signed by LPN #2 had one (1) less in the count of narcotic skids from the previous Shift Change Count Sheet. The facility determined Resident #9 had a missing skid of Percocet, and LPN #2 was suspended.

Immediate action was necessary to ensure residents' controlled medications were available to the residents per the Physician's Orders. The facility's failure to take immediate action has caused or is likely to cause serious injury, serious harm or death to other residents in the facility. Immediate Jeopardy (IJ) was identified on 08/20/2021, and was determined to exist on 07/09/2021, in the area of 42 CFR 483.45 Pharmacy Services, F-755, Pharmacy Services/Procedures/Pharmacist Records at a Scope and Severity (S/S) of a "K." The facility was notified of the IJ on 08/20/2021.

The facility provided an acceptable Immediate Jeopardy Removal Plan, on 09/01/2021, alleging removal of the IJ on 08/31/2021. The State Survey Agency determined the IJ had been removed on 08/31/2021, as alleged, prior to exit on 09/02/2021, with remaining non-compliance at a S/S of a "E" while the facility develops and implements a Plan of Correction and the facility's Quality Assurance (QA) monitors to ensure compliance with systemic changes.

The findings include:

Review of the facility's policy titled, "Controlled Substances," dated 09/2020, revealed Controlled Substance Count Sheets should include an entry for each dose administered, including date and time administered, quantity administered,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 755	Continued From page 290	F 755		

signature of the administering nurse, and an entry if the medication was destroyed, with the completed record forwarded to the DON. The policy stated records should be reconciled each shift by two (2) staff members authorized to administer medications, with staff signing their names on the Shift Change Controlled Substance Count Check Form, with any discrepancies reported to the responsible supervisor and any non-justified discrepancies reported to the DON. The policy stated any discrepancies reported to the responsible supervisor should be investigated to determine the cause, with any explanation reported to the DON, by filing a Medication Error Report. If a reason for the discrepancy could not be found, this must also be reported on the Medication Error Report. Per the policy, should the discrepancy involve more than one (1) dose of a controlled substance, the DON shall notify the Consultant Pharmacist immediately, who in turn shall notify the Kentucky Drug Control Unit and other State or Federal agencies if deemed necessary. Furthermore, the policy stated disposal of controlled substances should always be performed by a licensed nurse, witnessed by a second licensed nurse, and should be disposed of in a pharmaceutical waste device, such as a Drug Buster. The declining inventory sheet must indicate the date, time, and quantity of medication destroyed, and the method of destruction, signed by the nurse destroying and the nurse witnessing.

1. A) Review of Resident #9's medical record revealed the resident was readmitted by the facility, on 05/03/2021, with diagnoses to include Paraplegia Unspecified, Nicotine Dependence Unspecified Uncomplicated, Other Specified Anxiety Disorders, and Other Chronic Pain. The facility assessed Resident #9, in an Admission

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 755	Continued From page 291	F 755		

MDS Assessment Brief Interview for Mental Status (BIMS) as a fifteen (15) of fifteen (15), indicating no cognitive impairment. Continued review of Resident #9's medical record revealed 05/05/2021 a physician order for Klonopin 1 milligram (mg) twice a day as needed; 05/05/2021 a physician order for Neurontin (Gabapentin) 600 mg four times a day; and 05/27/2021 a physician order for Percocet 7.5/325 mg every eight (8) hours as needed. Resident #9's physician order for Klonopin was changed, on 07/08/2021, to 1 mg twice a day, and his/her physician order for Percocet 7.5/325 mg was changed, on 07/12/2021, to twice a day.

Interview with Resident #9, on 07/28/2021 at 3:01 PM, revealed one morning he/she had asked for pain medications, and staff informed him/her they could not provide the pain medication because they had been administered at 2:30 AM. Resident #9 shared he/she had not received pain medications at 2:30 AM, and LPN #1 had been working the night the medications were allegedly administered. Resident #9 stated he/she consistently had pain medications signed out and not given to him/her when LPN #1 worked. Resident #9 stated he/she had reported this to staff.

Review of Resident #9's Controlled Substance Count Record for Percocet 7.5/325 mg, initiated on 06/29/2021, revealed two (2) doses were signed by LPN #1 during her 07/05/2021, 7:00 PM to 07/06/2021, 7:00 AM shift on the North Unit. One (1) dose was documented as administered, on 07/05/2021 at 7:30 PM, a second dose was documented as administered, on 07/06/2021 at 2:30 AM. Although LPN #1 signed on the MAR for one (1) dose, she did not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 755	Continued From page 292	F 755		

sign for a second dose, and there was no indication on the back of the MAR these doses were given, for what purpose, or whether or not the doses were effective. Continued review revealed Resident #9 would normally receive a dose of Percocet 7.5/325 mg between 8:00 AM and 9:00 AM each morning.

Interview with LPN #12, on 08/13/2021 at 8:21 AM, revealed Resident #9 took his/her medication, would ask for it, knew what it looked like, and knew what pills he/she took. She revealed several staff members , including RN #1 and LPN #2, told her they had reported Resident #9 not receiving his/her medications in June 2021 to the Administrator, although she was not aware of the Administrator doing anything with that information.

Interview with LPN #5, on 08/03/2021 at 4:20 PM, revealed, on 07/06/2021, Resident #9 had indicated to her that he/she was not receiving his/her medications. She stated Resident #9 wanted his/her pain pill and Klonopin, but she was unable to give it because they had been given on the previous shift. She revealed she alerted the DON, at that time, via text message of Resident #9's allegation. LPN #9 stated Resident #9 was not in any pain that morning, but his/her routine was to receive his/her PRN pain medication in the morning.

Review of the Facility Concern/Grievance Form, dated 07/08/2021, initiated by Resident #9, revealed the resident complained about not getting pain pills on the night shift from one (1) or two (2) weeks ago, not sure of the date, and did not want LPN #1 taking care of him/her. The previous Administrator was listed as the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 755	Continued From page 293	F 755		

employee receiving and responding to the grievance, with the action taken to include interviewing Resident #9, interviewing nurses (did not indicate which nurses or what information was gathered), reviewing MAR's, removing the nurse, and an ongoing investigation with the facility and law enforcement. The form was signed as resolved by the previous Administrator on 07/09/2021.

Interview with Patient Care Assistant (PCA) #3, on 08/03/2021 at 3:02 PM, revealed she responded to Resident #9's call light, on 07/08/2021, and pushed Resident #9 to the nurse's station per his/her request. She revealed Resident #9 "went off " on LPN #1, calling her names and saying that she stole Resident #9's pills.

B) Review of Resident #69's medical record revealed the resident was admitted to the facility, on 07/03/2020 with diagnoses to include Chronic Obstructive Pulmonary Disease Unspecified, Type II Diabetes Mellitus with Diabetic Neuropathy Unspecified, Other Specified Anxiety Disorders, and Unspecified Osteoarthritis Unspecified Site. The facility assessed Resident #69, in an Annual MDS Assessment, dated 07/09/2021, as a ten (10) of fifteen (15) on the BIMS, indicating moderately impaired cognition. Continued review revealed a physician order for Tramadol 50 mg twice a day as needed, dated 01/05/2021, a physician order for Xanax 0 .5 mg at bedtime, dated 04/20/2021, and a physician order for Gabapentin 400 mg twice a day, dated 04/17/2021.

Interview with Resident #69, on 07/30/2021 at 3:14 PM, revealed the resident had times when

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 755	Continued From page 294	F 755		

he/she was not given his/her prescribed medications by LPN #1. Resident #69 stated he/she knew what medications he/she took, and one (1) time he/she was given a cup of pills which did not include his/her PRN pain medication or his/her Xanax. Resident #69 stated he/she informed LPN #1, who acted like she had forgotten them on the cart, and retrieved them for him/her.

Review of Resident #69's MAR for 06/2021, revealed the resident was administered Tramadol 50 mg a total of four (4) times during that month, twice by LPN #1. This was not documented on the back of the MAR, but was documented on the Controlled Substance Count Record, initiated on 06/06/2021. Review of Resident #69's Controlled Substance Count Record, initiated 05/08/2021 for Tramadol 50 mg twice a day PRN, revealed the resident was frequently administered Tramadol at 8:00 PM, as signed by LPN #1 and LPN #2.

Interview with RN #2, on 08/03/2021 at 3:33 PM, revealed she remembered filling out a grievance form regarding Resident #69 where the resident had reported not getting his/her medications when LPN #1 was working and stated it had happened more than once. She stated as she was turning in the grievance form, other staff was telling her, if Resident #69 had received the documented medications, he/she would have been "snowed in" which she defined as very tired in the morning and kind of loopy, which Resident #69 had not been. RN #2 stated when Resident #69 had not had his/her pain medications, he/she was clear minded and very alert. She stated Resident #69 knew if he/she had received his/her medications.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 755	Continued From page 295	F 755		

Review of the Facility Concern/Grievance Form, dated 06/26/2021, initiated by Resident #69, revealed the resident did not receive his/her medication until 10:30 PM on 06/25/2021 and did not receive his/her 6:00 AM medication on 06/26/2021, nor did he/she receive his/her finger stick or insulin. LPN #5 was the staff member receiving the grievance. The investigation was referred to the SDC/QI, who spoke with nurses and handed out education to all nursing staff. The grievance was documented as resolved on 06/30/2021.

C) Review of Resident #82's medical record revealed the resident was admitted by the facility, on 11/24/2019 with diagnoses to include Chronic Obstructive Pulmonary Disease, Peripheral Vascular Disease Unspecified, Acquired Absence of Left Leg below Knee, and Primary Osteoarthritis Unspecified Hand. The facility assessed the resident, in a Quarterly Minimum Data Set (MDS) Assessment, dated 07/26/2021, as scoring a thirteen (13) of fifteen (15) on the Brief Interview for Mental Status (BIMS), indicating intact cognition. Continued review of the resident's medical record revealed a Physician's Order for Hydrocodone 5/325 (a Schedule II narcotic pain reliever) milligrams (mg) every four (4) hours PRN, on 04/29/2021.

Interview with Registered Nurse (RN) #1, on 08/02/2021 at 3:52 PM, revealed she had reported to the Administrator, on 06/21/2021, a concern over narcotics. She revealed she had asked Resident #82 how he/she was doing, and the resident told her that he/she was doing well but a couple of nurses thought the resident was dying because he/she had received a lot of narcotics over the weekend. Further, RN #1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 755	Continued From page 296	F 755		

stated Resident #82 told her that he/she had not actually received the narcotics because, he/she had not needed any. RN #1 stated she examined Resident #82's narcotic sheet and discovered LPN #1 had signed out for one (1) Hydrocodone 5/325 mg on 06/19/2021, two (2) Hydrocodone 5/325 mg on 06/20/2021, and one (1) Hydrocodone 5/325 mg on 06/21/2021, which Resident #82 stated he/she had not received. She stated she showed the Administrator the MAR, and the Administrator stated this was "becoming a problem" and that Resident #9 had already "called the state on us." RN #1 stated the Administrator met with Resident #82 for about twenty (20) minutes, after which Resident #82 stated the Administrator told him/her she would get to the bottom of it, but as he/she had heard that before, he/she knew they "weren't going to do crap" about it. RN #1 stated Resident #82 usually took three (3) or four (4) Hydrocodone 5/325 mg a month for breakthrough pain.

Review of Resident #82's Medication Administration Record (MAR) for June 2021 revealed, on 06/19/2021, one (1) dose of Hydrocodone 5/325 mg was administered, followed by two (2) doses on 06/20/2021, and a fourth dose on 06/21/2021, all administered by LPN #1. Prior to that, Resident #82 had received a total of five (5) doses during the preceding three (3) weeks, with only two (2) doses on consecutive days. These four (4) doses were not signed out on the back of the MAR. Review of Resident #82's 07/2021 MAR revealed five (5) doses administered of Hydrocodone 5/325 mg, four (4) of which were on consecutive days. Further review revealed Hydrocodone 5/325 mg was administered, on 07/06/2021 and 07/13/2021, with no documentation on the back of the MAR

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 755	Continued From page 297	F 755		

indicating it was administered or the results.

Review of a Facility Concern/Grievance Form, dated 06/25/2021, initiated by Resident #82, with RN #1 receiving the grievance, revealed a concern that the resident was asked if he/she was having increased pain because the MAR showed he/she had taken several pain pills, but the resident stated he/she was not aware or did not remember taking any. The investigation was referred to the previous Administrator, whose findings were Resident #82 was uncertain whether or not he/she received pain pills. Therefore, the action taken was the resident would only be given pain pills when he/she requested them, and he/she would be watched more carefully. The Grievance form was signed by the Administrator as resolved on 06/25/2021.

Interview with LPN #7, on 08/05/2021 at 9:09 AM, revealed she recognized Resident #82 was receiving more narcotics on the nights that LPN #1 worked, and it was unexpected for him/her to have had so many administered. LPN #7 revealed when she interviewed Resident #82, he/she denied having pain or requiring pain medications at the times documented, and she informed the Staff Development Coordinator/Quality Improvement Nurse (SDC/QI) of her suspicions. She stated this did not seem to be a big concern until a skid of thirty (30) tablets of Percocet came up missing on 07/09/2021.

Interview with the SDC/QI, on 08/05/2021 at 12:22 PM, revealed she was uncertain of the date when Resident #82 first identified an issue, although she thought it was early to mid-July. She stated no one reported anything directly to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 755	Continued From page 298	F 755		

her about Resident #82, although there had been a grievance regarding the resident believing he/she was not getting pain medications that had been signed out during the night. She stated if someone had reported anything to her, she would have reported it to the Director of Nursing (DON). She stated if a nurse had a suspicion of drug diversion, the nurse should contact the DON immediately and initiate a grievance form. The SDC/QI said she would expect staff to follow the chain of command in reporting concerns, which would be nursing staff, herself, and the DON.

Interview with the DON, on 08/04/2021 at 8:28 AM, revealed the Administrator approached her after the grievance by Resident #82 and stated Resident #82 might not have received his/her medication. She stated the Administrator told her LPN #1 needed to be watched. The DON stated, in her review of the MAR's, she was unable to identify LPN #1 was signing out more PRN medications than other night shift staff.

2. Interview with the Facility Consultant, on 07/27/2021 at 1:15 PM and again on 08/18/2021 at 2:32 PM, revealed she had been brought in from corporate as a result of facility issues that needed to be addressed. She revealed there had been an audit, on 07/09/2021 by pharmacy which showed there was a missing skid of Percocet 5/325 mg belonging to Resident #17. She stated the investigation revealed three (3) skids of thirty (30) tablets each had been delivered by pharmacy, on 06/28/2021, as documented by LPN #2. But, she stated LPN #1 reported, in an interview, she had received only two (2) skids of thirty (30) tablets each of Percocet. She stated corporate realized there was a concern, as only one (1) nurse was signing for incoming controlled

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 755	Continued From page 299	F 755		

medications, and although she was uncertain what the policy stated, she revealed best practice would have been to have two (2) nurse signatures.

Interview with the Consultant Pharmacist, on 08/13/2021 at 10:31 AM, revealed any time she noted a concern or anything that raised her attention, she included it in her pharmacy report. She revealed on 07/09/2021, she noted a skid of Percocet missing and provided that information to the facility administration in her report.

Review of a Packing Slip, dated 06/28/2021, revealed LPN #2 signed for three (3) skids of thirty (30) tablets each of Percocet 5/325 mg, for a total of ninety (90) tablets of Percocet 5/325 mg for Resident #17.

Interview with LPN #2, on 07/29/2021 at 4:29 PM, revealed, on the night of 06/28/2021, LPN #1 had approached her repeatedly asking to be informed when the pharmacy came in, as LPN #2 was working on the South Unit, and the South Unit nurse was responsible for signing for deliveries from the pharmacy. LPN #2 stated she signed for three (3) skids of thirty (30) Percocet 5/325 mg each for Resident #17, on the night of 06/28/2021. However, LPN #2 stated she was informed, after the discovery of a missing skid, on 07/09/2021, LPN #1 alleged only receiving two (2) skids.

Review of Resident #17's medical record revealed the resident was admitted by the facility, on 03/27/2020, with diagnoses to include Hemiplegia and Hemiparesis following Cerebral Infarction Affecting Left Non-Dominant Side, Anxiety Disorder Unspecified, and Unspecified

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 755	Continued From page 300	F 755		

Dementia without Behavioral Disturbance. The facility assessed Resident #17, in a Quarterly MDS Assessment, dated 05/17/2021, as a three (3) of fifteen (15) on the BIMS, indicating severe cognitive impairment. Continued review revealed 01/18/2021 physician's order for Percocet 5/325 mg every eight (8) hours as needed.

Continued interview with LPN #7, on 08/05/2021 at 9:09 AM, revealed she had suspicions regarding LPN #1 and was counting medications with her one evening and noted Resident #17 had one (1) Percocet left in a card and a second skid of thirty (30) Percocet. She revealed Resident #17 would have received one (1) Percocet that shift, and he/she should have had a full skid remaining when she returned the following morning. However, she stated, when she came to work the following morning, the second skid only contained twenty-nine (29) Percocet, and only one (1) had been signed out by LPN #1. She stated she reported this to the SDC/QI, although she was uncertain of the date, and did not say anything to LPN #1. LPN #7 stated the DON came and was auditing her cart later, and the DON shared she was doing so because a whole skid of Percocet was missing, not due to her report of a single Percocet missing.

Additional interview with LPN #7, on 08/14/2021 at 10:29 AM, revealed at shift change, staff counted the number of skids in the narcotics drawer and counted the number of Controlled Substance Count Records to ensure the numbers matched. Then, both nurses signed off on the Shift Change Controlled Substance Count Sheet at the front of the book. She stated she had never had a missing skid or a count be off, and if she did, she would get the DON or Administrator

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 755	Continued From page 301	F 755		

immediately to try to figure out where the discrepancy was. She stated she had heard not all staff did a proper narcotics count at shift change, but she had never observed staff doing an improper count.

Interview with State Registered Nurse Aide/Kentucky Medication Aide (SRNA/KMA) #3, on 07/28/2021 at 10:05 AM, revealed when she started a shift, she and the outgoing nurse would do a medication count and match what was documented against what was in the cart. She stated if things did not match, they had to alert administration to check the medication cart and investigate.

Interview with LPN #6, on 08/10/2021 at 2:40 PM, and again, on 08/13/2021 at 8:28 AM, revealed pharmacy delivered medications every night around 10:00 PM, except Sunday. She revealed the nurse on duty was responsible to check in medications with the delivery person; the delivery person read off what was in the tote with the nurse and compared it to the manifest/packing slip of what was ordered. She stated controlled medications now (since 07/09/2021) required two (2) nurses to witness and sign off on the pink slip. She revealed pharmacy took one (1) slip and the other went to the DON. LPN #6 stated new sheets and skids were added to the medication cart, and the Shift Change Controlled Substance Count Check was updated with prescription numbers and number of skids added. She stated, at each shift change, the staff coming on counted the skids and confirmed this with the staff member leaving, then the staff reading the MAR said how many medications were in each skid, and the nurse with the skids confirmed the number. She stated any discrepancies were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 755	Continued From page 302	F 755		

reported immediately to the DON. Regarding disposal of medication skids, she LPN #6 stated, the process was for the nurse to wrap the Controlled Substance Count Record around the medication skid, hand it to the DON, and sign the skid out on the Shift Change Controlled Substance Count Check. She revealed she never had any discrepancies in her medication cart when working with either LPN #1 or LPN #2.

Interview with SRNA/KMA #9, on 08/02/2021 at 2:55 PM, revealed narcotics were delivered at night, with one (1) nurse signing them in, then giving them to the nurse in charge of each medication cart where the medications needed to go.

Review of Resident #17's Controlled Substance Count Record revealed a sheet, two (2) of three (3), delivered on 06/28/2021 with no receiving signature and date on the sheet. Despite repeated requests, the facility was unable to provide either sheet one (1) of three (3), or a Controlled Substance Count Record for Percocet 5/325 mg covering the time frame, 06/19/2021 through 07/08/2021. Sheet three (3) of three (3) was the sheet missing, as identified by pharmacy on 07/09/2021. Sheet 2 of 3 revealed LPN #1 signed the first medication out at 12:00 AM on 07/09/21, with LPN #7 replacing her on the medication cart on the morning of 07/09/2021. Review of Resident #17's MAR for July 2021 revealed eighty-two (82) doses of Percocet 5/325 mg had been administered. However, no staff signed on the back of the MAR indicating the administration or the results.

Interview with the SDC/QI, on 08/03/2021 at 9:29 AM and again on 08/13/2021 at 4:00 PM,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 755	Continued From page 303	F 755		

revealed staff had suspicions about LPN #1, and she and/or the DON had interviewed her on a couple of occasions. She was uncertain of the dates of the interviews, but revealed they were prior to 07/16/2021. She revealed the first interview was to express concern as Resident #9 stated he/she had not received medications at night and was unable to take his/her morning medications, as it was documented he/she had received medications at night. She stated, in the second interview, she believed, the following night, a Percocet was noted missing (could not remember the resident) on LPN #1's medication cart that was not accounted for. She stated LPN #1 told her that the LPN had forgotten to write it down, but if she pulled it, she had given it. The SDC/QI stated she had reported this to the DON.

Interview with the DON, on 08/04/2021 at 8:28 AM, on 08/05/2021 at 12:35 PM, and again on 08/16/2021 at 11:35 AM, revealed no one had reported to her any missing individual Percocet tablet belonging to Resident #17. She revealed the first she heard of missing Percocet was when pharmacy discovered a missing skid belonging to Resident #17, in an audit conducted on 07/09/2021. She revealed she had reported this to the previous Administrator and sent in a self-report to police on 07/09/2021. She stated when police came to the facility, she never spoke with them, the Administrator did. She stated pharmacy had delivered three (3) skids of thirty (30) Percocet 5/325 mg each for Resident #17, on 06/28/21; however, LPN #1 stated she only received two (2) skids. The DON stated she thought there was a "trigger call" (a call between management staff and corporate regarding facility concerns and reportable incidents) that day, but she was not on the trigger call. The DON

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 755	Continued From page 304	F 755		

revealed neither LPN #1 nor LPN #2 were suspended, and she had been told by the Administrator they were not suspending anyone as they could not prove who had taken the skid. The DON revealed it was not the facility's policy to drug test someone based on allegations of taking narcotics from residents, and she would have to suspect someone was under the influence to warrant a drug test, which she never suspected of LPN #1.

Interview with the Regional Vice President (RVP), on 08/20/2021 at 3:03 PM, revealed he was part of the trigger call that occurred on 07/09/2021. He revealed the facility reported the incident and also notified police of the missing skid of thirty (30) tablets of Percocet. However, he stated administrative staff was unable to determine which specific nurse might have taken the skid, so neither nurse was suspended at that time. He revealed he had not been informed of any prior allegations for LPN #1 diverting medications, and as RVP he would have expected to be notified of those types of allegations.

3. Interview with the Facility Consultant, on 07/27/2021 at 1:15 PM, revealed, on 07/18/2021, the DON informed her that LPN #2 had found two (2) pills taped into a Roxicodone (Oxycodone, Schedule II narcotic pain reliever) skid, belonging to Resident #32, which were not Roxicodone. In addition, she stated this was followed by a second resident, Resident #84, who also had two (2) pills taped into a Roxicodone skid which were not Roxicodone. She revealed the pills used to replace the Roxicodone were determined to be Primidone, an anti-seizure medication. The Facility Consultant revealed police were present and had already detained LPN #1. She stated it

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 755	Continued From page 305	F 755		

was discovered LPN #1 had taken medications from skids but not signed them out for Residents #71, #56, #1, #47, #34, #60, #48, #65, #79, and #8. The Facility Consultant stated, in addition to taping skids, it was discovered some staff were wasting narcotics without having a witness signature and were putting wasted medications in the sharps containers.

Review of a draft of a KYIBRS (Kentucky Incident Based Reporting System) Report (Police Report) of incident 21-0927-092, received on 07/18/2021 at 8:30 PM, revealed police were contacted on 07/18/2021 by Social Services Clinician I (SSCI) informing them LPN #1 was actively stealing resident medications at the facility. The Police report revealed LPN #1 was asked to empty her pockets and had an unmarked pill bottle with several different types of pills inside, along with several loose pills in her pocket. Review of the evidence revealed the following were found on LPN #1: one (1) Primidone 50 mg tablet along with three (3) empty packs, one (1) Oxycodone 10/325 mg, one (1) Tramadol 50 mg, two (2) Hydrocodone 10/325 mg, three (3) Gabapentin 600 mg, five (5) Gabapentin 300 mg, one (1) empty skid of Roxicodone labeled for Resident #32, and one (1) pack of birth control pills labeled for LPN #1. Continued review of the report revealed LPN #1 admitted to taking medications from the facility, as well as changing some narcotics out and replacing them with Primidone 50 mg, without regard for how this would affect the residents. When asked by officers what drugs would be found in her system upon drug testing her, LPN #1 revealed she would have Hydrocodone, Percocet, Gabapentin, and Marijuana (a recreational psychoactive drug) in her system. LPN #1 stated she did not document

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 755	Continued From page 306	F 755		

narcotics removed from her medication cart until the end of the shift and stated this was common practice among nurses at the facility. LPN #1 was charged with two (2) counts of Wanton Endangerment in the First Degree; thirteen (13) counts of Theft by Unlawful Taking, Controlled Substance; three (3) counts of Possession of a Controlled Substance; and two (2) counts of Abuse and Neglect of an Adult Person.

A) Interview with LPN #2, on 07/30/2021 at 4:29 PM, revealed she was working the night of 07/18/2021, and was on administering medications, when she noted Resident #32's narcotic skid had tape on it, with the medications taped inside being thicker than the other medications in the skid. She revealed she contacted the DON and had SRNA/KMA #20 witness, as she searched the rest of the cart and found two (2) more medications taped in place for Resident #84's narcotics. She stated she contacted Adult Protective Services and was advised by Social Services Clinician I (SSC I) to have other staff witness her medication administration involving any narcotics, which she did by having staff, SRNA/KMA #8 and SRNA/KMA #20, witness every narcotic pulled.

Interview with SRNA/KMA #20, on 08/11/2021 at 4:13 PM, revealed LPN #2 showed him, on 07/18/2021, taped skids belonging to Resident #32 where two (2) Roxicodone had been replaced with something else. He revealed, due to that, she wanted to check the rest of the narcotics in the drawer, and they found Resident #84 also had two (2) Roxicodone tablets removed from a skid and replaced with something else. He revealed LPN #2 reported this to the DON, and he knew they had looked at LPN #2's cart

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 755	Continued From page 307	F 755		

while he was still on the floor.

Interview with the DON, on 08/04/2021 at 8:28 AM, revealed she received a call from LPN #2, on the night of 07/18/2021 at 7:30 PM, who told the DON that she had found two (2) of Resident #32's narcotics had been replaced with other pills, and the DON received a text at 7:47 PM from LPN #2 that the LPN had found a second resident, Resident #84, also had two (2) narcotics replaced with other pills. The DON stated she alerted the Administrator, and they were on a trigger call at 7:52 PM with the Facility Consultant, the Clinical Director, and the Regional Vice President.

Continued interview with the DON, on 08/04/2021 at 8:28 AM, revealed the DON stated she and the Administrator came to the facility, around 9:00 PM on 07/18/2021. She stated the Police and SSCI were already present in the facility. She stated medication cart audits were done, and the Administrator made copies of everything that was missing that night; however, the DON was unaware of where those copies were. She stated she and the Administrator went through the medication carts and were following corporate guidance to destroy any medications that were taped in skids. She revealed she and the Administrator went through LPN #1's medication cart together, and she went through another medication cart with LPN #12, while the Administrator went through another one with LPN #2. She stated she timed any medications she wasted, and all medication carts were audited by 2:00 AM on 07/19/2021, when she left the facility. The DON stated she did not have a full record of what was wasted, on the evening of 07/18/2021 through the morning of 07/19/2021.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 755	Continued From page 308	F 755		

Interview with LPN #12, on 08/13/2021 at 8:21 AM, revealed she was working on the night of 07/18/2021, when another nurse and SSCI came around checking medication carts. She revealed her medication cart was okay, and the only medication cart she thought had an issue was LPN #1's cart.

B) Review of Resident #65's medical record revealed the resident was admitted by the facility, on 10/25/2019. The facility assessed Resident #65, in a Quarterly MDS Assessment, dated 06/29/2021, as fifteen (15) of fifteen (15) on the BIMS, indicating no cognitive impairment. Continued review revealed a physician's order for Neurontin (Gabapentin) 200 mg three times a day, dated 06/04/2021; and Roxicodone 5 mg every 6 hours, dated 06/21/2021.

Review of Resident #65's Controlled Substance Count Record for Roxicodone 5 mg revealed a missing (not documented) tablet, on 07/18/2021, which the DON documented as giving a dose for the missing tablet/previously undocumented midnight dose. Review of Resident #65's MAR for June 2021 revealed one (1) dose of Roxicodone 5 mg missing, at 6:00 PM on 06/24/21, with no documentation on the back of the MAR indicating the reason for the missed dose.

C) Review of Resident #34's medical record revealed Resident #34 was admitted by the facility, on 12/09/2019, and was assessed in a Quarterly MDS Assessment, dated 06/29/2021, as fifteen (15) of fifteen (15) on the BIMS, indicating no cognitive impairment. Continued review revealed a physician's order for Neurontin

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 755	Continued From page 309	F 755		

100 mg in the morning, dated 04/19/2021, and Neurontin 300 mg at bedtime, dated 04/16/2021.

Interview with Resident #34, on 07/28/2021 at 9:28 AM, revealed he/she did not have any current pain issues; although he/she used to have pain in his/her left leg, but it was treated with medication.

Review of Resident #34's Controlled Substance Count Record for Neurontin 300 mg revealed one (1) missing tablet, on 07/18/2021, typically given between 8:00 PM and 9:00 PM, not signed out, and noted by the DON at 10:39 PM.

D) Review of Resident #48's medical record revealed the resident was admitted by the facility, on 07/27/2018 and was assessed in a Quarterly MDS Assessment, dated 06/15/2021, as thirteen (13) of fifteen (15) on the BIMS, indicating no cognitive impairment. Continued review revealed a physician's order for Tramadol 50 mg three times per day, dated 05/25/2021.

Interview with Resident #48, on 07/28/2021 at 9:48 AM, revealed he/she had not had any issues with untreated pain.

Review of Resident #48's Controlled Substance Count Record for Tramadol 50 mg revealed one (1) missing tablet, typically given at 8:00 PM, and noted by the DON, on 07/18/2021 at 11:45 PM.

E) Review of Resident #84's medical record revealed Resident #84 was admitted by the facility, on 09/11/2020, and was assessed in a Quarterly MDS Assessment, dated 04/26/2021, as fourteen (14) of fifteen (15) on the BIMS, indicating no cognitive impairment. Continued

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 755	Continued From page 310	F 755		

review of the record revealed a physician's order for Neurontin 100 mg at bedtime, dated 03/23/2021; and a physician's order for Roxicodone 5 mg every 8 hours PRN, dated 05/10/2021.

Review of Resident #84's Controlled Substance Count Record for Roxicodone 5 mg, delivered on 06/10/2021, revealed frequent use of once a day, with use twice a day on multiple occasions. LPN #1 had signed out eight (8) tablets on the record, with two (2) tablets documented as replaced with Primidone, on 07/18/2021. Review of Resident #84's MAR, for July 2021, revealed a dose of Roxicodone 5 mg was administered on 07/08/2021, but was not documented on the Controlled Substance Count Record. In addition, per the record, of ten (10) documented administrations during July 2021, on the MAR, only six (6) were documented on the back of the MAR. Review of the June 2021 MAR revealed, of twenty-two (22) doses administered, only six (6) were documented on the back of the MAR. The last dose administered on the MAR was on 07/18/2021 at 8:00 PM by LPN #2. Continued review of Resident #84's Controlled Substance Count Record for Roxicodone 5 mg, delivered on 06/10/2021, revealed no signature or date by the receiving nurse. Further review of Resident #84's medical record revealed a Clinical Laboratory Report, dated 07/19/2021, revealing no Primidone detected in Resident #84's system and a negative result for opiates.

Interview with LPN #6, on 08/10/2021 at 2:40 PM, revealed she had observed on the MAR that Resident #84 did routinely receive pain medications with LPN #1 at night, although the resident did not routinely receive them when LPN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 755	Continued From page 311	F 755		

#6 was working during the day.

F) Review of Resident #32's medical record revealed the resident was admitted by the facility, on 04/01/2020, was assessed in the Quarterly MDS Assessment, dated 06/01/2021, as a seven (7) of fifteen (15) on the BIMS, indicating severely impaired cognition. Continued review of the record revealed a 04/01/2020 physician's order for Roxicodone 5 mg every 8 hours PRN.

Review of Resident #32's Controlled Substance Count Record for Roxicodone 5 mg, initiated on 06/15/2021, revealed the last two (2) medications on the skid had been replaced with Primidone. Review of Resident #32's MAR for July 2021 revealed two (2) doses of Roxicodone 5 mg documented as given for 07/03/21; however, the back of the MAR only listed one (1) dose given, as did the Controlled Substance Count Record. Review of the MAR for June 2021 revealed twenty-three (23) doses of Roxicodone 5 mg administered; however, only ten (10) were documented on the back of the MAR. Further review of Resident #32's medical record revealed a Clinical Laboratory Report, dated 07/19/2021, revealing no Primidone detected in Resident #32's system and a negative result for opiates.

Additional interview with LPN #6, on 08/19/2021 at 8:39 AM, and interview with LPN #9, on 08/19/2021 at 8:50 AM, revealed Resident #32 did not ask for pain medication often. Both stated Resident #32 had frequent UTI's, which caused the resident to be confused, saying off-the-wall things, and having delusions and fatigue. Both stated, around 07/18/2021, Resident #32 exhibited these behaviors.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 755	Continued From page 312	F 755		

G) Review of Resident #71's medical record revealed the resident was admitted to the facility, on 05/10/2018 and was assessed in the Quarterly MDS Assessment, dated 07/13/2021, as fifteen (15) of fifteen (15) on the BIMS, indicating no cognitive impairment. Continued review revealed a physician's order for Gabapentin 300 mg three times per day, dated 07/11/2019.

Review of Resident #71's Controlled Substance Count Record for Gabapentin 300 mg, delivered 07/13/2021, revealed a missing 8:00 PM dose, on 07/18/2021, noted by the DON at 11:50 PM. Continued review of Resident #71's MAR for July 2021 revealed a missing dose of Gabapentin 300 mg, on 07/26/2021 at 2:00 PM, with no documentation indicating the reason for the missed dose.

H) Review of Resident #1's medical record revealed the resident was admitted by the facility, on 12/22/2016, and was assessed in the Quarterly MDS Assessment, dated 05/03/2021, as fifteen (15) of fifteen (15) on the BIMS, indicating no cognitive impairment. Continued review revealed a 01/06/2021 physician's order for Gabapentin 300 mg at bedtime; a 05/25/2021 physician's order for Norco (Schedule II narcotic pain reliever) 5/325 mg PRN, which changed to twice a day, on 07/06/2021; and a 06/04/2021 physician's order for Lyrica (pain reliever for nerve pain) 150 mg twice per day.

Review of a July MAR for Resident #1 revealed Gabapentin 300 mg was not documented on the MAR as administered on 07/27/2021, with no documentation supporting why it was not administered. Further review of the resident's Controlled Substance Count Records revealed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 755	Continued From page 313	F 755		

one (1) dose each of Norco 5/325 mg, Lyrica 150 mg, and Gabapentin 300 mg missing on 7/18/2021 and not documented as given.

I) Review of Resident #8's medical record revealed the resident was admitted by the facility, on 03/12/2020 and was assessed in the Significant Change of Status Assessment, dated 05/05/2021, as three (3) of fifteen (15) on the BIMS, indicating severe cognitive impairment. Continued review revealed a 05/26/2021 physician's order for Hydrocodone 5/325 mg four times per day.

Further review of Resident #8's Controlled Substance Count Record for Hydrocodone 5/325 mg revealed a dose missing on 07/18/2021 and not documented as given.

Continued interview with the DON, on 08/04/2021 at 8:28 AM, revealed she and the Administrator, on 07/18/2021, went through the medication carts and were following corporate guidance to destroy any medications that were taped in skids. She stated she timed any medications she wasted, and all medication carts were audited by 2:00 AM on 07/19/2021, when she left the facility. The DON stated she did not have a full record of what was wasted, on the evening of 07/18/2021 through the morning of 07/19/2021.

Continued interview with LPN #2, on 07/30/2021 at 4:29 PM, revealed, following the arrival of the DON and Administrator, they identified multiple narcotic skids with tape on them, and were busy wasting meds on the night of 07/18/21 through the morning of 07/19/21. She stated some skids had tape all over them and had to be wasted, while others just had pills removed due to tape.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 755	Continued From page 314	F 755		

She stated she did not know which medications were wasted, but knew there were a lot.

4. Interview with the Facility Consultant, on 07/27/2021 at 1:15 PM, revealed, on 07/20/2021, the DON determined, in an audit with LPN #5, the Shift Change Count Sheet signed by LPN #2 was four (4) less than the previous Shift Change Count Sheet. The previous Shift Change Count Sheet had been misplaced, necessitating the need for LPN #2 to complete a new one during her shift. She revealed the DON and LPN #5 could not find Resident #9's skid two (2) of two (2) for Percocet 7.5/325 mg. She revealed Resident #9's medications had been delivered, on 07/15/2021, and not enough would have been administered to account for a missing skid sheet.

Review of Resident #9's Controlled Substance Count Records revealed no evidence skids were delivered, on 07/15/2021, despite multiple requests by the SSA Surveyor for all Controlled Substance Count Records for this resident for June 2021 and July 2021.

Review of a Shift Change Controlled Substance Count Check form, for Resident Rooms 136 to 149, revealed an incomplete form with LPN #2 not signing in, next to LPN #6, who signed out, on 07/18/2021 at 6:30 PM. The form indicated forty-six (46) count sheets remaining. However, review of the form revealed LPN #2 indicated the sheet count was forty-two (42).

Continued interview with LPN #2, on 07/30/2021 at 4:29 PM, revealed, when individual pills were taken from her cart, both she and the removing staff signed on the narcotics sheet, but the Administrator and DON had taken the Shift

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 755	Continued From page 315	F 755		

Change Count Sheet, which tracked the number of controlled substance skids in the cart. She stated she started another sheet, and counted forty-two (42) sheets. She stated she was not sure if everything that was destroyed had been signed out.

Interview with LPN #5, on 08/03/2021 at 4:20 PM, revealed when she came to work, on the morning of 07/20/2021, the DON had asked the LPN to go through a medication cart with her. She stated they noted a narcotic skid was on skid two (2) of two (2) for a medication that had just been delivered a week before for Resident #9. She revealed there was also a discrepancy in the Shift Change Count Sheets. However, LPN #5 stated, after the previous Shift Change Count Sheet had been located, it was determined there was a discrepancy of four (4) skids unaccounted for. However, she revealed, after investigation, only one (1) skid was found missing, for Resident #9. She revealed the previous Shift Change Count Sheet did not indicate any skids had been removed.

Interview with the DON, on 08/04/2021 at 8:28 AM, revealed she was conducting a narcotic count of the medication carts, on 07/20/2021 with LPN #5, and noticed Resident #9 was missing skid two (2) of two (2) of a prescription that had just been filled on the night 07/15/2021. She stated LPN #2 had never signed in to the medication cart, on 07/18/2021, and there had been forty-six (46) sheets when LPN #6 had left on 07/18/2021, turning the cart over to LPN #2. She stated the previous Shift Change Count Sheet had been misplaced (was discovered later), and when LPN #2 started a new Shift Change Count Sheet she counted forty-two (42)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 755	Continued From page 316	F 755		

skids of controlled medications. She revealed of the four (4) skids missing, all were accounted for except the missing one for Resident #9, for Percocet. She stated the decision was made to suspend LPN #2 at that time.

Interview with the SDC/QI, on 08/05/2021 at 12:22 PM and again on 08/16/2021 at 2:45 PM, revealed if someone reported a discrepancy on the medication count to her, she would report it to the DON, and whoever was on the medication cart would be removed until a full cart audit could be completed. She stated the process for disposal of narcotics, when a resident was discharged or died, was the nurse on the floor would pull them from the medication cart, verify the number in the skid with the Controlled Substance Count Sheet, reduce the number of skids on the Shift Change Controlled Substance Record, and take the sheet with the medications to the DON or SDC/QI. She stated she or the DON would then take them to lock up in the South Unit medication room, under triple lock, where only the DON had the key. She stated they would not be logged as they were put in the box, and at times, there was only herself or the DON (she would get keys from the DON) in and out of the box with no witness. She then said she or the DON would take the medications from the box to one (1) of their offices, log them on a reconciliation sheet, and pop them out into the drug buster, which was contained in a biohazard container in the dirty utility room. She stated they had not always followed policy in having two (2) nurses, or a nurse and a pharmacist, when wasting medications. She stated her expectation was that wasted medications would be witnessed by a second nurse and disposed of in the sharps container. She revealed it was important to have

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 755	Continued From page 317	F 755		

a witness to prevent drug diversion, and the Controlled Substance Count Sheet should have two (2) signatures when a medication was wasted.

Interview with the Pharmacy Operations Manager, on 08/13/2021 at 9:55 AM, revealed the facility has had a contract with their pharmacy since late 2020. She revealed the process for medication deliveries was the pharmacist ensured controlled substances on the facility's manifest were what was sealed in the bag. The sealed bag came to the facility, and facility staff verified the bag had not been tampered with and what was on the manifest was actually what they were receiving. She stated any discrepancy should be noted on the manifest, and a copy of the manifest was returned to the pharmacy.

Interview with the Consultant Pharmacist, on 08/13/2021 at 10:31 AM, revealed she conducted a controlled substance audit monthly. For this audit, she stated she did spot checks, would go to each medication cart, flip through the declining count sheets (Controlled Substance Count Records) to see if anything looked odd, to see how many medications were left. She stated, if any were wasted, she would look at the Shift Change Controlled Substance Count Check where nurses signed off and documented declining count sheets. The Consultant Pharmacist stated she did not typically open up a drawer where medications were kept unless she noted a discrepancy. She stated if the documentation looked appropriate, it would warrant no further investigation on her end. She stated she was auditing their documentation process more than anything. Per the interview, she would every now and then do a spot check of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 755	Continued From page 318	F 755		

a medication skid and compare it to the matching Controlled Substance Count Record for accuracy. She stated she thought any completed medication skids were taken to the DON, and any not completed skids due to a discharge or medication change, were taken to the DON to be wasted.

Interview with the Medical Director, on 08/10/2021 at 4:11 PM, revealed when medications were not administered as prescribed, it could lead to problems, such as untreated pain. Regarding Resident #32, he revealed he had ordered lab work primarily as he was concerned Resident #32 might have been overdosed, but found that was not the case. The Medical Director revealed the DON had been keeping him informed on issues surrounding the drug diversion situation at the facility, as well as their plans to address issues.

Interview with Advanced Practice Registered Nurse (APRN) #1, on 08/11/2021 at 11:44 AM, revealed her concern with residents not receiving their controlled pain medication would be residents not having their pain controlled. She revealed she was aware of the situation with Resident #84, and although her primary concern would have been with resident having uncontrolled pain, she stated, if Resident #84 started exhibiting new symptoms, no one would have been able to connect those symptoms to a medication the resident was not prescribed but was receiving. The APRN stated Resident #84 had experienced a stroke previously, so receiving an anti-convulsant could have affected him/her greatly.

Interview with the DON, on 08/18/2021 at 10:48

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 755	Continued From page 319	F 755		

AM, revealed prior to the current situation with drug diversion, the only medication cart audits were those conducted by the Pharmacy Consultant. She revealed she had seen some count sheets where (2) two staff members were not signing for wasted medications. She stated she expected, when medications were wasted, to have a second nurse sign on the narcotic sheet, and she would not expect wasted medications to be put in the sharps container. The DON stated, when a resident expired or was discharged, medications should be counted, the Shift Change Controlled Substance Count Record updated, and sheets and skids should be taken to her. She stated she did not log them when receiving them and did not always sign sheets to verify the count matched what was in the skids. She revealed it was important to do so to reduce the risk of drug diversion.

Continued interview with the DON, on 08/18/2021 at 10:48 AM, revealed she was uncertain what the policy said regarding discrepancies in medication counts, although she stated she would go to the medication cart and investigate until it could be determined what happened. She stated the decision was made, as a team, whether to drug test or suspend staff, and she had not historically been able to make that call. She revealed it was important to suspend a nurse implicated in drug diversion from medication administration to prevent further possible drug diversion. The DON stated she would receive copies of the packing slips for narcotics deliveries; however, she did not previously use those as an audit tool to ensure medications were delivered to carts. Also, she revealed any nurse could accept narcotics delivered with no accountability that they actually got to their cart.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 755	Continued From page 320	F 755		

She stated she also recognized staff were always counting narcotic sheets, so at times when something did go missing, staff did not notice it. In addition, the DON stated she was aware, prior to this incident, that skids were being taped when damaged.

The previous Administrator was not available during the course of the survey and did not return calls, the last of which was attempted, on 08/20/2021 at 9:48 AM, by the State Survey Agency Surveyor.

Interview with the Interim Administrator, on 08/20/2021 at 10:24 AM, revealed he expected the facility to have a good investigation program, a good audit program, and a good count program for narcotics that started when they came to the facility. He stated this included signing by two (2) nurses, to limit the possibility of drug diversion occurring.

Interview with the Senior Vice President, on 08/20/2021 at 1:40 PM, revealed if there was a drug diversion situation, she would expect the facility to initiate investigative protocols, determine if they could identify at what point diversion occurred, and take appropriate action with staff members. She stated, if administrative staff were able to determine a responsible party, she expected the responsible party to be suspended to protect other residents. She revealed she always referred to facility policies.

The facility provided an acceptable Immediate Jeopardy Removal Plan on 09/01/2021 that alleged removal of the Immediate Jeopardy (IJ) on 08/31/2021. The facility implemented the following:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 755	Continued From page 321	F 755		

1. On 07/09/2021, a Performance Improvement Plan (PIP) was initiated related to Missing Narcotics which was reported to the Office of Inspector General - Division of Health Care at 4:30 PM on 07/09/2021.

2. On 07/09/2021, an ad hoc meeting was held and the performance improvement plan (PIP) was reviewed.

3. On 07/09/2021, the Unit Manager and MDS nurses audited narcotics in the remaining medication carts as the North back hall had a blister pack missing. All count sheets were found to match the number of skids. Staff signing in and out of a medication cart was expected on controlled substance check sheets.

4. On 07/09/2021, the Staff Development Coordinator/Quality Improvement Nurse (SDC/QI) initiated staff education. The topics included narcotic count, counting sheets added and subtracted, signing packing slips, and logging narcotics into the narcotic books.

5. On 07/12/2021, the DON initiated additional education which included signing as needed (PRN) medications on the back of the medication administration record (MAR), giving discontinued narcotics to the DON, and labeling declining count sheets.

6. On 07/12/2021, the DON, SDC/QI, MDS nurses, unit manager (UM), supervisor nurse, Principle LTC RN not employed by the facility (support RN's), and corporate nurses started audits of medication carts and narcotic medication documentation. The audits included:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 755	Continued From page 322	F 755		

locking carts, MAR's, shift change count sheets, signatures, declining count sheets, wasted narcotics, back side of narcotic medication skids, skid cards numerical order, no missing skids, all narcotics accounted for, and/or pharmacy packing slips. These audits were completed five (5) times weekly. Any missing, incomplete, or incorrect documentation would be immediately reported to the DON and/or Administrator for investigation. Any concerns and trending would be reviewed and discussed weekly on Fridays. The audits would continue until the Quality Assurance Performance Improvement (QAPI) committee determined the audit frequency could be reduced.

7. On 07/12/2021, 07/13/2021, 07/20/2021, 07/21/2021, 07/22/2021, 07/24/2021 to 08/01/2021, 08/01/2021 to 08/13/2021, and 08/22/2021 to 08/29/2021, an RN Corporate consultant worked in the facility. An RN Corporate nurse continues to be at the facility five (5) days a week through September 2021, ensuring the facility adheres to proper signing of packing slips, properly counts and documents narcotics, correctly disposes of controlled medications, and maintains an effective system of reconciliation. An RN Corporate nurse continues at the facility to provide oversight of the performance improvement plan five (5) days a week through September 2021. An RN corporate nurse may complete any audit in place of the assigned auditor. An RN Corporate nurse continues to ensure the facility adheres to proper signing of packing slips, properly counts and documents narcotics, correctly disposes of controlled medications, and maintains an effective system of reconciliation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 755	Continued From page 323	F 755		

8. On 07/18/2021, an ad hoc meeting was held to review the additional action steps with the interdisciplinary team (IDT). The IDT was comprised of the Administrator, DON, Quality Improvement Nurse/Staff Development Coordinator (SDC/QI), Minimum Data Set (MDS) Nurse, Unit Manager, Activity Director, Social Services Director, and Dietary Manager.

9. On 07/19/2021, staff nurses performed assessments on all residents, including Resident #32. For residents with a BIMS of eight (8) or below, the assessment included observation of non-verbal signs of pain to include: breathing, facial expression, body language, consolability. No concerns were identified.

10. On 07/19/2021, the APRN assessed Resident #32.

11. On 07/19/2021, the DON, Unit Manager, Administrator, a Corporate RN, or a support RN began reconciling the narcotic packing slips to the narcotics received. The reconciliation would be completed three (3) times per week to ensure the correct number of delivered narcotics were logged into the narcotic count book, and the number of declining count sheets were updated. Any discrepancies would be reported immediately to the DON and/or administration.

12. On 07/20/2021, the DON audited the Shift Change Controlled Substance Count Check sheets and found one (1) facility nurse had recorded on the log sheet a reduced number of sheets counted. The nurse documented four (4) less sheets than the previous shift. There was no documented explanation why there were four (4) less sheets than the previous shift. The facility

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 755	Continued From page 324	F 755		

suspended the nurse and reported the information to the Office of Inspector General (OIG), Adult Protective Services (APS), and the Police.

13. On 7/20/2021, the DON, ADON (Assistant Director of Nursing), SDC/QI, MDS nurses, Weekend Supervisor, Social Services Director (SSD), Activities Director (AD), and/or support RN's began interviewing weekly three (3) random residents, with a BIMS of nine (9) or above, to ensure they had no concerns with when or how their narcotic medications were administered. Any concern regarding narcotic administration would be reported to the DON or Administrator for review at the morning interdisciplinary team (IDT) meeting. The three (3) audits would continue five (5) times a week until the QAPI committee determines a reduction can be made. The results of these audits would be reviewed in QAPI meetings.

In addition, each off-going licensed nurse/Kentucky medication aide (KMA) would report any concerns regarding narcotic administration and complete a concern form indicating a resident has expressed concern regarding their narcotic medication administration. The completed concern would include who the concern was reported to, if one was expressed. Any resident concern regarding narcotic medication administration would be reported to the DON or Administrator for review at the morning IDT meeting. The results of these audits will be reviewed in the monthly QAPI meeting.

14. On 7/21/2021, the DON, ADON, Unit Manager, SDC, QI, Weekend Supervisor, MDS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 755	Continued From page 325	F 755		

nurses, a Corporate RN, and/or a support RN would review the storage and documentation of narcotics when checking medication carts to ensure narcotics were stored appropriately and documentation was correct. Audits would occur five (5) times per week until the QAPI committee determined frequency could be reduced. The QAPI Committee consisted of the Administrator, DON, Infection Preventionist, Medical Director, Social Worker, Medical Records Director, Dietary Manager, and Housekeeping Supervisor, plus additional staff members as deemed necessary. Any concern regarding documentation or storage of narcotic administration would be addressed at the time of the audit and reported to the DON or Administrator. All new concerns would be reviewed in the morning IDT meeting.

15. On 7/22/2021, the DON and RN Consultants educated all nurses and KMA's on the Controlled Substance Policy which included the proper way to count narcotics and the correct record keeping for narcotics. As of 7/22/2021, twenty-nine (29) of thirty-one (31) nurses and KMA's were educated. One (1) nurse was on vacation and has since returned. One (1) nurse had a Family Medical Leave Act (FMLA) absence and remained on FMLA. This education included the off-going staff member should have the record for comparison to actual narcotics seen by the on-coming staff member. Narcotics should be signed out at the time they were removed from the packet; a nurse must witness destruction of a dropped or refused narcotic before signing as a witness. KMA's could not be the second signature. (A KMA cannot witness for a nurse.) Nurses and KMA's could not tape a medication to hold it in card. If a narcotic came loose, it must be wasted, and two (2) signatures must be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 755	Continued From page 326	F 755		

present. This education also included signing the Shift Change Controlled Substance Count Check sheet at the beginning and end of the shift. This education included the signature was the nurse's affirmation the count was correct and must be signed when counting. It could not be signed early or late. Nurses and KMA's were also educated regarding deliveries of multiple cards of narcotics. The nurse receiving the narcotics and the nurse whose cart would hold the narcotics must both sign for receipt. If the same nurse was both receiving and had the medication cart, a second nurse must sign. This education was added to the new employee orientation for new nurses, new KMA's, and new agency nurses.

16. On 7/26/2021, the DON, Unit Manager, SDC/QI, nurse supervisor, MDS nurse, and Corporate RN consultants began administering a medication administration post-test to all licensed nurses and KMA's. The quiz covered both medication administration and physician notification and validated licensed nurses and KMA's continued competency in a written form. Any licensed nurse or KMA not scoring one-hundred percent (100%) on the quiz would receive additional education.

17. On 7/29/2021, the DON facilitated a Medical Director Update telephone call.

18. On 8/10/2021, the DON facilitated a QAPI Committee meeting with the Medical Director present. The committee discussed the facility's survey status, including the abuse/neglect PIP. Review of actions taken and audit results concluded in the recommendation for the facility to: 1) continue with the narcotics PIP, 2) provide on-going education and 3) continue auditing.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 755	Continued From page 327	F 755		

19. On 8/11/2021, the DON completed narcotic medication cart audits on each of the five (5) medication carts. Audit result: no issue. The Corporate RN consultant noted the front-north narcotic drawer had a screw sticking out that caused tears/punched a hole in back of multiple narcotic skids. The screw was covered.

20. On 8/12/2021, the DON completed narcotic medication cart audits on each of the five (5) medication carts. Audit result: no issue.

21. On 8/13/2021, the SDC/QI completed narcotic cart audits on each of the five (5) medication carts. Audit result: no issue.

22. On 8/18/2021, the SDC/QI completed narcotic cart audits on each of the five medication carts. Audit result: no issue.

23. On 8/19/2021, the DON facilitated a Medical Director Update telephone call.

24. On 8/20/2021, the facility verified the facility rebilled and/or paid for the misappropriated medications.

25. On 8/20/2021, the DON notified the Medical Director of eight (8) IJ tags and the performance improvement plans (PIP) that were being worked on.

26. On 8/26/2021, the DON facilitated a Medical Director Update telephone meeting, including the DON, RVP, Medical Director, Interim Administrator, new Administrator, and RN Consultant. The discussion included the facility's immediate jeopardy (IJ) status, including F-755

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 755	Continued From page 328	F 755		

Pharmacy Services/Procedures. Review of the actions taken and the audit results concluded in the recommendation for the facility to: 1) provide continued education and 2) continue auditing.

27. On 8/28/2021, the SDC/QI monitored and audited the north-front medication cart and verbally quizzed the cart nurse, to include how to sign a pharmacy packing slip and properly dispose of narcotics. The nurse was able to answer questions correctly.

28. On 8/28/2021, the SDC/QI, support RN, and Corporate RN consultant monitored medication carts, narcotic medication documentation, and the facility's progress with the plan of correction.

29. On 8/29/2021, the DON, four (4) support RN's, and a Corporate RN interviewed staff and residents, inspected medication carts, and reviewed narcotic documentation. No new staff concerns were received. No new resident concerns were received. Residents stated they were receiving their medications. No narcotic medications were identified as missing.

30. The Pharmacy consultant would visit the facility, at least monthly, to validate narcotics were being monitored and counted per standard of practice.

The State Survey Agency validated the implementation of the facility's Immediate Jeopardy Removal Plan as follows:

1. Review of a QAPI PIP, dated 07/09/2021, revealed, as a result of one (1) missing blister pack of thirty (30) Percocet tablets, identified in a pharmacy audit completed on 07/09/2021, the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 755	Continued From page 329	F 755		

facility identified only one (1) staff was signing for narcotics arriving at the facility and initiated education on controlled substances, to include having a second person sign for controlled substances arriving at the facility.

Review of a Long Term Care Facility Self-Reported Incident Form, dated 07/09/2021, confirmed the facility reported incident of misappropriation to all appropriate parties, to include the Office of Inspector General, on 07/09/2021.

2. Review of the PIP, dated 07/09/2021, confirmed staff signatures indicating meeting attendance to discuss the PIP.

Interview with Facility Consultant #1, on 07/27/2021 at 1:15 PM, revealed corporate realized the facility had a problem, as had a nurse receiving something with only her signature. Although the policy did not clearly state two (2) signatures were required when narcotics arrived from the pharmacy, it was good nursing practice that there should be two (2) signatures. She stated she had started education with staff, to let them know you had to have two (2) signatures.

3. Review of documentation confirmed facility staff audited narcotics in all medication carts on 07/09/2021. Review of audits revealed no other missing narcotics.

4. Review of a 07/09/2021 Complete In-Service Training Report with Staff Attending confirmed the SDC/QI initiated staff education, attended by licensed nursing staff and KMA's. Education covered the need for both off going and on coming shift staff to sign the Shift Change

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 755	Continued From page 330	F 755		

Controlled Substance Count Check sheet at change of shift, the importance of completing an appropriate narcotic count at shift change, adding and subtracting sheets from the Shift Change Controlled Substance Count Check sheet, and the employees accepting delivery for narcotics must sign each individual sheet of the packing slips.

Interview with the SDC/QI, on 09/02/2021 at 4:49 PM, revealed she provided all nurses and KMA's a packet of education on medication administration as well as having each nurse signing for delivery of narcotics.

5. Review of the Complete In-Service Training report with Staff Attending, dated 07/12/2021, confirmed the DON initiated staff education for licensed nursing staff and KMA's. Education covered (1) all PRN medications must be signed on the back of the MAR, (2) all narcotics no longer in use must stay locked up in the medication cart until they could be given to the DON, and (3) the declining count sheet must be labeled with room numbers at the top of the sheet.

Interview with the DON, on 09/02/2021 at 9:10 AM, revealed it had been determined not everything was signed out consistently on the back of the MAR, so the education initiated on 07/12/2021 emphasized to staff the need to do this, including documenting the effectiveness of pain medication administered to residents.

Interview with Facility Consultant #1, on 08/05/2021 at 12:35 PM, revealed on 07/09/2021, she started education with nurses and KMA's about signing at shift change, accepting the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 755	Continued From page 331	F 755		

medication cart, adding and subtracting drug skids/blister packs to the count sheet each shift, to include the prescription number. On 07/12/2021, she stated she added to the education, if the nurse receiving the narcotics to put on the medication cart was different than the one signing for delivery, both signatures were needed. In addition, she stated another licensed nurse was required to sign in medications from the pharmacy.

Interview with LPN #6, on 08/13/2021 at 8:28 AM, revealed she had received training from both the SDC/QI and the DON regarding controlled substances. She revealed the nurse on duty was responsible to check in the medications with pharmacy. She revealed pharmacy read off what medications were in the tote with the nurse and compared it to manifest/packing slip of what was ordered. LPN #6 stated controlled medications required two (2) nurses to witness what was ordered, count, and sign. Pharmacy took one (1) slip, and the other went to the DON. She stated each nurse added the sheets for controlled medications to their count sheets, to include the prescription number on the skids. She stated, for each shift, the off going nurse counted the skids in the controlled drawer and the oncoming nurse counted the sheets for all controlled medications to ensure they matched, with any discrepancy reported immediately to the DON.

6. Review of documentation revealed the DON audited all medication carts on 07/13/2021, confirming staff were signing in and out of carts as expected, narcotic skids were being counted as expected, and the narcotic count sheets matched the number of narcotic skids in the cart.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 755	Continued From page 332	F 755		

Continued review revealed ongoing audits completed by the DON, SDC/QI, MDS nurse, support RN's, and Corporate nurses. No concerns were identified in review of these audits.

7. Interview with the Clinical Director, on 09/02/2021 at 9:10 AM, revealed she, and prior to her arrival, the Facility Consultant, had been in the facility on the dates documented in the IJ Removal Plan. She revealed her daily routine consisted of talking to residents on both the South and North Units of the building, observing staff providing care, and talking with staff. She stated she conducted chart reviews and audits, and validated the facility was continuing audits and doing everything they were supposed to be doing. The Clinical Director stated she had made surprise visits to the facility at 2:00 AM, as well as on weekends, to ensure staff were following procedures they had been educated on.

8. Review of the Narcotic PIP confirmed, as result of the 07/18/2021 incident in which two (2) residents had narcotics replaced with non-prescribed medications, a PIP addendum was added to identify the scope of residents affected as well as further staff education on controlled substances and monitoring by management staff.

9. Review of Pain Assessments revealed Pain Assessments were completed for all facility residents on 07/19/2021. No concerns were identified through review of the pain assessments. Additionally, Resident Interview Medication Administration papers were reviewed, with no concerns identified.

Interview with the DON, on 09/02/2021 at 9:10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 755	Continued From page 333	F 755		

AM, revealed no new or untreated pain was identified through the pain assessments conducted on 07/19/2021.

10. Review of the documentation of the visit by the Medical Director with Resident #32, on 07/20/2021, revealed possible indicators Resident #32's opiates had been replaced with Primidone. Further review revealed Resident #32's condition was improving at the time of documentation. In addition, documentation further revealed APRN #2 had assessed Resident #32 on 07/19/2021.

Interview with the Medical Director, on 08/10/2021 at 4:11 PM, revealed he had been informed about the situation with Resident #32, from both the DON and the Police. He revealed, based on his interview with Resident #32 as well as lab results, he was unable to tell if Resident #32 had been receiving either his opiates or Primidone.

11. Review of Packing Slips revealed two (2) staff nurses were consistently signing for incoming narcotics, with nursing staff additionally initialing the count slips for medications specifically received for their carts. Review confirmed all packing slips were being signed, however, there was not consistent documentation indicating they had been reviewed by either the DON, Unit Manager, Administrator, a Corporate RN, or a support RN.

One Packing Slip, dated 07/22/2021, was signed for by one (1) nurse. Further review determined this nurse received consultation and reeducation by Facility Consultant #1 regarding the need for two (2) signatures always.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 755	Continued From page 334	F 755		

Interview with the DON, on 09/02/2021 at 9:10 AM, revealed when reviewing packing slips, she confirmed there were two (2) signatures and checked to ensure everything listed on the packing slips was on the medication cart; then, she would initial the packing slips to show she reviewed them.

12. Review of documentation confirmed the DON audited medication carts, on 07/20/2021, and, after investigation of the initial four (4) missing skids, finally determined Resident #9 was missing one (1) skid, skid two (2) of two (2) for Percocet.

Review of a Long Term Care Facility/Self-Reported Incident Form, dated 07/20/2021, confirmed the facility reported an allegation of misappropriation to appropriate parties on 07/20/2021, to include OIG, and documented suspension of LPN #2.

13. Review of Resident Interview Medication Administration confirmed facility staff interviewed three (3) or more residents each week, beginning on 07/20/2021. Residents were questioned whether or not they had concerns regarding administration of their medications. If residents indicated concerns, this was explored further, to include to whom residents reported concerns, and when. No unaddressed issues were identified during documentation review.

Further, review of Shift Change Narcotic Review sheets, also used to document nurse and KMA concerns regarding narcotics administration, revealed no forms had been completed, indicating no concerns had been reported as of the review date of 09/02/2021.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 755	Continued From page 335	F 755		

Interview with the DON, on 09/02/2021 at 9:10 AM, revealed she frequently interviewed residents as part of the audit process, asking about any concerns regarding their medications. She revealed, if residents were to express a concern, she would educate them on reporting and share their concerns in QAPI meetings. To date, she revealed no residents had expressed any concerns to her. She stated no staff had expressed any concerns to her regarding narcotics administration.

14. Review of Narcotic Cart Audit forms, dated 07/21/2021, confirmed the DON audited the storage and documentation of all facility medication carts. Continued review revealed audits were occurring five (5) or more times each week by various licensed nursing staff. Review of Narcotic Cart Audit forms revealed a KMA had pulled narcotics but did not sign at the time the narcotics were given; however, the education on this not being acceptable practice had not been done until 07/22/2021.

15. Review of a Complete In-Service Training Report with Staff Attending, initiated on 07/19/2021, revealed licensed nursing staff and KMA's were educated on the Controlled Substances policy, dated 09/2020. Although the policy itself did not cover damaged skids, documentation revealed the training covered not taping the backs of skids.

Interview with the DON, on 09/02/2021 at 9:10 AM, revealed education emphasized skids could not be taped and discussed the proper way to waste narcotics. She revealed a nurse could sign for a KMA to waste narcotics; however, a KMA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 755	Continued From page 336	F 755		

could not sign for a nurse. She stated drugs were all to be wasted in the Drug Buster, which was a chemical container that drugs were placed in for disposing. She stated staff members were educated on the requirement for two (2) staff to sign for receipt of narcotics.

Interview with LPN #11, on 09/02/2021 at 3:03 PM, revealed she had been educated on the proper way to do a narcotic count at shift change, counting skids and comparing to the number of controlled substance sheets, and wasting medications in the Drug Buster kept in the medication rooms with another nurse witnessing and signing. She stated education also covered the importance of signing and completing the back of the MAR for PRN medications, and signing with another nurse when narcotics arrived. She also stated, if a skid was damaged, to report this to the DON, and if a medication was in danger of falling out of a damaged skid, it was to be wasted with another nurse witnessing and signing. She stated she had seen and experienced management staff, including the DON, doing medication cart audits, and she stayed with her cart while it was being audited.

Interview with RN #3, on 09/02/2021 at 3:14 PM, revealed she had been educated since the drug diversion on the importance of signing out narcotics on the narcotic count sheet as well as the front (and for PRN, the back) of the MAR. She revealed for PRN pain medications, a pre and post pain assessment was documented on the back of the MAR. RN #3 was able to verbalize the procedure for medication cart transfers at shift change and reconciling narcotic counts. RN #3 revealed now, when narcotics were received, two (2) nurses were required to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 755	Continued From page 337	F 755		

sign for receipt.

Interview with LPN #7, on 08/14/2021 at 10:49 AM, revealed when changing medication carts, staff counted the skids that were in the narcotics drawer and counted papers to make sure they matched. Then staff counted the amount of narcotics in each skid. Then both nurses signed off on the narcotic count sheet in the front of the book. LPN #7 revealed she had never had any situation with a missing skid and had never experienced a count being off. She stated, if the count was off, she would go get the DON or Administrator immediately and try to figure out where the missing drugs were. She revealed she would call the on-call nurse first, but also the DON, if the DON was not present to ensure she was aware.

Interview with SRNA #20, a KMA, on 09/02/2021 at 3:39 PM, revealed he received the same education nursing staff received. He revealed education included the importance of signing out narcotics when you gave them and not waiting until the end of the shift to sign them out. He stated he signed them out right after they were given, and if a resident refused, he would mark it as a refusal and have a nurse witness and sign the medication as wasted. He stated, if a pill or skid was compromised, or if anything looked tampered with, he would alert the DON so she could assess and determine if the medications needed to be wasted. He stated corporate nurses had audited his cart recently.

16. Review of the Narcotic Administration Quiz revealed licensed nurses and KMA's completed the written quiz beginning on 07/26/2021. Quiz responses reviewed were appropriate, with no

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 755	Continued From page 338	F 755		

concerns identified during review of the narcotics quizzes.

17. Review of documentation confirmed the Medical Director was updated regarding the PIP's for Abuse and Narcotics and ongoing audits on 07/29/2021.

18. Review of a QAPI Committee meeting agenda, from 08/10/2021, revealed staff was continuing to work on the issue of narcotics misappropriation, with pharmacy continuing to monitor medication administration and narcotics during facility visits. Review of a sign in sheet, dated 08/10/2021, revealed the Medical Director was in attendance at the meeting.

Interview with the Medical Director, on 08/10/2021 at 4:11 PM, revealed the DON had been in contact with him two (2) to three (3) times a week, and had provided him all the PIP's that had been planned. The Medical Director revealed he was extremely pleased at the progress the facility had made addressing their problems.

19. Review of the Narcotic Cart Audit sheets revealed staff completing audits were auditing to ensure (1) all staff were signing the Controlled Substance Count Sheet (CSCS) at shift change, (2) all narcotic sheets had been counted, (3) the number of narcotic count sheets matched the number of skids on the cart, (4) skids on the cart did not have tape on the backs, (5) skids were checked to ensure there were no missing skids, (6) CSCS were being logged in and out of the cart on the Shift Change Controlled Substance Count Check form as the sheet count number changed (new skids arrived, skids were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 755	Continued From page 339	F 755		

completed), and (7) all narcotics were signed out and accounted for.

Review of Narcotic Cart Audit completed on 08/11/21 at 11:42 AM by the DON revealed audit completed with no issues noted or corrective action required or taken. The corporate RN consultant noted the front-north narcotic drawer had a screw sticking out that caused tears/punch hole in back of multiple narcotic skids: The screw was covered.

20. Review of the Narcotic Cart Audit, completed on 08/12/2021 at 5:10 PM, by the DON revealed the audit was completed with no issues noted or corrective action required or taken.

21. Review of the Narcotic Cart Audit, completed on 08/13/2021 at 2:25 PM, by the DON revealed the audit was completed with no issues noted or corrective action required or taken.

22. Review of the Narcotic Cart Audit, completed on 08/18/2021 at 10:30 AM by the SDC/QI, revealed the audit was completed with no issues noted or corrective action required or taken.

23. Documentation review confirmed the DON provided the Medical Director an update call on 08/19/2021.

24. Review of facility documentation, not labeled or dated, revealed a total of one hundred and eight (108) narcotics were documented as missing, which included three (3) skids of thirty (30) medications each that were missing, and four (4) non-controlled medications that were documented as missing. The document listed residents by name, along with discrepancies in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 755	Continued From page 340	F 755		

medication counts noted, the cost for each individual dose, resident payors, and the total cost of all medications reimbursed, which was three hundred and four dollars and ninety-seven cents ($304.97).

25. Review of facility documentation confirmed the DON informed the Medical Director, on 08/20/2021, of the eight (8) IJ tags and the PIP's that were being worked on.

26. Review of documentation entitled Communication with Medical Director, signed by the Medical Director, on 08/28/2021, confirmed the Medical Director was provided an update by the DON on the Immediate Jeopardy (IJ) citations and corrective actions the facility was taking to address the citations.

Interview with the Administrator on 09/02/21 at 6:32 PM revealed he was present for the phone call with the Medical Director on 08/26/21 in which the jeopardy citations were discussed, as well as the audits the facility had been doing and the education the facility had provided. He revealed they went down each one of the tags, discussing issues and what was being done to address issues.

27. Review of Shift Change Narcotic Review sheet completed by SDC/QI, on 08/28/2021, confirmed the north front medication cart was audited, and LPN #6 was verbally quizzed, with no concerns identified.

28. Review of Shift Change Narcotic Review sheets, completed by the SDC/QI, support RN's, and Corporate RN's, revealed medication carts and narcotic documentation were monitored on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 755	Continued From page 341	F 755		

08/28/2021, 08/29/2021, and 08/30/2021, with no issues identified.

Interview with the Clinical Director on 09/02/21 at 9:10 AM revealed she, the SDC, and a sister facility nurse went from cart to cart on 08/28/21 at shift change with their audit tools and went through the packet of audit tools with medication cart staff, asking questions about documentation and reporting. She revealed this process was repeated on 08/29/21 with a nurse from a different sister facility. She revealed there had been no concerns with the audits.

29. Review of Weekend Audits, dated 08/29/2021, confirmed the Administrator and a support RN interviewed staff and residents regarding abuse, code of conduct, and medication administration. Staff was able to answer questions accurately, and residents did not express any concerns during interviews. Further, nursing staff conducted an audit of narcotic documentation and did not determine any concerns.

30. Interview with the Consultant Pharmacist confirmed she visited the facility monthly and conducted a narcotics audit during her monthly visits.

Interview with the DON, on 09/02/2021 at 9:10 AM, confirmed the Consultant Pharmacist conducted monthly visits, reviewed charts, and conducted a medication administration audit. She revealed the only time the Consultant Pharmacist was not coming were times, during the last year, when the facility was in lock down due to the pandemic.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 801	Continued From page 342	F 801		
F 801 SS=D	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the	F 801		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 801	Continued From page 343	F 801		

requirements of paragraphs (a)(1)(i) and (ii) of this section.
(iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law.

§483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services who-
(i) For designations prior to November 28, 2016, meets the following requirements no later than 5 years after November 28, 2016, or no later than 1 year after November 28, 2016 for designations after November 28, 2016, is:
(A) A certified dietary manager; or
(B) A certified food service manager; or
(C) Has similar national certification for food service management and safety from a national certifying body; or
D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; and
(ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and
(iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional.

This REQUIREMENT is not met as evidenced by:
Based on interview, record review, and review of the facility's job description, it was determined the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 801	Continued From page 344	F 801		

facility failed to meet current requirements for a qualified Dietary Manager. The current Dietary Manager (DM) was not certified or currently enrolled in a Certified Dietary Manager (CDM) course, as to meet the requirements to be certified within one (1) year after hire. In addition, the Consultant Registered Dietitian (RD) was not available to provide proper supervision/consultations for the Dietary Manager.

The findings include:

Review of the facility's job description titled, "Food Service Manager," dated 01/12/2007, revealed the primary purpose of the position was to plan, organize, develop, and direct the overall operation of the Dietary Department. In addition, the job description stated the Dietary Department must be operated in accordance with the current applicable federal, state, local standards, guidelines, regulations, the facility's established policies and procedures, and as could be directed by the Administrator, Regional Vice President, Consultant, and Dietitian, to assure that quality food service was provided at all times.

Review of the Health Department certificate titled, "Certified Food Service Manager," with an expiration date of 12/12/2022, revealed the certificate belonged to the Assistant Food Service Manager, which showed she was a Certified Food Service Manager. The facility did not have a copy of the Health Department certificate titled "Certified Food Service Manager" for the Dietary Manager.

Review of the Health Department report, dated 01/29/2021, revealed staff needed training for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 801	Continued From page 345	F 801		

food managers and food handlers certificates.

Review of the Dietary schedule, dated 08/2021, revealed, on 08/02/2021 and 08/16/2021, there was no Certified Food Service Manager or Certified Dietary Manager coverage for the evening shifts to provide supervision.

Review of the consulting company's form Validation of Supervision, not dated, revealed the Consultant RD would provide an approximate number of RD supervision hours per month, of thirty-two (32) to forty-eight (48) hours, which corresponded to eight (8) to twelve (12) hours per week. Continued review of the form revealed the current RD agreed to provide supervision of dietary services to ensure overall quality of care for residents of the facility.

Review of the calendar for the RD's facility visits, dated 07/2021, revealed the RD planned visits on 07/02/2021, 07/09/2021, 07/16/2021, 07/23/2021, and 07/30/2021. Continued review of the calendar, dated 08/2021, revealed the RD planned visits for 08/12/2021 and 08/26/2021.

Review of the consultant company's form SupremeCare Dietary Department Review-Score Card, dated 06/2021, revealed many areas of concern throughout the month. The final report was signed by the RD on 06/25/2021.

Interview on 08/11/2021 at 12:19 PM with the Consultant Registered Dietitian (RD), revealed she visited the facility during July 2021 once a week on Friday's. She stated she walked through the kitchen, did sanitation audits, and provided a list of the top five (5) things needed to be addressed. She stated she had spoken with the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 801	Continued From page 346	F 801		

Interim Administrator about hiring a CDM. The consultant company, she stated, had instructed her not to enter a facility with an active case of COVID. Per the interview, she stated she was available by phone for questions by the Dietary staff.

Interview with the Assistant Dietary Manager, on 08/13/2021 at 3:00 PM, revealed the RD was here last week. She stated she called the RD and often sent messages with questions to her. In addition, she stated sister facilities were available to assist the facility with food service as needed. The Assistant Dietary Manager stated the RD conducted sanitation walk-throughs and talked with dietary staff about sanitation of the department. She stated the RD provided staff copies of the sanitation inspections the RD performed.

Interview with the Dietary Manager (DM), on 08/13/2021 at 3:15 PM, revealed she had been employed at the facility for one (1) year. She stated the RD was present at the facility last week. She stated the contract company's policy for the RD was for her to only visit virtually with an active case of COVID in the building. The DM also stated she could not locate any earlier copies of the RD inspection reports prior to 06/2021. She stated she had been offered Certified Dietary Manager (CDM) classes, but had not been able to schedule the classes yet.

Interview with the Director of Nursing (DON), on 08/18/2021 at 10:48 AM, revealed the RD had not visited the facility lately due to a resident with an active case of COVID, and the contract company did not allow her to enter the building. The DON stated the RD used electronic means for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 801	Continued From page 347 meetings to communicate with the facility; however, the RD was not able to enter the kitchen for visits. Per the interview, the DON said the RD usually scheduled visits once weekly to the facility. Interview with the Interim Administrator, on 08/18/2021 at 3:55 PM, revealed the role of the RD consultant was to provide training and improve the quality of food in the facility. He stated the RD visited the facility and provided a report of her recommendations for the kitchen. The Administrator further stated he would prefer the RD to visit more often to provide the needed training for Dietary Staff and provide quality food for the residents, especially in the absense of a Certified DM.	F 801		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 812	Continued From page 348	F 812		

standards for food service safety.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review, and review of the facility's policies, it was determined the facility failed to store, prepare, and distribute food under sanitary conditions and in accordance with professional standards for food safety.

Observations, during the initial tour on 08/09/2021 and the tour on 08/10/2021, revealed dried grease on a wall, frozen hamburger on the top shelf of the walk-in refrigerator, and condensation falling from the air conditioner vent. Continued tour of the nourishment refrigerators on the North, South, Memory Care Units, and the Dining Room revealed the temperatures for freezers not recorded.

The findings include:

Review of the facility's policy titled, "Cleaning of Equipment and Utensils," not dated, revealed nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris.

Review of the facility's form "Assigned Cleaning Jobs," not dated, revealed only two (2) initialed tasks completed by staff. Per the form, on 07/03/2021, under cooks, revealed only one (1) signature for deep fryer. In addition, the form showed, on 07/27/2021, there was only one (1) initial for Walk-in Cooler, straighten and sweep. Per the form, the wall behind the fryer area, between the production equipment, was not listed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 812	Continued From page 349	F 812		

Review of the facility's policy titled, "Preparation of Raw Fruits and Vegetables," dated 08/2013, revealed fresh fruits and vegetables would be stored away from potentially hazardous foods and below ready to eat foods.

Review of the facility's form Temperature Chart for Refrigerators and Freezers, dated 08/2021, revealed for the four (4) nourishment unit refrigerators located on the North, South, Memory Care Units, and the main Dining Room, documentation of the refrigerator temperatures. However, the temperature chart revealed there was no documentation of the freezer temperatures, for the four (4) refrigerators, from 08/01/2021 to 08/10/2021.

Observation, on 08/09/2021 at 3:32 PM, with the Assistant Dietary Manager during the initial kitchen tour, revealed a frozen roll of hamburger on the second shelf from the top shelf in the walk-in refrigerator; there was no pan underneath. Further observation revealed the Assistant Dietary Manager moved the roll of hamburger to a lower shelf. Further observation of the kitchen revealed the wall between the production equipment had the appearance of dried grease.

Interview with the Assistant Dietary Manager, on 08/09/2021 at 3:32 PM, revealed the frozen hamburger roll should not have been left on an upper shelf in the walk-in refrigerator. The Assistant Dietary Manager stated frozen hamburger should have been placed on the lowest shelf to prevent any juice from dripping onto other foods and to prevent the potential for cross contamination.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 812	Continued From page 350	F 812		

Observation, on 08/10/2021 at 9:00 AM, during the continued tour of the kitchen, revealed inside the main entrance door, ceiling tiles with water stains and peeling tile. The appearance of grease remained on the wall between production areas.

Observations of the four (4) unit nourishment refrigerators, on 08/10/2021 between 8:40 AM and 9:07 AM revealed in the North Unit, Memory Care Unit, and Dining Room, there were no thermometers in the freezer and no freezer temperature documentation. In addition, observation in the South Unit revealed no documentation of freezer temperature, but a thermometer was present. Further observation of the North Unit refrigerator revealed a blue, flowered cloth snack bag that was not labeled with an identification, room location, or date. The blue, flowered cloth snack bag contained perishable snack foods. Additionally, a clear plastic cup was found left in the ice chest.

Observation of the kitchen, on 08/10/2021 at 11:15 AM, during the lunch resident tray line, revealed the appearance of dried grease remained on the wall behind the production equipment. In addition, the air duct near the food service line was observed with condensation and dripping, between the resident tray line and the refrigerator, to the floor.

Interview with the Consultant Registered Dietitian (RD), on 08/11/2021 at 12:19 PM, revealed she visited once weekly, usually on a Friday. She stated she conducted sanitation audits and provided the top five (5) things to work on after her visits. She stated she tried to stay in touch

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 812	Continued From page 351	F 812		

with the department and was contacted often by the managers of the department. Per the interview, she stated the wall behind the production equipment that had the appearance of dried grease on it should be cleaned before the wall was cladded with stainless steel, which was planned for in the near future.

Interview with the Dietary Aide/Cook and Dietary Aide #1, on 08/13/2021 at 2:47 PM, revealed the frozen hamburger should be kept on the bottom shelf and not over other foods. They stated hamburger, as it thawed could drip onto other foods and cause cross contamination, so it needed to be stored on the bottom shelf. According to the cleaning list, they said, grease on the wall should be wiped down daily, but it was not. They stated the cleaning chart was only checked twice weekly, and staff should sign when an area was cleaned. Per the interview, both stated that staff rotated jobs every other week. They also said the staff took food stock to the nourishment refrigerators and were responsible to record the refrigerator temperatures only and not the freezer temperatures. However, both of the dietary aides stated the freezer temperatures should be recorded to ensure correct operation and to prevent food spoilage.

Additional interview with the Assistant Dietary Manager, on 08/13/2021 at 3:00 PM, revealed again the frozen hamburger roll should not have been left on an upper shelf in the refrigerator; it should have been left on the lowest shelf to prevent any juice from dripping onto the other foods and create the potential for cross contamination. She stated the cleaning schedule was weekly, and if she had time, she would check if cleaning had been done. She stated staff were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 812	Continued From page 352	F 812		

responsible to clean their area after every use, including the wall behind the fryer because grease could attract insects and grow bacteria. The drips over the resident tray line, she stated, could create the potential for cross contamination. She further revealed she called the Consultant RD, and the RD messaged them often. She stated the Consultant RD talked with dietary staff about sanitation of the department and possibly provided copies to the administrator of the content of the talks. The Assistant Dietary Manager stated the RD could only visit virtually due to the Consultant RD company policy with COVID in the facility.

Interview with the Dietary Manager (DM), on 08/13/2021 at 3:15 PM, revealed the hamburger was left on the wrong refrigerator shelf, and it was moved from the top shelf to the bottom shelf to prevent cross contamination of other foods. She stated the cleaning list was posted for the month with assigned areas and extra areas to clean, and the posted cleaning schedule was signed by staff about half of the time. Per the interview, the DM stated the wall in the production area had grease and needed to be cleaned to prevent cross contamination of food. The DM further revealed maintenance could not address the water dripping over the resident tray line, and she was not aware of the peeling ceiling tiles above the door, which could cause cross contamination of food. She further stated the Consultant RD visited last week; however, due her company policy, her visit was virtual because of the case of COVID in the facility. Additionally, she stated it was important to record nourishment freezer temperatures to check the operation of the freezer.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 812	Continued From page 353	F 812		

Interview with Kentucky Medication Assistant (KMA) State Registered Nursing Assistant (SRNA) #8, on 08/13/2021 at 3:42 PM, revealed, on the North Unit, the plastic cup left in the ice chest should not have been left there due to concerns with infection control.

Interview with Licensed Practical Nurse (LPN) #6, on 08/13/2021 at 3:43 PM, revealed no cup or scoop should be left in the ice chest due to concerns with infection control. She also stated all resident food items should be identified and dated when placed into the nourishment refrigerator.

Interview with the Maintenance Director, on 08/14/2021 at 10:00 AM, revealed not much could be done with the air conditioning system in the kitchen.

Interview with Registered Nurse (RN) Quality Improvement/Infection Control Preventionist/Staff Development Coordinator, on 08/16/2021 at 10:38 AM, revealed her expectation for the kitchen was for it to be clean/sanitary and for staff to follow the cleaning schedule to prevent cross contamination of food. She stated the grease should be cleaned off the wall before it was clad with stainless steel to prevent the spread/build up of bacteria. Further, she stated the freezer temperature should be recorded on all the nourishment refrigerators to prevent food spoilage. In addition, she stated there was an infection control concern with the plastic cup left in the ice chest and the potential for cross contamination.

Interview with the Director of Nursing (DON), on 08/16/2021 at 11:53 AM and 08/18/2021 at 10:48

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 812	Continued From page 354 AM, revealed she expected the kitchen to be clean, sanitized, and staff to follow the cleaning schedule. She stated she expected the kitchen wall in the production area to be cleaned of grease to prevent possible fire, bugs, growth of bacteria, and cross contamination of food. All staff, she said, needed to record nourishment refrigerator freezer temperatures to prevent food spoilage if the freezer was not working properly. The DON stated a plastic cup should not be used to scoop out of the ice chest and presented a potential for physical cross contamination. Per the interview, the DON stated the Consultant RD had been scheduled to visit weekly; however, during any facility reported case(s) of COVID, the RD could only perform virtual visits. Interview with the Interim Administrator, on 08/18/2021 at 3:55 PM, revealed he expected staff to follow the cleaning schedule for cleanliness and sanitation of the kitchen. In addition, he stated the Maintenance Director should address any concerns related to repairs. Per the interview, he stated nourishment refrigerators on the units should record the freezer temperatures to keep food at a safe temperature. Further, the Administrator said he expected the Consultant RD to be available to train the staff and promote quality of food for the residents. Additionally, he stated the RD provided him reports with her dietary recommendations.	F 812		
F 835 SS=K	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and	F 835		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 835	Continued From page 355	F 835		

efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

This REQUIREMENT is not met as evidenced by:
Based on interview, record review, review of the Administrator's Job Description, and review of the facility's policies, it was determined the facility failed to be administered in a manner that enabled effective use of its resources to attain and maintain the highest practicable physical, mental, and psychosocial well-being for three (3) of forty-four (44) sampled residents (Residents #9, #82, and #242).

Allegations of drug diversion had been identified by the facility, for Residents #9 and #82, but this information was not acted upon by administration, leading to further drug diversion and placing residents at risk.

Despite allegations implicating Licensed Practical Nurse (LPN) #1 in drug diversion, as well as the implication of LPN #2, on 07/09/2021. The facility's administration failed to take appropriate actions to ensure resident safety, which led to residents being placed in danger. On 07/18/2021, police found LPN #1 to have in her possession controlled mediations that were the property of residents. The LPN had Oxycodone (Scheduled II narcotic), Tramadol (opiate narcotic analgesic), Hydrocodone (Scheduled II narcotic), and Gabapentin (Scheduled III anticonvulsant). Additionally, LPN #1 was found to have Primidone on her person, a non-controlled

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 835	Continued From page 356	F 835		

anti-convulsive medication, which she stated she had switched with Resident #32's and Resident #84's controlled medications.

Further, on 01/26/2021 at 6:30 PM, LPN #15 assessed Resident #242 to be non-responsive with no pulse and called a Code Blue. The Staff Development Coordinator/Quality Improvement (SDC/QI) nurse responded to the resident's room and initiated chest compressions. The previous Administrator responded to the code and provided breaths to the resident without a mask. After two (2) minutes of cardiopulmonary resuscitation (CPR), LPN #15 alerted the SDC/QI and previous Administrator that Resident #242 had a pulse and to stop chest compressions. However, the previous Administrator directed that CPR could not stop until the resident had a pulse of sixty (60) beats per minute (bpm) or a physician's order to stop CPR. Additionally, the previous Administrator placed her hands over the SDC/QI nurse's hands and forced chest compressions for approximately one (1) more minute. Emergency Medical Services (EMS) arrived on-site and transported the resident to the local hospital.

The facility failed to have an effective system to ensure staff were familiar with the facility's policies related to Cardiopulmonary Resuscitation (CPR) in accordance with standards of practice for sampled Resident #242.

The facility's failure to be administered in an effective manner enabled misappropriation of medications to occur and failure to ensure that the Administrator followed facility policies, has caused, or is likely to cause, serious injury, harm, impairment, or death. Immediate Jeopardy (IJ)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 835	Continued From page 357	F 835		

was identified on 08/20/2021, and determined to exist on 01/26/2021, in the areas of 42 CFR 483.70 Administration, F-835 Administration at a Scope and Severity (S/S) of a "K." The facility was notified of the IJ on 08/20/2021.

The facility provided an acceptable Immediate Jeopardy Removal Plan, on 09/01/2021, alleging removal of the IJ on 08/31/2021. The State Survey Agency determined the IJ had been removed on 08/31/2021, as alleged, prior to exit on 09/02/2021, with remaining non-compliance at a S/S of an "E" while the facility develops and implements a Plan of Correction and the facility's Quality Assurance (QA) monitors to ensure compliance with systemic changes.

In addition, the Administrator failed to follow guidance provided by corporate regarding the spending of residents' Stimulus monies. Purchases of durable medical equipment (DME), which the facility should have provided, were made using residents' Stimulus monies,

The findings include:

Review of the facility's job description titled, "Administrator," dated 07/01/2016, revealed the Administrator was accountable to the Vice President of Operations and had the overall purpose of directing facility operations in accordance with current federal, state, and local standards, guidelines, and regulations, to assure that the highest degree of quality resident care was maintained at all times. Under major duties and responsibilities, the Administrator ensured resident rights to fair and equitable treatment, property, and civil rights, including the right to ensure that compliant was well-established and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 835	Continued From page 358	F 835		

maintained at all times. Further review revealed, under duties, the Administrator was responsible for reviewing and monitoring the competence of the work force and assuring the facility was maintained in a safe manner for resident comfort and convenience.

Review of the facility's policy titled, "Administrative Policies," dated 01/2009, revealed, in the section on Philosophy, that each person had physical, mental, emotional, and spiritual needs and rights that must be respected and advocated for and must not be violated.

Review of the facility's policy titled, "Abuse, Neglect, or Misappropriation of Resident Property Policy," last revised 03/10/2017, revealed the facility would do whatever was in its control to prevent misappropriation of resident property. The policy revealed the Administrator was responsible to ensure complaints of misappropriation of property were investigated and to report allegations to the appropriate agencies. Under the section on Prevention, the policy revealed staff would investigate allegations in a timely manner and develop corrective measures as indicated. Under the section on Investigation, the policy revealed the Administrator was responsible to direct the investigation and to ensure appropriate agencies were notified. The appropriate agencies for the facility, included the Division of Licensure and Regulation (Office of Inspector General/State Survey Agency) and Adult Protective Services.

Review of the facility's CPR policy, titled "Cardiopulmonary Resuscitation, Nursing Procedure Manual," Version Date: April 2013, revealed the objective was to ventilate the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 835	Continued From page 359	F 835		

resident until adequate circulation to the brain was reestablished. Procedure steps included to call 911 if the resident was not breathing and begin CPR. The policy instructed that CPR would continue for two (2) minutes, then stop, check for breathing; if the resident was not breathing, repeat the process, checking for breath every (2) minutes. The policy stated the CPR process was to continue until there were signs of life, another rescuer took over, EMS arrived and took over, or a Physician gave an order to discontinue CPR.

The former Administrator was not available during the course of the survey and did not return calls, the last of which was attempted on 08/20/2021 at 9:48 AM.

Interview with Registered Nurse (RN) #2, on 08/03/2021 at 3:33 PM, revealed Licensed Practical Nurse (LPN) #1 had previously worked with the Administrator in another facility, at which LPN #1 had been terminated due to drug diversion issues while the Administrator had been employed there. She revealed the Administrator hired LPN #1 despite her history and allowed her to administer medications.

Interview with the Corporate Business Office Trainer (CBOT), on 08/17/2021 at 2:51 PM, revealed the Administrator reported to the Regional Vice President who was his/her supervisor. The CBOT stated guidelines for use of resident Stimulus checks were sent to the Administrators originally, on 05/2020, and when revised, on 07/2020. The CBOT stated the former Administrator failed to follow the guidance provided.

Interview with the Director of Nursing (DON), on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 835	Continued From page 360	F 835		

08/04/2021 at 8:28 AM, and again, on 08/18/2021 at 10:48 AM, revealed the former Administrator made many decisions without involving other staff and did not delegate authority or keep other staff involved. She revealed she was not part of the trigger call (a call between management staff and corporate regarding facility concerns and reportable incidents), on 07/09/2021, when the decision was made by the Administrator and corporate not to suspend LPN #1 or LPN #2, despite evidence one (1) of them had diverted medications.

Interview with the Interim Administrator, on 08/20/2021 at 10:24 AM, revealed the Administrator was the Chief Operating Officer of the facility and was responsible for each action and decision in the building. He stated the Administrator was responsible to investigate any concerns thoroughly.

Interview with the Regional Vice President (RVP), on 08/20/2021 at 3:03 PM, revealed the Administrator was responsible to report to him allegations of medication misappropriation and any identified concerns. He stated he was not aware of previous concerns identified by residents and staff regarding LPN #1, when he participated in a trigger call on 07/09/2021. He further stated the former Administrator did not make him aware of the concerns about CPR and Resident #242. The RVP stated the facility had processes and systems in place to catch or identify concerns, and it was the Administrator's responsibility to bring anything to his attention.

Interview with the Senior Vice President, on 08/20/2021 at 1:40 PM, revealed it was her absolute expectation that the Administrator keep

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 835	Continued From page 361	F 835		

the RVP aware of situations going on at the facility. Then, she stated, the RVP could ensure the facility followed established policies, which were in place to protect residents.

The facility provided an acceptable Immediate Jeopardy Removal Plan, on 09/01/2021, that alleged removal of the IJ on 08/31/2021. The facility implemented the following:

1. On 07/12/2021, 07/13/2021, 07/20/2021, 07/21/2021, 07/22/2021, 07/24/2021 to 08/13/2021, and 08/22/2021 to 08/29/2021, an RN Corporate consultant worked in the facility. An RN Corporate nurse (CN) continued at the facility to provide oversight of the performance improvement plan (PIP) five (5) days a week, including nights and weekends, through September 2021. An RN CN could complete any audit in place of the assigned auditor, and assist with education. The RN CN would speak with the Administrator and/or Regional Vice President (RVP) five (5) days a week through September 2021. The RN CN would help ensure the facility's governing body was effective in establishing and implementing policies regarding the management and operation of the facility.

2. On 07/12/2021, the DON, SDC/QI nurse, MDS nurses, Unit Manager (UM), Nurse Supervisor, Principle LTC RN's not employed by the facility (support RN's), and corporate nurses started audits of medication carts and narcotic medication documentation. The audits included: locking carts, Medication Administrator Records (MAR), shift change count sheets, signatures, declining count sheets, wasted narcotics, back side of narcotic medication skids, skid cards numerical order, no missing skids, all narcotics

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 835	Continued From page 362	F 835		

accounted for, and/or pharmacy packing slips. These audits were completed five (5) times weekly. Any missing, incomplete, or incorrect documentation would be immediately reported to the DON and/or Administrator for investigation. Any concerns and trending would be reviewed and discussed weekly on Fridays. The audits would continue until the Quality Assurance Performance Improvement (QAPI) committee determined the audit frequency could be reduced. The QAPI Committee consisted of the Administrator, DON, Infection Preventionist, Medical Director, Social Worker, Medical Records Director, Dietary Manager, and Housekeeping Supervisor, plus additional staff members as deemed necessary.

3. On 07/21/2021, the RVP arrived on-site to initiate and coordinate the investigation. The investigation focused on abuse/neglect/misappropriation of resident/residents' property.

4. On 07/21/2021, the RVP interviewed and suspended the facility Administrator.

5. On 07/21/2021 through 07/23/2021, the RVP provided administrative coverage for the facility.

6. On 07/23/2021, the Interim Administrator participated in a QAPI meeting to go over the current plan of correction that was developed by the QAPI Committee.

7. On 07/27/2021, the RVP educated and reviewed, with the Interim Administrator, the responsibilities of the management and operation of the facility and reviewed job duties with the Interim Administrator.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 835	Continued From page 363	F 835		

8. On 07/27/2021 to 08/09/2021, the RVP provided oversight to the Interim Administrator.

9. On 08/20/2021, a Code of Conduct in-service was initiated by the corporate staff with all nurses, nursing assistants, housekeeping staff, therapy staff, department managers, and dietary staff. The in-service emphasized the guidance and reporting integrity line, compliance officer, and employee affirmation statement to validate knowledge and understanding of the training in the Code of Conduct book. Staff who were not working would be mailed a copy of the in-service.

10. On 08/21/2021 employee surveys were amended and initiated by the SDC/QI, DON, and RN CN consultant, with questions to include but not limited to (1) Do you have any concerns? (2) Is Management addressing your concerns? and (3) Do you know who to report Management related concerns to? The RVP would review all identified areas of concern from the employee surveys with oversite by the RN CN consultant. Seventy-nine percent (79%) of staff completed in-person training, and twenty-one percent (21%) received education by mail. This education will be provided to new staff and new agency staff at orientation.

11. On 08/23/2021, the Senior Vice President of Health Services trained the RVP on responsibilities of the management and operation of the facility.

12. On 08/23/2021, the RVP reviewed all audits and in-services related to tags F-600, F-602, F-610, F-658, F-678, F-755, and F-835 for completion and to ensure all areas of concern

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 835	Continued From page 364	F 835		

were addressed. The RN CN consultant would provide oversite to ensure compliance.

13. On 08/23/2021 and 08/24/2021, the Vice President of Employee Experience was at the facility offering education on the Code of Conduct and providing support to the Interim Administrator.

14. On 08/23/2021 through 08/27/2021 and on 08/30/2021, a sister facility Administrator was on-site to provide guidance and support to the Interim Administrator.

15. On 08/23/2021 through 08/27/2021, a sister facility Administrator was on-site to provide education and quiz staff on the Code of Conduct. Also, the sister facility Administrator talked with staff to complete employee surveys.

16. On 08/26/2021, the RVP brought in the new Administrator. The RVP educated the new Administrator to include the Appointment Letter as Facility Administrator. The Appointment Letter outlined the Administrator's responsibilities: enforce rules and regulations; and maintain an ongoing liaison among the governing body, medical and nursing staff, and other professional and supervisory staff of the facility. The facility had a five (5) times a week interdisciplinary team (IDT) meeting, which was part of the quality assurance process, during which the RN CN attended. And, the RVP attended the IDT meeting during facility visits.

17. On 08/26/2021 through 08/29/2021, the RVP, sister facility Administrator, and RN CN educated the new Administrator on: abuse, misappropriation, investigations, ensuring

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 835	Continued From page 365	F 835		

pharmacy practices were in place, professional standards for all tags, the Administrator's role of oversight as it relates to all issues identified in the plan of correction, policies and procedures in place for the Administrator, and how the Administrator would ensure policies were followed.

18. On 08/28/2021 through 08/29/2021, multiple sister facilities provided support RN's. The support RN's assisted with auditing medication carts and monitoring shift change narcotic counts. Also, support RN's reinforced with staff education and executed a Code Blue Drill.

19. The RVP was the facility's governing body and was responsible for ensuring the new Administrator knew his role so oversight of the policies and procedures was effective.

20. Narcotic Cart Audits were completed five (5) times weekly. Any missing, incomplete, or incorrect documentation would be immediately reported to the DON and/or Administrator for investigation. Any concerns and trending would be reviewed and discussed weekly on Fridays. The audits would continue until the Quality Assurance Performance Improvement (QAPI) committee determined the audit frequency could be reduced.

21. The Pharmacy Consultant would visit the facility at least monthly to validate narcotics were being monitored and counted per standard of practice.

22. The facility increased the QAPI Committee meetings from quarterly to monthly for three (3) months, beginning on 08/10/2021. The QAPI

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 835	Continued From page 366	F 835		

committee meetings would include the Medical Director and at least two (2) corporate staff.

23. A Corporate Vice President continued to provide oversight of the facility. Oversight was provided daily via telephone and weekly via on-site visits through September 2021.

The State Survey Agency validated the implementation of the facility's Immediate Jeopardy Removal Plan as follows:

1. Interview, on 09/02/2021 at 9:10 AM, with the Clinical Director revealed she, and prior to her arrival, the Facility Consultant, had been in the facility on the dates documented in the IJ Removal Plan. She revealed her daily routine consisted of talking to residents on both the South and North halls of the building, observing staff providing care, and talking with staff. She revealed she conducted chart reviews and audits, and validated the facility was continuing audits and doing everything they were supposed to be doing. The Clinical Director stated she had made surprise visits to the facility at 2:00 AM, as well as on weekends, to ensure staff was following procedures they had been educated on and to provide immediate education where needed.

2. Review of documentation revealed the DON audited all medication carts, on 07/13/2021, confirming staff was signing in and out of medication carts as expected, narcotic skids were being counted as expected, and the narcotic count sheets matched the number of narcotic skids in the cart.

Continued review revealed ongoing audits beginning on 07/21/2021 were completed on the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 835	Continued From page 367	F 835		

Narcotic Cart Audit tool, which monitored for (1) all staff signing controlled substance sheet at shift change, (2) all narcotic sheets had been counted, (3) sheet count matched the medication cart count, (4) back of cards checked for tape, (5) cards checked to ensure no missing skids (1 of 2, 2 of 2), (6) sheets were being logged in/out of medication carts as sheet count number changed, and (7) all narcotics were signed out and accounted for. Audits reviewed were completed by the DON, SDC/QI, MDS nurse, support RN's, and corporate nurses. No concerns were identified in the review of audits.

3. Interview with the RVP, on 09/02/2021 at 7:07 PM, revealed he was present at the facility with other corporate personnel, on 07/21/2021 as a result of the 07/18/2021 drug diversion situation with LPN #1.

4. Continued interview with the RVP, on 09/02/2021 at 7:07 PM, revealed as a result of corporate investigation, the RVP stated there were concerns with how the former Administrator had handled the drug diversion situation, resulting in her suspension from the facility.

5. The RVP stated, in the 09/02/2021 at 7:07 PM interview, he was at the facility from 07/21/2021 through 07/23/2021 acting in the capacity as Administrator while that position was vacant.

6. Review of the QAPI Meeting minutes, dated 07/23/2021, confirmed the Interim Administrator attended the meeting in which the facility plan to correct identified deficiencies was reviewed.

7. Review of documentation confirmed the RVP reviewed the responsibilities of the Interim

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 835	Continued From page 368	F 835		

Administrator regarding management and operation of the facility on 07/27/2021.

8. Interview with the RVP, on 09/02/2021 at 7:07 PM, confirmed he was present to provide support and oversight for the Interim Administrator, from 07/27/2021 through 08/09/2021.

Interview with the Interim Administrator, on 08/05/2021 at 2:48 PM, confirmed the RVP had been available and provided guidance in facility management.

9. Review of Code of Conduct in-servicing, revealed a sign-in sheet documenting all staff had completed training. Review of employee quiz information revealed employees were educated on reporting of fraud or abuse, as well as the availability of the corporate compliance line, and the ability to make anonymous reports if desired, with the goal of ensuring all potential violations were reported and addressed.

Interview with State Registered Nurse Aide (SRNA) #24, on 09/02/2021 at 3:30 PM, revealed she had received training on the Code of Conduct, which included abuse, neglect, misappropriation, what to report, who to report to, and when to report. She revealed if she were to report an allegation to her supervisor and did not feel like it was being addressed, she could contact the DON and Administrator, as well as call or fax the corporate compliance line.

Interview with the Occupational Therapist, contracted to work at the facility, revealed she had received the Code of Conduct in-service, which covered abuse, neglect, and misappropriation. She revealed she would report

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 835	Continued From page 369	F 835		

any allegations to her supervisor, and if she did not feel they were being addressed, to the DON, Administrator, and finally the corporate compliance line.

10. Review of the facility's surveys, amended as of 08/21/2021, revealed staff was interviewed by the Clinical Director and other non-facility staff with questions, which included (1) Do your residents have what they need? (2) Do you have any concerns? (3) Is management addressing your concern? and (4) Do you know who to report management related concerns to?

Interview with the DON, on 09/02/2021 at 1:18 PM, revealed corporate personnel had been doing the employee surveys, as had staff from sister facilities. She stated no one had brought any concerns to her.

Interview with Housekeeper #4, on 09/02/2021 at 2:27 PM, confirmed she had received papers and had been interviewed by corporate asking if she had any concerns.

11. Review of Complete In-Service Training Report with Staff Attending, dated 08/23/2021, confirmed the Senior Vice President trained the RVP on facility management, to include the role of the RVP, the responsibility of the RVP to make sure policies were established and implemented regarding management and operation of the facility, and the responsibility of the RVP for appointing the licensed Administrator who reported to and was accountable to the RVP.

12. Review of a Governing Body Internal Audit confirmed the RVP completed review of inservices and audits on 08/23/2021. Continued

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 835	Continued From page 370	F 835		

review revealed the RVP reviewed inservices and audits again, on 08/25/2021 and 08/29/2021.

13. Review of quizzes on the Code of Conduct confirmed employees were trained and tested on 08/23/2021 and 08/24/2021. Review of the Principle LTC Code of Conduct booklet, revised 04/2019, revealed "Principle LTC is committed to its role in preventing health care fraud and abuse and complying with applicable state and federal laws related to health care fraud and abuse." The booklet provided guidance on the reporting chain of command, as well as the availability of the corporate compliance phone number.

14. Review of documentation confirmed a licensed Administrator from a sister facility was on-site 08/23/2021 through 08/27/2021 and again on 08/30/2021.

15. Review of documentation, to include Employee Surveys, revealed the sister facility Administrator met with staff and provided education on the Code of Conduct.

16. Review of the Appointment Letter as Facility Administrator, dated 08/26/2021, confirmed the RVP appointed the new Administrator on 08/26/2021. Review of an Administrator job description, dated 08/26/2021, confirmed the Administrator reviewed and agreed to his job duties and responsibilities.

Interview with the Administrator, on 09/02/2021 at 6:32 PM, revealed he was informed the previous Administrator was not following processes corporate wanted to be followed. He stated he wanted to make sure he knew what had occurred when he was came into this situation. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 835	Continued From page 371	F 835		

Administrator stated he had gone into facilities before that had IJ situations. He revealed if the Administrator worked hard and took care of staff, they took care of the residents.

17. Continued interview with the Administrator, on 09/02/2021 at 6:32 PM, confirmed several other sister facility Administrators had gone over policies, the grievance process, self-reportables, investigation requirements, and follow up with staff doing root cause analysis. He stated they educated him on timeliness of reporting, what to report, keeping corporate in the loop so they could provide direction, and following through until there was a resolution. He revealed nurses went over the CPR process, to include once there was a pulse CPR was stopped, and that was discussed on a call with the Medical Director as well, to follow Basic Life Support (BLS) guidelines.

Continued interview with the Administrator, on 09/02/2021 at 6:32 PM, revealed he received additional education by the RVP over governing and training of the QAPI process and the Facility Assessment. He stated the big focus was the QAPI report, daily IDT in morning meetings with follow up in afternoon meetings, and communicating that process. The Administrator stated the RVP stressed the importance of reporting to the RVP. The Administrator revealed the RVP had a weekly call with all Administrators and DON's, every Tuesday.

18. Review of a Quality Initiative (QI) CPR Drill, dated 08/29/2021, confirmed support RN's executed a Code Blue Drill during day shift. Review of the drill revealed staff responded appropriately, with no retraining required.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 835	Continued From page 372	F 835		

Review of the Narcotic Cart Audits confirmed support RN's conducted audits on 08/28/2021 and 08/29/2021 of all facility medication carts, with no concerns identified.

Continued interview with the DON, on 09/02/2021 at 1:18 PM, confirmed staff did well on the CPR drill and responded appropriately.

Interview with the Clinical Director, on 09/02/2021 at 9:10 AM, revealed, on 08/28/2021 and 08/29/2021 a mock survey/audit was done, by her and sister facility support RN's, on all medication carts. The Clinical Director revealed there had been no concerns identified during their audits.

Interview with the SDC/QI, on 09/02/2021 at 4:49 PM, revealed she was uncertain what was written in the plan of correction regarding frequency of CPR drills, but she planned on ensuring CPR drills were conducted at least monthly for six (6) months, then maybe quarterly after that. She revealed she had been present during all three Code Blue drills, and it seemed like they were getting a little smoother each time.

19. Review of the Quality Assurance and Performance Improvement Guidance Manual, revised 06/26/2019, revealed the RVP functioned as the governing body, appointed the Administrator, and with the Administrator, was accountable for developing, leading, and closely monitoring the facility QAPI program for which the facility administration was responsible.

Interview with the RVP, on 09/02/2021 at 7:07 PM, revealed he had known the new Administrator for many years, describing him as a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 835	Continued From page 373	F 835		

fine gentleman, an Administrator that had been with and was familiar with the company, and a very trustworthy individual that was going to do what was right for the resident. The RVP stated he felt comfortable with him being in this role.

20. Review of the Narcotic Cart Audits confirmed audits were being conducted five (5) times a week or more frequently. Review of audits revealed no concerns identified.
Review of Cardinal IDT Meeting Minutes, dated 08/30/2021, confirmed audits were being reviewed.

21. Interview with the Pharmacy Consultant, on 08/13/2021 at 10:31 AM, confirmed she visited the facility monthly and conducted a narcotics audit during her monthly visits.

Interview with the DON, on 09/02/2021 at 9:10 AM, confirmed the Pharmacy Consultant conducted monthly visits, reviewed charts, and conducted a medication administration audit. She revealed the only time the Pharmacy Consultant was not coming were times during the last year when the facility was in lock down due to the pandemic.

22. Interview with the Clinical Director, on 09/02/2021 at 1:18 PM, revealed the first QAPI meeting was held on 08/10/2021, and there would be additional QAPI meetings in September and October. She stated the Medical Director had attended on 08/10/2021, and the dates for the September and October meetings had not yet been set, as the plan was to schedule them to ensure the Medical Director would be in attendance.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 835	Continued From page 374 23. Continued interview with the Clinical Director, on 09/02/2021 at 1:18 PM, revealed the RVP did onsite visits and phone calls and had been at the facility frequently since the incident of drug diversion. She revealed whenever the RVP was not present, RVP #2, or another corporate Vice President was present at the facility. Continued interview with the RVP, on 09/02/2021 at 7:07 PM, revealed he worked with the Administrator and the facility as an overseer to ensure they had what they need. He stated, as RVP, he did a weekly clinical call (when not on-site) where he reviewed with each facility what was going on clinically in the building and got basic updates on different things. He stated the Administrator and DON for each building were usually on the call.	F 835		
F 837 SS=K	Governing Body CFR(s): 483.70(d)(1)(2) §483.70(d) Governing body. §483.70(d)(1) The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and §483.70(d)(2) The governing body appoints the administrator who is- (i) Licensed by the State, where licensing is required; (ii) Responsible for management of the facility; and (iii) Reports to and is accountable to the governing body.	F 837		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 837	Continued From page 375	F 837		

This REQUIREMENT is not met as evidenced by:
Based on interview, record review, review of the facility's Regional Vice President job description, and review of the facility's policy, it was determined the facility failed to have an effective governing body that was responsible for establishing and implementing policies regarding the management and operation of the facility.

This was evidenced by the facility's failure to take immediate action to prevent further abuse; and, failure to follow their policy to ensure all residents were free from abuse in relation to 42 CFR 483.12 Freedom from Abuse, Neglect, Exploitation (F-600); to take immediate action to prevent further misappropriation of residents' property in relation to 42 CFR 438.12 Free from Misappropriation (F-602); to ensure a timely and thorough investigation, protection of residents, and prevention of further potential misappropriation of controlled substances after an allegation of misappropriation in relation to 42 CFR 483.12 Investigate/Prevent/Correct Alleged Violation (F-610); to ensure care provided to a resident met professional standards of quality as related to 42 CFR 483.21 Comprehensive Resident Centered Care Plan (F 658); to ensure appropriate cardiopulmonary resuscitation (CPR) was provided to a resident as related to 42 CFR 483.25 Quality of Life (F-678); to take immediate action to ensure residents' controlled medications were available and to have an effective system in place for reconciliation of each controlled narcotic medication as related to 42 CFR 483.45 Pharmacy Services/Procedures/Pharmacist Records (F-755); and to ensure the facility was administered in an effective manner as related to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 837	Continued From page 376 42 CFR 483.70 Administration (F-835) and Governing Body (F-837). The facility's failure to provide an effective governing body responsible for establishing and implementing policies regarding the management and operation of the facility has caused or is likely to cause serious injury, harm, impairment, or death to residents. Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) were identified at 42 CFR 483.12 Freedom from Abuse, Neglect, Exploitation (F-600), with a scope and severity (S/S) of a "J" and were determined to exist on 07/18/2021; Free from Misappropriation (F-602), with a S/S of a "K" and was determined to exist on 07/09/2021; Investigate/Prevent/Correct Alleged Violation (F-610), with a S/S of a "K" and was determined to exist on 07/09/2021; and 42 CFR 483.25 Quality of Life, Cardio-Pulmonary Resuscitation (F-678), with a S/S of a "J" and was determined to exist on 01/26/2021. In addition, Immediate Jeopardy (IJ) was identified at 42 CFR 483.21 Comprehensive Resident Centered Care Plan, Services Provided Meet Professional Standards (F-658), with a S/S of a "J" and was determined to exist on 01/26/2021; 42 CFR 483.45 Pharmacy Services, Pharmacy Services/Procedures/Pharmacist Records (F-755) with a S/S of a "K" and was determined to exist on 07/09/2021; and 42 CFR 483.70 Administration, Administrator (F-835) and Governing Body (F-837) with a S/S of a "K" and was determined to exist on 01/26/2021. The facility was notified of the IJ and SQC on 08/20/2021.	F 837		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 837	Continued From page 377	F 837		

The facility provided an acceptable IJ Removal Plan on 09/01/2021, alleging removal of the Immediate Jeopardy on 08/31/2021. The State Survey Agency determined the IJ had been removed on 08/31/2021, as alleged, prior to exit on 09/02/2021, with remaining non-compliance at a S/S of an "E" while the facility develops and implements a Plan of Correction and the facility's Quality Assurance (QA) monitors to ensure compliance with systemic changes.

The findings include:

Review of the facility's job description "Regional Vice President", not dated, revealed the primary purpose of a Regional Director was to oversee the total operation of the facilities under his/her charge and make certain that they operate in accordance with current applicable Federal, State, and local standards, guidelines, and refutations, and as directed by the Chief Operating Officer to assure that an acceptable degree of quality patient care was maintained.

Review of the facility's policy titled, "Guidelines for Governance and Leadership", revision date 06/26/2019, revealed the Regional Vice President of Operations functioned as the Governing Body and appointed the Administrator. The Governing Body and the Administrator were accountable for developing, leading, and closely monitoring the facility's Quality Assurance Performance Improvement (QAPI) program for which the facility's administration was responsible.

The previous Administrator was not available during the course of the survey, and did not return calls, the last of which was attempted on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 837	Continued From page 378	F 837		

08/20/2021 at 9:48 AM.

The Chief Operations Officer was not available for interview on 08/20/2021 at 2:53 PM.

Interview with Registered Nurse (RN) Facility Consultant #1, on 07/27/2021 at 1:15 PM, revealed the Pharmacist did an audit, on 07/09/2021, and discovered the facility was missing a skid (package of thirty (30) tablets) of narcotics. The facility had a problem of a nurse receiving medications with only her signature. She stated she did not know that the policy clearly said two (2) signatures were required when narcotic medications arrived from the Pharmacy. However, she stated it was good nursing practice to do so.

Interview with the Director of Nursing (DON), on 08/05/2021 at 12:22 PM, and, on 08/18/2021 at 10:48 AM, revealed the first time she heard about the missing medications was when the Pharmacy Consultant it on 07/09/2021. The DON stated the facility policy did not specifically talk about narcotic delivery and did not address the best practice of two (2) nurses signing the narcotic delivery instead of one (1) nurse. She further stated, if a nurse was suspected of drug diversion, he/she should be suspended from medication administration to prevent further potential diversion.

Interview Regional Vice President (RVP) #2, on 08/12/2021 at 8:21 AM, revealed according to policy, the Regional Vice President (RVP) was a part of the governing body. Her role was to be supportive, provide guidance, reinforce procedure, and provide policy education through communication with administration.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 837	Continued From page 379	F 837		

Interview with the Pharmacy Consultant, on 08/13/2021 at 10:31 AM, revealed she completed audits once monthly at the facility. On 07/09/2021, she revealed she noted a skid unaccounted for and notified the facility in her report. She also gave the information verbally to the Administrator and the DON.

Interview with the Staff Development Coordinator/Quality Improvement (SDC/QI) nurse, on 08/16/2021 at 2:45 PM, revealed any discrepancies should be reported immediately to the supervising nurse. In addition, she stated the nurse should be suspended from the facility when the medication discrepancy could not be cleared until the investigation was finished.

Interview with Facility Consultant #1, on 08/17/2021 at 2:32 PM, revealed RVP #1 was responsible for overseeing the Administrator of the facility.

Interview with the Interim Administrator, on 08/20/2021 at 10:24 AM, revealed his expectation was to have a good investigation program, good audit program, and good count program, which started as the medications entered the door, signed by two (2) nurses. He stated the facility should have a good program to limit the possibility of drug diversion occurring.

Interview with the Senior Vice President, on 08/20/2021 at 1:40 PM, revealed if there was a drug diversion situation, she would expect the RVP to initiate investigative protocols, report the incident to the required authorities, take appropriate action with staff members, and refer to the facility's polices. She stated she expected

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 837	Continued From page 380	F 837		

the RVP to be knowledgeable about the areas under his/her supervision.

Interview with RVP #1, on 08/20/2021 at 3:03 PM, revealed he was the overseer of the facility, and he was not aware of the prior allegations concerning the two (2) nurses and drug diversion. However, he stated he expected to be notified of those types of allegations. He stated the Administrator was responsible to bring anything to his attention. In addition, he stated he expected the processes and systems the facility had in place to have caught or identified any concerns.

Additional interview with the DON, on 08/19/2021 at 2:00 PM, revealed, regarding Resident #242, she had not been present for the full code. She stated she had met with the former Administrator the next day and told her it was wrong to continue CPR if there was a pulse. She further stated the former Administrator again stated a resident needed a pulse of at least sixty (60) beats per minute to stop CPR. Additionally, the DON stated she sought guidance from the Advanced Practice Nurse Practitioner (APRN), who advised to stop CPR if there was a pulse.

Interview with the Medical Director, on 08/10/2021 at 4:11 PM, revealed the former Administrator had overstepped her bounds in ordering continued chest compressions when Resident #242 had a pulse. He stated the resuscitation was not handled in an appropriate way. In addition, the Medical Director stated that continuing CPR on someone with a pulse could harm them drastically.

Continued interview with RVP #1, on 08/20/2021 at 3:03 PM, revealed he had no knowledge of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 837	Continued From page 381	F 837		

incident regarding Resident #242 and the fact that CPR continued after a pulse was obtained. He stated he was aware that CPR should be discontinued if there was a pulse, and he was not aware the Medical Director had concerns when notified of this situation. He stated he expected the former Administrator would have reported the incident to him; others could have reported it as well. He stated any staff member could have reported it through the compliance line or called him specifically. He stated he had no thoughts on why it was not reported. RVP #1 stated, in his role, the Administrator did report to him.

The facility provided an acceptable Immediate Jeopardy Removal Plan, on 09/01/2021, that alleged removal of the IJ on 08/31/2021. The facility implemented the following:

1. On 07/12/2021, 07/13/2021, 07/20/2021, 07/21/2021, 07/22/2021, 07/24/2021 to 08/13/2021, and 08/22/2021 to 08/29/2021, an RN Corporate consultant worked in the facility. An RN Corporate nurse (CN) continued at the facility to provide oversight of the performance improvement plan (PIP) five (5) days a week, including nights and weekends, through September 2021. An RN CN could complete any audit in place of the assigned auditor, and assist with education. The RN CN would speak with the Administrator and/or Regional Vice President (RVP) five (5) days a week through September 2021. The RN CN would help ensure the facility's governing body was effective in establishing and implementing policies regarding the management and operation of the facility.

2. On 07/12/2021, the DON, SDC/QI nurse, MDS nurses, Unit Manager (UM), Nurse Supervisor,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 837	Continued From page 382	F 837		

Principle LTC RN's not employed by the facility (support RN's), and corporate nurses started audits of medication carts and narcotic medication documentation. The audits included: locking carts, Medication Administrator Records (MAR), shift change count sheets, signatures, declining count sheets, wasted narcotics, back side of narcotic medication skids, skid cards numerical order, no missing skids, all narcotics accounted for, and/or pharmacy packing slips. These audits were completed five (5) times weekly. Any missing, incomplete, or incorrect documentation would be immediately reported to the DON and/or Administrator for investigation. Any concerns and trending would be reviewed and discussed weekly on Fridays. The audits would continue until the Quality Assurance Performance Improvement (QAPI) committee determined the audit frequency could be reduced. The QAPI Committee consisted of the Administrator, DON, Infection Preventionist, Medical Director, Social Worker, Medical Records Director, Dietary Manager, and Housekeeping Supervisor, plus additional staff members as deemed necessary.

3. On 07/21/2021, the RVP arrived on-site to initiate and coordinate the investigation. The investigation focused on abuse/neglect/misappropriation of resident/residents' property.

4. On 07/21/2021, the RVP interviewed and suspended the facility Administrator.

5. On 07/21/2021 through 07/23/2021, the RVP provided administrative coverage for the facility.

6. On 07/23/2021, the Interim Administrator

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 837	Continued From page 383	F 837		

participated in a QAPI meeting to go over the current plan of correction that was developed by the QAPI Committee.

7. On 07/27/2021, the RVP educated and reviewed, with the Interim Administrator, the responsibilities of the management and operation of the facility and reviewed job duties with the Interim Administrator.

8. On 07/27/2021 to 08/09/2021, the RVP provided oversight to the Interim Administrator.

9. On 08/20/2021, a Code of Conduct in-service was initiated by the corporate staff with all nurses, nursing assistants, housekeeping staff, therapy staff, department managers, and dietary staff. The in-service emphasized the guidance and reporting integrity line, compliance officer, and employee affirmation statement to validate knowledge and understanding of the training in the Code of Conduct book. Staff who were not working would be mailed a copy of the in-service.

10. On 08/21/2021 employee surveys were amended and initiated by the SDC/QI, DON, and RN CN consultant, with questions to include but not limited to (1) Do you have any concerns? (2) Is Management addressing your concerns? and (3) Do you know who to report Management related concerns to? The RVP would review all identified areas of concern from the employee surveys with oversite by the RN CN consultant. Seventy-nine percent (79%) of staff completed in-person training, and twenty-one percent (21%) received education by mail. This education will be provided to new staff and new agency staff at orientation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 837	Continued From page 384	F 837		

11. On 08/23/2021, the Senior Vice President of Health Services trained the RVP on responsibilities of the management and operation of the facility.

12. On 08/23/2021, the RVP reviewed all audits and in-services related to tags F-600, F-602, F-610, F-658, F-678, F-755, and F-835 for completion and to ensure all areas of concern were addressed. The RN CN consultant would provide oversite to ensure compliance.

13. On 08/23/2021 and 08/24/2021, the Vice President of Employee Experience was at the facility offering education on the Code of Conduct and providing support to the Interim Administrator.

14. On 08/23/2021 through 08/27/2021 and on 08/30/2021, a sister facility Administrator was on-site to provide guidance and support to the Interim Administrator.

15. On 08/23/2021 through 08/27/2021, a sister facility Administrator was on-site to provide education and quiz staff on the Code of Conduct. Also, the sister facility Administrator talked with staff to complete employee surveys.

16. On 08/26/2021, the RVP brought in the new Administrator. The RVP educated the new Administrator to include the Appointment Letter as Facility Administrator. The Appointment Letter outlined the Administrator's responsibilities: enforce rules and regulations; and maintain an ongoing liaison among the governing body, medical and nursing staff, and other professional and supervisory staff of the facility. The facility had a five (5) times a week interdisciplinary team

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 837	Continued From page 385	F 837		

(IDT) meeting, which was part of the quality assurance process, during which the RN CN attended. And, the RVP attended the IDT meeting during facility visits.

17. On 08/26/2021 through 08/29/2021, the RVP, sister facility Administrator, and RN CN educated the new Administrator on: abuse, misappropriation, investigations, ensuring pharmacy practices were in place, professional standards for all tags, the Administrator's role of oversight as it relates to all issues identified in the plan of correction, policies and procedures in place for the Administrator, and how the Administrator would ensure policies were followed.

18. On 08/28/2021 through 08/29/2021, multiple sister facilities provided support RN's. The support RN's assisted with auditing medication carts and monitoring shift change narcotic counts. Also, support RN's reinforced with staff education and executed a Code Blue Drill.

19. The RVP was the facility's governing body and was responsible for ensuring the new Administrator knew his role so oversight of the policies and procedures was effective.

20. Narcotic Cart Audits were completed five (5) times weekly. Any missing, incomplete, or incorrect documentation would be immediately reported to the DON and/or Administrator for investigation. Any concerns and trending would be reviewed and discussed weekly on Fridays. The audits would continue until the Quality Assurance Performance Improvement (QAPI) committee determined the audit frequency could be reduced.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 837	Continued From page 386	F 837		

21. The Pharmacy Consultant would visit the facility at least monthly to validate narcotics were being monitored and counted per standard of practice.

22. The facility increased the QAPI Committee meetings from quarterly to monthly for three (3) months, beginning on 08/10/2021. The QAPI committee meetings would include the Medical Director and at least two (2) corporate staff.

23. A Corporate Vice President continued to provide oversight of the facility. Oversight was provided daily via telephone and weekly via on-site visits through September 2021.

The State Survey Agency validated the implementation of the facility's Immediate Jeopardy Removal Plan as follows:

1. Interview, on 09/02/2021 at 9:10 AM, with the Clinical Director revealed she, and prior to her arrival, the Facility Consultant, had been in the facility on the dates documented in the IJ Removal Plan. She revealed her daily routine consisted of talking to residents on both the South and North halls of the building, observing staff providing care, and talking with staff. She revealed she conducted chart reviews and audits, and validated the facility was continuing audits and doing everything they were supposed to be doing. The Clinical Director stated she had made surprise visits to the facility at 2:00 AM, as well as on weekends, to ensure staff was following procedures they had been educated on and to provide immediate education where needed.

2. Review of documentation revealed the DON

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 837	Continued From page 387	F 837		

audited all medication carts, on 07/13/2021, confirming staff was signing in and out of medication carts as expected, narcotic skids were being counted as expected, and the narcotic count sheets matched the number of narcotic skids in the cart.

Continued review revealed ongoing audits beginning on 07/21/2021 were completed on the Narcotic Cart Audit tool, which monitored for (1) all staff signing controlled substance sheet at shift change, (2) all narcotic sheets had been counted, (3) sheet count matched the medication cart count, (4) back of cards checked for tape, (5) cards checked to ensure no missing skids (1 of 2, 2 of 2), (6) sheets were being logged in/out of medication carts as sheet count number changed, and (7) all narcotics were signed out and accounted for. Audits reviewed were completed by the DON, SDC/QI, MDS nurse, support RN's, and corporate nurses. No concerns were identified in the review of audits.

3. Interview with the RVP, on 09/02/2021 at 7:07 PM, revealed he was present at the facility with other corporate personnel, on 07/21/2021 as a result of the 07/18/2021 drug diversion situation with LPN #1.

4. Continued interview with the RVP, on 09/02/2021 at 7:07 PM, revealed as a result of corporate investigation, the RVP stated there were concerns with how the former Administrator had handled the drug diversion situation, resulting in her suspension from the facility.

5. The RVP stated, in the 09/02/2021 at 7:07 PM interview, he was at the facility from 07/21/2021 through 07/23/2021 acting in the capacity as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 837	Continued From page 388	F 837		

Administrator while that position was vacant.

6. Review of the QAPI Meeting minutes, dated 07/23/2021, confirmed the Interim Administrator attended the meeting in which the facility plan to correct identified deficiencies was reviewed.

7. Review of documentation confirmed the RVP reviewed the responsibilities of the Interim Administrator regarding management and operation of the facility on 07/27/2021.

8. Interview with the RVP, on 09/02/2021 at 7:07 PM, confirmed he was present to provide support and oversight for the Interim Administrator, from 07/27/2021 through 08/09/2021.

Interview with the Interim Administrator, on 08/05/2021 at 2:48 PM, confirmed the RVP had been available and provided guidance in facility management.

9. Review of Code of Conduct in-servicing, revealed a sign-in sheet documenting all staff had completed training. Review of employee quiz information revealed employees were educated on reporting of fraud or abuse, as well as the availability of the corporate compliance line, and the ability to make anonymous reports if desired, with the goal of ensuring all potential violations were reported and addressed.

Interview with State Registered Nurse Aide (SRNA) #24, on 09/02/2021 at 3:30 PM, revealed she had received training on the Code of Conduct, which included abuse, neglect, misappropriation, what to report, who to report to, and when to report. She revealed if she were to report an allegation to her supervisor and did not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 837	Continued From page 389	F 837		

feel like it was being addressed, she could contact the DON and Administrator, as well as call or fax the corporate compliance line.

Interview with the Occupational Therapist, contracted to work at the facility, revealed she had received the Code of Conduct in-service, which covered abuse, neglect, and misappropriation. She revealed she would report any allegations to her supervisor, and if she did not feel they were being addressed, to the DON, Administrator, and finally the corporate compliance line.

10. Review of the facility's surveys, amended as of 08/21/2021, revealed staff was interviewed by the Clinical Director and other non-facility staff with questions, which included (1) Do your residents have what they need? (2) Do you have any concerns? (3) Is management addressing your concern? and (4) Do you know who to report management related concerns to?

Interview with the DON, on 09/02/2021 at 1:18 PM, revealed corporate personnel had been doing the employee surveys, as had staff from sister facilities. She stated no one had brought any concerns to her.

Interview with Housekeeper #4, on 09/02/2021 at 2:27 PM, confirmed she had received papers and had been interviewed by corporate asking if she had any concerns.

11. Review of Complete In-Service Training Report with Staff Attending, dated 08/23/2021, confirmed the Senior Vice President trained the RVP on facility management, to include the role of the RVP, the responsibility of the RVP to make

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 837	Continued From page 390	F 837		

sure policies were established and implemented regarding management and operation of the facility, and the responsibility of the RVP for appointing the licensed Administrator who reported to and was accountable to the RVP.

12. Review of a Governing Body Internal Audit confirmed the RVP completed review of inservices and audits on 08/23/2021. Continued review revealed the RVP reviewed inservices and audits again, on 08/25/2021 and 08/29/2021.

13. Review of quizzes on the Code of Conduct confirmed employees were trained and tested on 08/23/2021 and 08/24/2021. Review of the Principle LTC Code of Conduct booklet, revised 04/2019, revealed "Principle LTC is committed to its role in preventing health care fraud and abuse and complying with applicable state and federal laws related to health care fraud and abuse." The booklet provided guidance on the reporting chain of command, as well as the availability of the corporate compliance phone number.

14. Review of documentation confirmed a licensed Administrator from a sister facility was on-site 08/23/2021 through 08/27/2021 and again on 08/30/2021.

15. Review of documentation, to include Employee Surveys, revealed the sister facility Administrator met with staff and provided education on the Code of Conduct.

16. Review of the Appointment Letter as Facility Administrator, dated 08/26/2021, confirmed the RVP appointed the new Administrator on 08/26/2021. Review of an Administrator job description, dated 08/26/2021, confirmed the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 837	Continued From page 391	F 837		

Administrator reviewed and agreed to his job duties and responsibilities.

Interview with the Administrator, on 09/02/2021 at 6:32 PM, revealed he was informed the previous Administrator was not following processes corporate wanted to be followed. He stated he wanted to make sure he knew what had occurred when he was came into this situation. The Administrator stated he had gone into facilities before that had IJ situations. He revealed if the Administrator worked hard and took care of staff, they took care of the residents.

17. Continued interview with the Administrator, on 09/02/2021 at 6:32 PM, confirmed several other sister facility Administrators had gone over policies, the grievance process, self-reportables, investigation requirements, and follow up with staff doing root cause analysis. He stated they educated him on timeliness of reporting, what to report, keeping corporate in the loop so they could provide direction, and following through until there was a resolution. He revealed nurses went over the CPR process, to include once there was a pulse CPR was stopped, and that was discussed on a call with the Medical Director as well, to follow Basic Life Support (BLS) guidelines.

Continued interview with the Administrator, on 09/02/2021 at 6:32 PM, revealed he received additional education by the RVP over governing and training of the QAPI process and the Facility Assessment. He stated the big focus was the QAPI report, daily IDT in morning meetings with follow up in afternoon meetings, and communicating that process. The Administrator stated the RVP stressed the importance of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 837	Continued From page 392	F 837		

reporting to the RVP. The Administrator revealed the RVP had a weekly call with all Administrators and DON's, every Tuesday.

18. Review of a Quality Initiative (QI) CPR Drill, dated 08/29/2021, confirmed support RN's executed a Code Blue Drill during day shift. Review of the drill revealed staff responded appropriately, with no retraining required.

Review of the Narcotic Cart Audits confirmed support RN's conducted audits on 08/28/2021 and 08/29/2021 of all facility medication carts, with no concerns identified.

Continued interview with the DON, on 09/02/2021 at 1:18 PM, confirmed staff did well on the CPR drill and responded appropriately.

Interview with the Clinical Director, on 09/02/2021 at 9:10 AM, revealed, on 08/28/2021 and 08/29/2021 a mock survey/audit was done, by her and sister facility support RN's, on all medication carts. The Clinical Director revealed there had been no concerns identified during their audits.

Interview with the SDC/QI, on 09/02/2021 at 4:49 PM, revealed she was uncertain what was written in the plan of correction regarding frequency of CPR drills, but she planned on ensuring CPR drills were conducted at least monthly for six (6) months, then maybe quarterly after that. She revealed she had been present during all three Code Blue drills, and it seemed like they were getting a little smoother each time.

19. Review of the Quality Assurance and Performance Improvement Guidance Manual, revised 06/26/2019, revealed the RVP functioned

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 837	Continued From page 393	F 837		

as the governing body, appointed the Administrator, and with the Administrator, was accountable for developing, leading, and closely monitoring the facility QAPI program for which the facility administration was responsible.

Interview with the RVP, on 09/02/2021 at 7:07 PM, revealed he had known the new Administrator for many years, describing him as a fine gentleman, an Administrator that had been with and was familiar with the company, and a very trustworthy individual that was going to do what was right for the resident. The RVP stated he felt comfortable with him being in this role.

20. Review of the Narcotic Cart Audits confirmed audits were being conducted five (5) times a week or more frequently. Review of audits revealed no concerns identified.
Review of Cardinal IDT Meeting Minutes, dated 08/30/2021, confirmed audits were being reviewed.

21. Interview with the Pharmacy Consultant, on 08/13/2021 at 10:31 AM, confirmed she visited the facility monthly and conducted a narcotics audit during her monthly visits.

Interview with the DON, on 09/02/2021 at 9:10 AM, confirmed the Pharmacy Consultant conducted monthly visits, reviewed charts, and conducted a medication administration audit. She revealed the only time the Pharmacy Consultant was not coming were times during the last year when the facility was in lock down due to the pandemic.

22. Interview with the Clinical Director, on 09/02/2021 at 1:18 PM, revealed the first QAPI

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 837	Continued From page 394 meeting was held on 08/10/2021, and there would be additional QAPI meetings in September and October. She stated the Medical Director had attended on 08/10/2021, and the dates for the September and October meetings had not yet been set, as the plan was to schedule them to ensure the Medical Director would be in attendance. 23. Continued interview with the Clinical Director, on 09/02/2021 at 1:18 PM, revealed the RVP did onsite visits and phone calls and had been at the facility frequently since the incident of drug diversion. She revealed whenever the RVP was not present, RVP #2, or another corporate Vice President was present at the facility. Continued interview with the RVP, on 09/02/2021 at 7:07 PM, revealed he worked with the Administrator and the facility as an overseer to ensure they had what they need. He stated, as RVP, he did a weekly clinical call (when not on-site) where he reviewed with each facility what was going on clinically in the building and got basic updates on different things. He stated the Administrator and DON for each building were usually on the call.	F 837		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 880	Continued From page 395 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 880	Continued From page 396	F 880		

contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review, review of the manufacturer's directions for use, and review of the facility's policy, it was determined the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent and control the development and transmission of communicable diseases and to implement interventions per the Centers for Medicare and Medicaid Services (CMS), the Centers for Disease Control and Prevention (CDC), and the Kentucky Department for Public Health (Health Department) state guidelines for COVID-19.

Observation of medication administration for Resident #64, on 08/11/2021, with Registered Nurse (RN) # 4 revealed improper hand hygiene

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 880	Continued From page 397	F 880		

before administering medications: via a gastrostomy tube, topical patch, inhalation, and per mouth (PO). Additional observations for Resident #64, on 08/11/2021, with RN # 4 revealed improper infection control technique and improper glucometer disinfecting. Further interview with Kentucky Medication Aide (KMA) #9, on 08/11/2021 revealed improper glucometer disinfection between five (5) residents: Resident #1, Resident #3, Resident #49, Resident #60, and Resident #64.

Observation, on 08/10/2021, revealed staff performing improper hand washing on the South Unit during resident meal service.

Observations, on 08/13/2021, revealed staff not wearing appropriate masks with active COVID-19 in the facility.

The findings include:

Review of the facility's policies titled "Administration of Oral Medications through a Nasogastric Tube or Gastrostomy Tube," and "Administration of Oral Medications," both dated 09/2020, revealed the goal was for medications to be prepared and administered safely and accurately. Further the procedure included washing hands before medication preparation and administration.

Review of the facility's policy titled, "Glucometer Cleaning and Disinfection," dated 09/04/2014, revealed the objective was to prevent infection due to potential blood-borne pathogen exposure. Additionally, the equipment and supplies necessary were gloves, germicidal disposable cloth/wipe, and a plastic disposable cup.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 880	Continued From page 398	F 880		

Continued review revealed gloves should be applied prior to cleaning a glucometer. Per the policy, an Environmental Protection Agency (EPA) registered germicidal disposable cloth/wipe should be used to thoroughly wet the entire external surface of the glucometer. Then cover/wrap the entire glucometer with the wipe and place in a plastic disposable cup on the medication cart and allow full minutes' exposure time according to the manufacture's product directions for disinfection. Further, after full minutes' exposure time, remove the cloth wipe and discard. Return the glucometer to the plastic cup to allow thorough air dry time. Continued review revealed gloves should be removed at that time and hand hygiene should be performed. When the glucometer was completely dry, it then could be used for the next resident or stored in the medication cart, and the plastic cup should be discarded.

Review of the "Long Term Care Facility Guidance Principle Inc", dated 04/03/2020, revealed full PPE should be worn per CDC guidelines for the care of any resident with known or suspected COVID-19.

Review of the facility's procedures "Handwashing" and "Alcohol Hand Sanitizer" both dated 03/10/2020, revealed hands should be washed before and after contact with residents, after handling contaminated items, and whenever hands were visibly soiled. In addition, alcohol-based hand sanitizer could be used, unless hands were visibly soiled.

Review of Professional Disposables International (PDI) Incorporated, website https://pdihc.com/, dated 2021, revealed Super Sani-Cloth

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 880	Continued From page 399	F 880		

Germicidal Disposable Wipes and Sani-Cloth Bleach Germicidal Disposable Wipes could be used on hard nonporous surfaces such as blood glucose meters (glucometers) and were effective against blood borne pathogens. Additionally, Super Sani-Cloths required two (2) minute continuous wet contact with medical devices and complete air dry time to be an effective disinfection per manufacture guidelines. Further, Sani-Cloths required four (4) minute continuous wet contact with medical devices and complete air dry time to be an effective disinfection per manufacture guidelines.

1. Observation of medication administration for Resident #64, on 08/11/2021 between 11:31 AM and 12:21 PM, of RN #4/Unit Manager South Hallways, revealed the RN repeatedly entered the resident's room and did not wash her hands prior to medication administration; eight (8) times. RN #4 took two (2) medications at a time into the resident's room and then would return to the medication cart to prepare two (2) more medications until all the prescribed medication was administered. Observation revealed, on 08/11/2021 at 11:34 AM, the RN did not was her hands before preparing medications at the medication cart. Additionally, the RN closed the Medication Administration Record (MAR), locked the medication cart, knocked on the resident's door, and entered the resident's room with medications prepared in a plastic medication cup. Continued observation revealed the RN then donned gloves; however, she did not perform hand hygiene prior to donning the gloves and administering the medications via the gastrostomy tube. Additional observation, on 08/11/2021 at 11:43 AM, revealed RN #4, entered the resident's room, donned gloves without

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 880	Continued From page 400	F 880		

performing hand hygiene, and applied a topical Nicotine patch to the resident's right upper arm. The RN did not perform hand hygiene after doffing gloves and re-donning gloves to administer medication via the gastrostomy tube. Further observation, on 08/11/2021 at 12:15 PM, revealed RN #4 entered the resident's room, donned gloves without performing hand hygiene and administered medication via the resident's gastrostomy tube, then setup an inhalation medication in a nebulizer machine without performing hand hygiene or changing her gloves. Continued observation, on 08/11/2021 at 12:20 PM, revealed RN #4 entered the resident's room, donned gloves without performing hand hygiene, and administered a swish and spit oral medication.

2. Continued observation of Resident #64, on 08/11/2021 at 12:25 PM, by RN #4 revealed the nurse gathered the glucometer, a lancet, an alcohol pad, and the test strip bottle from the medication cart and entered the resident's room. The nurse placed the gathered items on the bedside table without preparing a clean area. Observation revealed the nurse washed her hands and donned gloves and performed a finger stick blood glucose check. Additionally, the glucometer was then placed on the bedside table until the reading was calculated; then RN #4 removed her gloves around the contaminated test strip and placed the glucometer in her scrub top pocket and discarded the soiled gloves into the trash can at the bedside. Continued observation revealed RN #4 then picked up the bottle of test strips, turned the resident's tube feeding back on, exited the room, signed the MAR, and sat the test strip bottle on top of the medication cart. Further RN #4 then entered the resident's room and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 880	Continued From page 401	F 880		

donned gloves; the RN did not perform hand hygiene. Continued observation revealed RN #4 turned on the nebulizer machine and handed the resident the pipe (mouth piece). The RN then doffed her gloves and washed her hands before exiting the room.

Further observations, on 08/11/2021 at 12:27 PM, revealed RN #4 took the glucometer and test strip bottle to the nurse's station counter. Additional observation revealed the nurse did not don gloves. She obtained a Super Sani-Cloth Wipe and wiped the surface of the glucometer and test strip bottle and discarded the wipe. However, she did not ensure the surface of the medical equipment and bottle remained wet for two (2) minutes. Further, RN #4 stated the items had to air dry for two (2) minutes. She left the glucometer and test strip bottle on the counter top and stocked the medication cart with Sani-Cloth Bleach wipe individual packets.

Interview with Kentucky Medication Aide (KMA) #9, on 08/11/2021 at 4:22 PM, revealed two (2) residents had orders for finger stick blood glucose checks on the hallway; Resident #49 and Resident #64. The KMA stated the residents were checked four (4) times a day at 6:00 AM, 11:00 AM, 4:00 PM, and 8:00 PM. Additional interview revealed she had already completed the checks for both residents at 4:00 PM and documented in the MAR (verified). Further, she stated she only cleaned the machine after each resident and did not clean the machine before she obtained Resident # 64's 4:00 PM check. The State Survey Agency (SSA) Surveyor requested the KMA to demonstrate cleaning of the glucometer; observations revealed KMA #9 donned gloves and briefly wiped all surfaces of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 880	Continued From page 402	F 880		

the machine with a Sani-Cloth Bleach wipe, discarding the wipe and laid the machine to dry on top of the medication cart. The KMA doffed her gloves and did not perform hand hygiene. The KMA stated it was her understanding to wipe the glucometer's surface for fifteen (15) to twenty (20) seconds after each use and allow it to dry for two (2) minutes. Per the interview, it was important to clean the glucometer properly to ensure germs were not cross contaminated and to maintain infection control.

Record review revealed, on 08/11/2021, KMA # 9 worked on four (4) of the six (6) hallways in the facility and performed finger stick blood glucose checks with the same glucometer. There were three (3) additional residents who were ordered finger stick blood glucose checks, which KMA #9 performed: Resident #1, Resident #3, and Resident #60. Therefore, a total of five (5) residents received finger stick blood glucose checks with a glucometer that had been improperly disinfected by KMA #9.

3. Observation of the Speech Therapist, on 08/10/21 at 12:05 PM, revealed she was in a resident room assisting a resident with his/her meal tray. Additionally, the Speech Therapist was observed to touch the resident while assisting with the meal tray, without the use of gloves.

Observations and interviews, on 08/10/21 at 12:17 PM, revealed two (2) State Registered Nurse Aides (SRNA) were passing dinner trays on the South Unit and entered residents' rooms without sanitizing or washing their hands. A bottle of hand sanitizer was observed on top of the meal tray cart but was not being used by staff. Food

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 880	Continued From page 403	F 880		

trays were taken into residents' rooms, food was prepped and cut up by staff, and no hand hygiene was performed before or after these tasks. SRNA #16 was asked about handwashing procedure and stated, "We're supposed to sanitize after every tray and wash our hands after every 3rd tray." SRNA #15, who was also delivering meal trays to residents stated, "I'm allergic to hand sanitizer. I can't use it. I know we're supposed to wash our hands but sometimes we just get busy." Both aides stated they had received training on infection control which included hand hygiene, by the Staff Development Coordinator (SDC).

However, additional observation of SRNA #16, during meal service, on 08/10/2021 at 12:23 PM, revealed she failed to perform proper hand hygiene after the SSA Surveyor inquired on proper hand hygiene during meal service.

Interview with RN #4/Unit Manager, on 08/12/2021 at 4:21 PM, revealed when passing meal trays, hands should be sanitized between trays and washed every third tray. Additionally, she stated residents should also be encouraged to wash their hands before and after meals. RN #4 stated there was no shortage of PPE or supplies at the facility. Additionally, RN #4 stated she had received training on Infection Control from the SDC during monthly Quality Assurance and Performance Improvement (QAPI) meetings and training or staff education materials related to Infection Control once or twice a month.

4. On 08/13/2021 at approximately 9:00 AM, it was reported to the SSA Surveyor that a resident was confirmed positive for COVID-19, and the resident had been transferred to another facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 880	Continued From page 404	F 880		

Further, the resident's roommate was now placed in quarantine.

Observation and interview, on 08/13/2021 at 2:03 PM, revealed Housekeeper #3 was wearing a surgical mask in the hallway outside of the Memory Care Unit; however, it had been reported a resident had tested positive for COVID-19 that morning. Housekeeper #3 stated she did not know she was supposed to wear an N95 mask. Additional interview revealed she had received training on Personal Protective Equipment (PPE) from the SDC.

Observation and interview, on 08/13/2021 at 2:12 PM, revealed PCA #3 was wearing a surgical mask in the hallway near the South Unit nurse's station; however, it had been reported a resident had tested positive for COVID-19 that morning. PCA #3 stated she had been told there was a positive case of COVID-19 at the facility but chose not to wear an N95 mask. The PCA stated she had been trained on PPE and Infection Control.

Interview with Resident #69, on 08/14/2021 at 12:16 PM, revealed the resident saw the nurses wearing their masks and washing their hands but stated several of the aides would come into his/her room with their masks under their chins. Additionally, the resident stated he/she was unsure if aides performed hand hygiene. Further, the resident stated he/she had COVID-19 last year and was in the hospital for a few days and did not want it again.

Interview with Central Supply (CS), on 08/14/2021 at 11:30 AM, revealed the facility did not have a shortage of supplies or PPE. Further, the CS had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 880	Continued From page 405	F 880		

been provided training on Infection Control by the SDC and updates were given during daily morning meetings.

Interview with the Infection Preventionist (IP) Nurse, on 08/16/2021 at 2:45 PM, revealed she expected nursing staff (nurses and KMA's) to perform hand hygiene (hand washing or hand sanitization) prior to preparing medications for administration. Continued interview revealed, prior to donning gloves to administer medication, nursing staff should also perform hand hygiene. She stated she also expected staff to perform hand hygiene in between gloves changes during medication administration. Additional interview revealed the facility policy related to cleaning and disinfecting glucometers should be followed by nursing staff to reduce the risk of cross contamination. Per the interview, the pharmacy provided a formal medication audit monthly for two (2) nurses and had not identified any concerns with hand hygiene during medication administration; however, the facility had not utilized a medication administration audit to ensure hand hygiene was performed appropriately. She stated she expected the nursing staff to clean and disinfect the glucometer before use and in between each resident. Per the interview, glucometers should be disinfected by using Sani-Cloths per the manufacturer's guidelines. The IP Nurse stated it was important to decrease the cross contamination risk. She stated nursing staff received annual competency training on hand hygiene and glucometer cleaning and disinfection, and she had not identified any concerns with glucometer cleaning and disinfection.

Interview with the Director of Nursing (DON), on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 880	Continued From page 406	F 880		

08/18/2021 at 11:00 AM, revealed she expected the facility policies related to medication administration/hand hygiene, and glucometer cleaning and disinfecting to be maintained at all times. Additionally, she expected nursing staff to perform hand hygiene and don gloves per standards of practice. Continued interview revealed it was important to maintain infection control practices related to gloves and hand hygiene to decrease the risk of cross contamination. Further, she expect staff to clean glucometers prior to use and after each use with residents per the facility policy and manufacturer's recommendations. Per the interview, it was important to ensure infection control was maintained with medical devices to reduce the spread of communicable disease.

Continued interview with the DON, on 08/18/2021 at 11:00 AM, revealed training and education was provided to staff by the DON, SDC, facility consultants and the former Administrator. Additionally, she stated updated policies were provided to staff as updates were received and training given as needed through in-services or policies reviewed. Per the interview, all COVID-19 positive cases were discussed in daily IDT meetings and monthly QAPI meetings. Further, the DON stated she expected staff to follow Infection Control procedures and wear N95 masks when the facility had a COVID-19 positive resident, and surgical masks should be worn at other times. Also, she stated staff who entered a COVID-19 positive room were expected to wear proper PPE (gloves, gown, N95 masks) and to dispose of PPE properly, before exiting the resident's room. Per the interview, she would tell staff to put on N95 masks if she saw them not wearing one when they should be and follow

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	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 880	Continued From page 407 progressive discipline if they did not. Interview with the Administrator, on 08/16/2021 at 3:30 PM, revealed he had worked at the facility since July 27, 2021. Per the interview, the facility should maintain infection control practices at all times per the facility policies. He stated staff had received training and education on COVID-19 and the appropriate use of PPE. Additionally, he stated the Infection Preventionist nurse was responsible in the oversight and compliance of infection control practices in the facility. The Administrator stated he was not aware of any issues related to infection control in the facility. Further, he stated it was important to ensure infection control practices were maintained to provide a safe environment and to prevent the spread of illness.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/10/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	**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 000	INITIAL COMMENTS CFR: 42 CFR 483.70(a) BUILDING: 01 PLAN APPROVAL: 1962, RENOVATED IN 1994 SURVEY UNDER: 2012 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 was initiated and concluded on 8/10/2021. The facility was found not to be in compliance with title 42, Code of Federal Regulation, 483.90(a)et seq (Life Safety from Fire). The facility was licensed for one hundred four (104) beds with a census of eighty-eight (88) the day of the survey. Deficiencies were cited at the highest scope and	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/10/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	**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 000	Continued From page 1 severity of an "D"	K 000		
K 271 SS=D	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: Based on observation, it was determined the facility failed to maintain discharge from exits in accordance with National Fire Protection Association (NFPA) standards. The deficient practice had the potential to affect one (1) of five (5) smoke compartments, residents, staff, and visitors. The findings include: Observation, on 8/10/2021 at 10:00 AM, with the Director of Maintenance (DOM) and Regional Director of Maintenance (RDOM), revealed the sidewalk outside of Door Number Sixteen (16) was not level due to ground movement. The sidewalk and discharge area had abrupt vertical changes in elevation at approximately 1/4" due to breaks in the sidewalks. Additionally, the sidewalk had a gap of approximately 1 ¼" in width and 1" in depth. These breaks in the concrete and unleveled surfaces created tripping hazards, which could cause injury and hinder a timely evacuation in case of a fire.	K 271		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/10/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	**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 271	Continued From page 2 The findings were verified by the DOM and acknowledged by the Administrator at the exit interview. Reference: NFPA 101 (2012 edition) 7.1.6.2 Changes in Elevation. Abrupt changes in elevation of walking surfaces shall not exceed 1/4 in. (6.3 mm). Changes in elevation exceeding 1/4 in. (6.3 mm), but not exceeding 1/2 in. (13 mm), shall be beveled with a slope of 1 in 2. Changes in elevation exceeding 1/2 in. (13 mm) shall be considered a change in level and shall be subject to the requirements of 7.1.7. 7.1.6.3 Level. Walking surfaces shall comply with all of the following: (1) Walking surfaces shall be nominally level. (2) The slope of a walking surface in the direction of travel shall not exceed 1 in 20, unless the ramp requirements of 7.2.5 are met. (3) The slope perpendicular to the direction of travel shall not exceed 1 in 48. Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface in accordance with CMS Survey and Certification Letter 05-38. 18.2.7, 19.2.7, S&C 05-38	K 271		
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure	K 321		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/10/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	**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 321	Continued From page 3 Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements for Protection of Hazards, in accordance with the National Fire Protection Agency (NFPA) standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments, residents, staff and visitors.	K 321		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/10/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	**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 321	Continued From page 4 The findings include: Observation, on 8/10/2021 with the Director of Maintenance (DOM) and Regional Director of Maintenance, (RDOM) revealed large amounts of combustibles, i.e., paper files were being stored in the Medical Records Office thus creating a Hazardous Area. The Medical Records Office Door did not have a door closer on it and was not self or automatic closing as required by NFPA 101 (2012) 19.3.2. The Medical Records Office Door opened to the corridor and was in excess of fifty (50) square feet in size. The findings were acknowledged by the Administrator and verified by the DOM upon exit. Actual NFPA Standard: Reference: NFPA 101 (2012 Edition) 19.3.2 Protection from Hazards. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating (with ¾ hour fire rated doors) or shall be provided with an automatic fire extinguishing system in accordance with 8.7.1. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Laundries (larger than 100 square feet)	K 321		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/10/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	**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 321	Continued From page 5 (3) Repair, Maintenance, and Paint shops (4) Soiled Linen Rooms (exceeding 64 gal) (5) Trash Collection Rooms (exceeding 64 gal) (6) Combustible Storage Rooms (over 50 sq ft) (7) Laboratories (if classified as Severe Hazard)	K 321		