PRINTED: 10/11/2021

	DO EGO LATERALIA	AND HUMAN SERVICES				FORM APPROVED
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			(OMB NO. 0938-0391
STATEMENT AND PLAN (OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(XI) DATE SURVEY COMPLETED
NAMEOF	PROVIDER OR SUPPLIER	185028	B. WING			C 09/02/2021
TOURLE OF	PROVIDER OR SUPPLIER		- 1	51	TREET ADDRESS, CITY, STATE, ZIP CODE	
JOHNSC	N MATHERS NURSIN	IG HOME			323 CONCRETE ROAD ARLISLE, KY 40311	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DRE COMPLETION
F 000	INITIAL COMMENT An Abbreviated Sui KY00033997, KY00		FO	000	Johnson Mathers Nursing Hacknowledges receipt of the Deficiencies and proposes to	Statement of his Plan of
	KY00034202, KY00 was initiated on 07/ review with the Stat survey transitioned Recertification/Exte on 08/09/2021, while in addition, a COVII Control Survey was the facility was not if 483.80, Infection Co	2034203, and KY00034222 26/2021. After supervisory as Survey Agency (SSA), the to a Standard inded and Abbreviated Survey, th concluded on 09/02/2021. D-19 Focused Infection conducted, which identified in compliance with 42 CFR portrol, F 880, and had not			Correction to the extent that findings is factually correct a maintain compliance with apand provisions of quality of cresidents. The Plan of Corresubmitted as a written allegation compliance.	and in order to oplicable rules care of oction is
	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.				Johnson Mathers Nursing H to this Statement of Deficient denote agreement with the Statement does it considerately admission that any deficience Further, Johnson Mathers N	cies does not Statement of stitute an cy is accurate.
	unsubstantiated witi identified. Complaints KY0003 KY00034203, and k	h no deficient practice 3997, KY00034202, 3997, KY00034202, 3997, KY00034202, 3997, KY00034002,			reserves the right to refute a deficiencies on this Stateme Deficiencies through Informa Resolution, formal appeal prany other administrative or least	iny of the int of a! Dispute rocedure and/or
	suffered a cardiopul Practical Nurse (LP full CPR to be given Coordinator/Quality initiated CPR for ap Then, LPN #15 assa pulse and stated to	30 PM, Resident #242 Imonary arrest and Licensed N) #15 called a Code Blue for a The Staff Development Improvement (SDC/QI) nurse proximately two (2) minutes, essed Resident #242 to have to stop CPR. However, the tor directed the SDC/QI nurse			proceeding.	

Administrator 11/19/2021 Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is regulate to continued

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

TITLE

(X8) DATE

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

STATSAGAE		& WEDICAID SERVICES				OMB NO. 0938-0391
AND PLAN	COFFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		PLE CONSTRUCTION	(XX) DATE SURVEY COMPLETED
		185028	8. WING	;		C 09/02/2021
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	UBIUZIZUZI

JOHNSC	N MATHERS NURSIN	G HOME		9	2323 CONCRETE ROAD	
				<u>L</u> '	CARLISLE, KY 40311	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 000	Hydrocodone (Sche Gabapentin (Sched Additionally, LPN # Primidone (non-comperson, which she a Resident #32's and narcotic medication misappropriated. Ten (10) additional fourteen (14) controut signed out propout which were the samon LPN #1 by the P #1, #79, #47, #34, # Review of a Uniform revealed LPN #1 was of Wanton Endange thirteen (13) counts Controlled Substance Possession of a Co (2) counts of Abuse Person. On 07/20/2021, the determined, in an action of the signed by LP count of narcotic sk Change Count Sheet signed by LP Count of narcotic sk Change Count Sheet signed by LP The facility's failure to follow their policie and to ensure all reand to prevent furth	aduled II narcotic), and uled III anticonvulsant). If was found to have atrolled anticonvulsive) on her admitted she used to replace Resident #84's controlled s, which she had a total of olled medications missing and erly, on 07/18/2021, some of the type of medications found olice: Resident #71, #8, #56, #60, #48, and #65. In Citation, dated 07/18/2021, as charged with two (2) counts arment in the First Degree; of Theft by Unlawful Taking, ce; three (3) counts of introlled Substance; and two and Neglect of an Adult Director of Nursing (DON) udit, the Shift Change Count N #2 had one (1) less in the ids from the previous Shift et. The facility determined missing skid of Percocet, and inded. To take immediate action and as to prevent further abuse esidents were free from abuse er misaopropriation of		D90	DEFICIENCY)	
	medications were a	so that their controlled				

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

		A MEDIONIO OLIVIOLO			C C	MB NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTR		(X3) DATE SURVEY COMPLETED
		185028	B. WING			C 09/02/2021
NAME OF	PROVIDER OR SUPPLIER			STREET ADD	DRESS, CITY, STATE, ZIP CODE	08/02/2021
					RETE ROAD	
JOHNSO	N MATHERS NURSIN	IG HOME				
13444.00	CHANNEY				KY 40311	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (E	PROVIDER'S PLAN OF CORRECTIC ACH CORRECTIVE ACTION SHOUL SS-REFERENCED TO THE APPROF DEFICIENCY)	BE COMPLETION
F 000	483.70 Administration of an "E" while the fimplements a Plan Quality Assurance (compliance with syn Additional deficience 483.10 Resident Riand F-571 at a S/S Assessment F-641 483.21 Comprehen Plans F-656 at a S/of an "E"; 42 CFR 4 and F-689 both at a Food and Nutrition "D" and F-812 at a	a S/S of an "E"; and 42 CFR fon, F-835 and F-837 at a S/S facility develops and of Correction and the facility's (QA) monitors to ensure	F	000		
F 550. SS≃D	Resident Rights/Ex CFR(s): 483.10(a)(ercise of Rights	F	550	F 550	
	§483.10(a) Resider The resident has a self-determination, access to persons a outside the facility, this section. §483.10(a)(1) A fac with respect and dig resident in a manne promotes maintena her quality of life, re-	nt Rights. right to a dignified existence, and communication with and and services inside and including those specified in will must treat each resident gnity and care for each er and in an environment that ince or enhancement of his or ecognizing each resident's	6		Residents #13 and #3 assessed by the Regi Staff Development Co (SDC), on 09/02/21 are ensure the residents wand/or their privacy cupulled to ensure the retreated with dignity whall residents have the affected by the deficie	stered Nurse, ordinator nd 09/08/21, to vere covered intains were esidents were nile in bed. potential to be
	individuality. The fa promote the rights of §483.10(a)(2) The fa	cility must protect and		3.	Beginning 8/26/21, 10 were educated by the of Nursing (DON), Ad (ADM), Activities Dire	0% of staff SDC, Director ministrator

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

	THE PROPERTY OF MEDICALD SERVICES				(DMB NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILC		ONSTRUCTION	(X3) DATE SURVEY COMPLETED
		185028	B. WING			C 09/02/2021
	PROVIDER OR SUPPLIER ON MATHERS NURSIN	IG HOME		2323	ET ADDRESS, CITY, STATE, ZIP CODE CONCRETE ROAD LISLE, KY 40311	09/02/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPLETION
F 550	Continued From pa facility failed to prot the residents for tw residents; Resident	ect and promote the rights of o (2) of forty-four (44)	F:	550		
	Agency (SSA) Survithe resident was lyillegs exposed; the rebrief from the waist Observations, on Osurveyor of Reside was lying in bed waresident's room doc #13 and #31, staff cresidents' rooms withe residents were	8/10/2021, by the State Survey eyor of Resident #13 revealed ong in bed with his/her bare esident was wearing only a down and was uncovered. 8/12/2021, by the SSA on the waste of the exident earing only briefs with the er wide open. For Resident entered and exited the thout notifying nursing staff exposed or providing privacy culling the privacy curtain.				
	document, undated right to live with dig	ry's "Resident Rights" , revealed the resident had the nity and to be treated with the document stated residents				ā
6.	revealed the facility 07/28/2017, with dia	lent #13's medical record admitted the resident, on agnoses including Dementia, Disorder, Arthritis, and order.				
	Plan, revised on 11. resident required as goal was the reside dressed. The inter-	#13's Comprehensive Care //08/2019, revealed the ssistance for dressing. The ent would be appropriately vention was the resident assistance of one (1) staff for				

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES					D. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILO		STRUCTION	(X3) DA	TE SURVEY
		185028	8. WING				C 9/02/2021
NAME OF F	ROVIDER OR SUPPLIER			STREET	ADDRESS, CITY, STATE, ZIP CODE	U	9/02/2021
JOHNSO	N MATHERS NURSIN	G HOME		2323 C	ONCRETE ROAD ISLE, KY 40311		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLO BE	(XS) COMPLETION DATE
F 550	#13. He then open pushing the curtain wall. Resident #13 legs bare from the state the resident was we walst down. Further stood outside Resident medication cart preadministration and door two (2) times, the resident's room staff the resident was linterview with Main 08/10/2021 at 12:11 at the facility for eleinterview, he had be training by the facility usually would knock entering, ensure prewould let nursing state to be covered up; had it that today. Fut those things ensure and privacy. Interview with RN # revealed she had we months. Per the in Resident Rights to Additionally, she state entering, ensure premate ensure resident or covered up. Fur continuously round	with his back to Resident ed the privacy curtain by back between the beds to the was lying in bed, with his/her waist down and uncovered; saring only a brief from the or observation revealed RN #3 dent #13's room on the paring medications for walked past Resident #13's Maintenance staff #1 exited and did not notify nursing as exposed. Itenance staff #1, on 5 PM, revealed he had worked oven (11) years. Per the een provided Resident Rights ity. Additionally, he stated he know if a resident needed ovever, he said he forgot to other, he stated he was aware at Resident Rights of dignity. If yorked at the facility for two (2) terview, she was aware of include dignity and privacy, ated all staff should ensure d knock on doors before ivacy curtains were closed, ats were dressed appropriately ther, RN #3 stated she would on the hallways and watch the		550			
	medications and di	, today she was passing d not notice Resident #13 was					

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			MB NO. (0938-0391	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		LE CONSTRUCTION	(X3) DATE	
		185028	8. WING	i		09/0	2/2021
NAME OF F	ROVIDER OR SUPPLIER			9	STREET ADDRESS, CITY, STATE, ZIP CODE		
IOMNEO	N MATHERS NURSIN	IC LICHT		2	2323 CONCRETE ROAD		
JOHIJO	MENON CHAIRMAN			(CARLISLE, KY 40311		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	86	(X3) COMPLETION DATE
F 550	Continued From pa	age 10	E	550			
		covered or the curtain pulled	' `	500	'		
	for privacy, and it w	as a dignity issue.					
	08/12/2021 at 1:40 should have been of for privacy. SRNA history of playing with blankets. SRN issue with staff paspulling the curtain. Interview with Licer on 08/12//2021 at 1 #31 should have builted. LPN #9 staknocked at the dooresident; and it was addition, LPN #9 stocover the resident.	A #14, North Unit, on PM, revealed Resident #31 covered or the curtain pulled #14 stated Resident #31 had a lith his/her briefs or kicking off A #14 stated it was a dignity sing by and not covering up or nsed Practical Nurse (LPN) #9, 1:45 PM, revealed Resident een covered up or the curtain sted, first, staff should have ur and asked to cover up the sa dignity concern. In lated staff should be educated not, pull curtains, dress the or close the resident's door.					
	Improvement/Infect Development Coor 10:30 AM, revealer himself/herself. St resident or pull the she expected staff	stered Nurse (RN) Quality tion Control Preventionist/Staff dinator, on 08/16/2021 at d Resident #31 uncovered ne stated staff should cover the curtain. Further she stated to round and check on keep him/her covered due to /her dignity.					
	08/18/2021 at 10:5 should have been She stated SRNA; pulled the curtain a the roommate into	Director of Nursing (DON), on 4 AM, revealed Resident #31 covered or the curtain pulled. #22 could have covered or after the staff member brought the resident's room. Further, is was a dignity issue.					

CENTERS FOR MEDICARE	AND HUMAN SERVICES			F	RINTED: 10/11/2021 FORM APPROVED
				C	MB NO. 0938-0391
AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A BUILD	LTIPLE CONS	TRUCTION	(X3) DATE SURVEY COMPLETED
Allah Basan	185028	B. WING			C 09/02/2021
NAME OF PROVIDER OR SUPPLIER			STREET	DDRESS, CITY, STATE, ZIP CODE	1 10/03/12/03/1
JOHNSON MATHERS NURSING	3 HOME		2323 COI	CRETE ROAD	
			CARLIS	LE, KY 40311	
PREFIX (EACH DEFICIENCY)	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI ROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
charge against the program for any item or service under Medicaid or Mapplicable deductible. The facility may charservices that are more excess of covered signification on facility services for which Migham for the Medicaid program as payment in full, Migham for the Medicaid program for the Medicaid program for the Medicaid program for the Medicaid charge a resident for Items and services: (A) Nursing services: (A) Nursing services: (A) Nursing services: (B) Food and Nutrition §483.80. (C) An activities program for the maint (E) Routine personal as required to meet including, but not liming comb, brush, bath so specialized cleansing treat special skin program, shaving cream denture adhesive, demoisturizing lotion, till	acility must not Impose a personal funds of a resident ce for which payment is made ledicare (except for a and coinsurance amounts). The resident for requested re expensive than or in ervices in accordance with ter. (This does not affect the charges for items and ledicald has pald. See ter, which limits participation ram to providers who accept, ledicald payment plus any ince, or copayment required do by the individual.) in Medicare or Medicaid course of a covered distay, facilities must not or the following categories of as required at §483.35. On services as required at gram as required at	F	2	F 571 Residents #30, #34, a trust fund accounts we by the corporate busin 07/27/21. Resident # trust fund account was by the corporate busin 08/18/21. Regional business off and corporate complia conducted audits of all patient trust fund account was purchased on 07/22/2 08/19/21. Any items p which were identified a responsibility were rei residents' patient trust 5. The Administrator and Office Manager (BOM educated on 07/22/21 by the Regional Vice I (RVP) and Corporate Office, on what items purchased with reside must be provided by the General accounting putilized which includes duties. The Administr will have oversight of accounts. Residents written information religion.	ere reimbursed ness office on 77's patient s reimbursed ness office on ice personnel ance staff Il residents' bunts and Items 1 and surchased as facility mbursed to the t accounts. I Business I) were and 07/23/21, President Business cannot be ant funds and the facility. rinciples are s separation of rator and BOM the RFMS were provided

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

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA			ONSTRUCTION	(X3) DAT	E SURVEY
	o o o o o o o o o o o o o o o o o o o	DENTIFICATION NUMBER:	A. BUILD	ING			APLETED .
		185028	B. WING				C /02/2021
NAME OF	PROVIDER OR SUPPLIER			l .	ET ADDRESS, CITY, STATE, ZIP CODE		
JOHNSC	N MATHERS NURSIN	IG HOME		1	CONCRETE ROAD LLISLE, KY 40311		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECT	ION	(20)
PRÉFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRI DEFICIENCY)	LDBE	COMPLETION DATE
F 571	Continued From pa	ige 14	F:	571			
	control).						:
	(L) Except as provi	ded in (e)(11)(ii)(L)(1) and (2)					
	of this section, spe	cially prepared or alternative					
		tead of the food and meals					
	§483.60.	by the facility, as required by					
		not charge for special foods					
	and meals, includir	ng medically prescribed dietary					
		red by the resident's physician,					
		, nurse practitioner, or clinical					
	\$483.60.	s these are included per					
	₩	with §483.60(c) through (f),					
	when preparing for	ods and meals, a facility must					
		ition residents' needs and					
		e overall cultural and religious					
	make-up of the fac (iii) Requests for ite	ams and services					
	(A) The facility can	only charge a resident for any					
		or service if such item or					
		illy requested by the resident.					
		st not require a resident to					
		r service as a condition of					
	admission or continue (C) The facility must	nued stay. st inform, orally and in writing,					
	the resident reques	sting an item or service for					
l	which a charge will	I be made that there will be a					
		or service and what the					
	charge will be.	10.1700					
[by:	NT is not met as evidenced					
		ation, interview, record review,					
		acility's documents and policy,					
	it was determined	the facility failed to have an					
		place to limit charges on					
		I funds. In addition, the facility					
		sidents' personal funds from					
		hasing of Items for residents oney and for any item not					

		& MEDICAID SERVICES					C	MB NO	. 0938-0391
STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTIO	N		(X3) DATE SURVEY COMPLETED	
		185028	B. WING					1	C /02/2021
	PROVIDER OR SUPPLIER IN MATHERS NURSIN	IG HOME		232	REET ADDRESS, 23 CONCRETE ARLISLE, KY	ROAD	ZIP CODE	į us	102/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	K	PROVII	DER'S PLAN OF ORRECTIVE AC FERENCED TO DEFICIEN	TION SHOULD THE APPROP	D RE	(X5) COMPLETION DATE
F 571	Review of 42 CFR facility must not impersonal funds of a service for which particles and coin addition, the regula only charge a resid or service if such its requested by the revealed the facility writing, the resident for which a charge would be a charge would be a charge what the charge would be a charge what the charge would be a charge what the charge would be a charge what the charge would the Stimulus and Repressionsibilities, da 07/21/2021, revealed used solely at the resident liability at the money did not cour federal programs life attempt by the facilianter with residents discuss what could the Stimulus monie what to do if the facilianter what the charge which was a constanter where where where where which was a constanter where where where where where where we was a constanter where	A83.10(f)(111) revealed the cose a charge against the resident for any item or ayment was made under are (except for applicable surance amounts). In tion stated the facility could ent for any non-covered item em or service was specifically sident. Further review must inform, orally and in trequesting an item or service would be made that there for the item or service and ould be. Ly's document Guideline: escentative Payee atted 05/29/2020 and updated ed Stimulus money was to be discretion of the resident or Under no circumstances a money be used to pay the facility. The Stimulus at as resources to affect the Medicald for a year and any ity to seize the money was the Guideline stated that an arm (IDT) meeting should be and responsible parties to foculd not be purchased with s, who should be invited, and allity staff became aware of	F	771					
	07/21/2021, reveale	n Meeting minutes, dated ad Corporate became aware hecks were used to purchase							

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

CENTER	NTERS FOR MEDICARE & MEDICAID SERVICES								
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		LE CONSTRUCTION	(X3) DAT	. 0938-0391 E SURVEY IPLETED		
		165028	B. WING		·		C /02/2021		
NAME OF P	ROVIDER OR SUPPLIER			- 5	STREET ADDRESS, CITY, STATE, ZIP CODE				
IONNEO	N MATUEBO MURON	IC LIONE		1	2323 CONCRETE ROAD		- 1		
JOHNSO	N MATHERS NURSIN	IG HOME			CARLISLE, KY 40311				
(X4) IO PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(XS) COMPLETION DATE		
F 571	Continued From pa	ege 18	F.s	571					
		thorized payment of \$3,334.74		J					
		that included a forty Inch							
1		99 and an Optima Evolution							
); that authorization form was							
	signed by the previ	ious Administrator.							
		t #77's progress notes, dated							
	October 2020 until	March 2021, revealed no							
		nce the POA was contacted							
		ision or chair. There were re the POA was notified of							
		sults and testing for COVID.							
		tional Therapy notes revealed							
	no documented ev	idence of an assessment of							
	the evolutionary ch	air. Interview, on 08/18/2021							
		he DON revealed there were							
	no therapy notes a	bout the resident's evolutionary lesident #77's care plan, dated							
	10/2019, revealed	the evolutionary chair was for							
	comfort and position								
	Review of Residen	nt #77's financial statements,							
		revealed a total of \$2,853.42							
	was refunded to R	esident #77's RTA account.							
	This amount include	ded the cost of the chair, laxes,							
	shipping, and inter	est for April-July 2021.							
	Attempts to reach								
		(POA) via phone, on							
		15 AM and 08/18/2021 at 9:30							
		essful; the voice mail was not							
	set up.								
		dent #36's RTA revealed							
		timulus monies on 04/07/2021							
		09/2021, authorization for							
		ments from patient trust I the facility, as Resident/Legal							
	Representative, at	the facility, as Resideni/Legal uthorized payment of \$1,286.82							
R									

PRINTED: 10/11/2021 FORM APPROVED

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES		MB NO.	0938-0391			
	OF DEFICIENCIES IF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION		(X3) DATI	E SURVEY IPLETED
·		185026	B. WING	;				C 02/2021
NAME OF	PROVIDER OR SUPPLIER			57	REET ADDRESS, CITY, STATE, ZIP CODE	_	401	UZIKUZ I
JOHNSO	N MATHERS NURSIN	IG HONE		23	23 CONCRETE ROAD			
				C.	ARLISLE, KY 40311			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREI (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	משעכ	BE	(XS) COMPLETION DATE
F 571	Interview with the M Registered Nurse (AM, revealed that has a fall intervention #36 had issues with stated a resident genot be a decision sibecause there were She stated Resider mattress for a day bed, and it was against tress. Per the indecision to replace former Administrate her reasoning. Interview with Staff Coordinator/Quality nurse, on 08/17/20 she knew was that ordered Resident #comfort. However, not complained the had requested a new Review of Resident #comfort to Reside 3. Review of Resident #comfort to Reside 13. Review of Resident #comfort trust account the Resident/Legal payment, by signat	Minimum Data Set (MDS) RN) #7, on 08/17/2021 at 9:20 ypically mattresses were used as and was unaware Resident at the winged mattress. She elting a new mattress would be would make by herself adifferent factors involved. at #36 had not been on the air before he/she fell out of the alin replaced by the winged anterview, she stated the the mattress was made by the bor, and she was uncertain of Development a improvement (SDC/QI) 21 at 10:21 AM, revealed all the former Administrator 36 the air mattress for she stated Resident #36 had bed was uncomfortable nor	F	571				
	\$482.99 and a Lift	Chair for \$617.00.						

		& MEDICAID SERVICES					0938-0391
STATEMENT AND PLAN (OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		185028	B. WING				C 02/2021
	PROVIDER OR SUPPLIER ON MATHERS NURSIN	IG HOME		23	REET ADDRESS, CITY, STATE, ZIP CODE 23 CONCRETE ROAD		ozrava t
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	ıx	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD 8F	(X5) COMPLETION DATE
F 571	for \$482, a microAl low air loss mattres 4100 bed frame for \$390.00, and a 3-di \$237.00. Interview with Residable to say how hele specific items and of the same to chest and television. However, per observation of Residest and television his/her room. Interview with the EAM, revealed the mass unaware of who DON stated she we locate the bed fram unaware of any item because the former	Included a forty inch television R MA500 alternating pressure is system for \$892.99, a Matrix \$932.99, a 4-drawer chest for rawer bedside cabinet for dent #34, 08/19/2021 at 10:20 a "ordered'em" but was not she knew to order those did not look at a catalogue. Ident #34's room, with the me, revealed the cabinet, in were in Resident #34's room, wation, the bedframe was not except the bedframe was. The folding get with Maintenance and e. She also stated she was instituted to she was doing with the	F	571			
	08/19/2021 at 1:40 resident electrical it Resident #34 did remattress, which wa Administrator. How not have a headboaddition, he stated did not meet safety enough to prevent it	faintenance Director, on PM, revealed he inspected all ems for safety. He stated eceive a new bed frame and sordered by the former vever, he stated, the bed did and nor a foolboard. In the wheel locking mechanism standards for locking tightly the bed from slipping if a out of the bed. Therefore, he					

		& MEDICAID SERVICES						0938-0391
AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUI A. BUILC		LE CONSTRUCTION		(X3) DA	TE SURVEY MPLETED
		185028	8. WING	•				С
NAME OF	PROVIDER OR SUPPLIER	100020	B. WING				09	/02/2021
						CITY, STATE, ZIP CODE		
JOHNS	ON MATHERS NURSIN	IG HOME		ı	2323 CONCRETE			
734 41 MB	21 24 44 24 24				CARLISLE, KY	40311		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CO	DER'S PLAN OF CORRECT DRRECTIVE ACTION SHOU ERENCED TO THE APPRO DEFICIENCY)	DAF	(X5) COMPLETION DATE
F 571	purchased.	eral items had been	F	571	I			
	revealed the facility RTA account \$1657	plus Payment Tracking Report reimbursed Resident #246's .60 on 07/13/2021.						
	Trust Accounts Cler revealed the facility 05/2020, she thought Resident Stimulus of or a year. She statused until this year durable medical equithe former Administ	ccounts Receivable/Resident ik, on 08/13/2021 at 2:05 PM, was given information in ht from Corporate, that thecks would not affect RTA and Stimulus monles were not (2021) to buy residents uipment (DME). She stated rator initiated using RTA for the country of th						
	on 08/19/2021 at 9 questioned the form Stimulus monies, the purchased Items could be the residents. The requisition slips as a stems because she was administrator she was further, she stated administrator the 05 documentation regate former Administrator the pit was okay. Further did not report the former th	at Trust Accounts (RTA) Clerk, 15 AM, revealed when she are Administrator about using the Administrator told her all the used or were needed the Clerk stated she signed the switness for all the ordered was told by the former as always the witness, when she showed the former						

		& MEDICAID SERVICES				MB NO. 0938-0391	į
AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUU A. BUILD		ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185028	B. WING			C 09/02/2021	
NAME OF I	PROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE		1
IOHNSO	N MATHERS NURSIN	IO LIGHT			CONCRETE ROAD		ı
30111130	MICHUR CHARLING	G HOME			LISLE, KY 40311		1
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID			·	4
PREFIX TAG	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFE TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION	
F 571	outsided i tolli pe		F 5	571			
	Administrator. He s	stated, until July, there was no					I
	awareness the form	ner Administrator had used					ı
	have furnished and	rchase items the facility should that this had happened as					ı
	early as January or	February 2021. He stated the					ı
	facility needed a mo	ore regular audit of the					ı
	business office, and	this was going to be put in					ı
	place. He stated th	e facility did have audits that					ı
	looked into those th	ings that were usually done					i
	there were different	mes semi-annually. He stated to price levels where the RVP					ı
	was triggered to loc	ok at a purchase. He stated he					ı
	expected if the Adm	inistrator was using resident					ı
	money for DME pur	rchases, someone would call					ı
	Corporate. He state	ed he believed staff had been					ł
	intimidated by the fo	ormer Administrator. He					1
	earlier to someone.	e incidents had been reported					
	Interview with the R	Regional Vice President (RVP),					
	on 08/20/2021 at 3:	03 PM, revealed there was a					ı
	checks should be a	/2021 regarding how Stimulus pent and Stimulus monies					Į
	would not affect cas	pent and Stimulus montes sident Medicaid status for at					ı
	least a year. An ad	ditional update was sent					ı
	07/21/2021 reiterati	ing Stimulus expenditures and					ı
	the public health en	nergency was in effect until					ı
	October 2021. He:	stated he was not aware					I
	Stimulus monies we	ere used inappropriately and					
	that is something th	at is taken very seriously. He					ı
	stated the facility ha	ad addressed it through a					ı
	from a Quality Asset	and looking at processes trance standpoint. The facility					ı
	had made some ref	funds of purchased items that					ı
	the facility should o	r would have normally					ı
	purchased. He stat	ted those items were not					
	expensive enough I	to require prior approval. The					J
	RVP stated he did r	not have a great answer					ı
	regarding what syst	em should have caught this,					1

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDERSUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVICES COMPLETED B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 2323 CONCRETE ROAD CARLISLE, KY 40311 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETED COMPLET			AND HUMAN SERVICES			F	'RINTED: 10/11/2021
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER SUPPLIER (X2) MULTIPLE CONSTRUCTION A. BUILDING NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2323 CONCRETE ROAD CARLISLE, KY 40311 (X4) NO SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 600 Continued From page 28 F 600 Meeting will be completed, five tim (anti-convulsive) and taped into the Roxicodone (X3) MULTIPLE CONSTRUCTION (X3) DATE SURVICCION (X3) DATE SURVICCION (X3) DATE SURVICCION (X3) DATE SURVICCION (X4) MULTIPLE CONSTRUCTION (X5) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X7) MULTIPLE CONSTRUCTION (X6)	CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				FORM APPROVED MB NO. 0938-0391
NAME OF PROVIDER OR SUPPLIER JOHNSON MATHERS NURSING HOME STREET ADDRESS, CITY, STATE, ZIP CODE 2323 CONCRETE ROAD CARLISLE, KY 40311 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) FROM COMPARE OF PROVIDERS PLAN OF CORRECTION PREFIX TAG PROVIDERS PLAN OF CORRECTION SHOULD BE COMPARED TO THE APPROPRIATE DATE OF COMPARED TO THE APPROPRIATE DEFICIENCY) FROM COMPARE OF PROVIDER OR STATE OF DEFICIENCIES PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) FROM COMPARE OF PROVIDER OR SUPPLIES (EACH CORRECTIVE ACTION SHOULD BE COMPARED TO THE APPROPRIATE DEFICIENCY) FROM CARLISLE, KY 40311 PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPARED TO THE APPROPRIATE DEFICIENCY) FROM CARLISLE, KY 40311 PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPARED TO THE APPROPRIATE DEFICIENCY) FROM CARLISLE, KY 40311 PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPARED TO THE APPROPRIATE DEFICIENCY) AND DEFICIENCY DATE OF THE APPROPRIATE DEFICIENCY DEFICIENCY DATE OF THE APPROPRIATE DEFICIENCY DATE OF THE APPROPRIATE DEFICIENCY DATE OF THE APPROPRIATE DATE			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
JOHNSON MATHERS NURSING HOME 2323 CONCRETE ROAD CARLISLE, KY 40311 (XA) IO SUMMARY STATEMENT OF DEFICIENCIES PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) FREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) FREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) FREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPARED TO THE APPROPRIATE DEFICIENCY) FREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPARED TO THE APPROPRIATE DEFICIENCY) FREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPARED TO THE APPROPRIATE DEFICIENCY) FREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPARED TO THE APPROPRIATE DEFICIENCY) FREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPARED TO THE APPROPRIATE DEFICIENCY) FREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPARED TO THE APPROPRIATE DEFICIENCY) FREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPARED TO THE APPROPRIATE DEFICIENCY) FREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPARED TO THE APPROPRIATE DEFICIENCY) FREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPARED TO THE APPROPRIATE DEFICIENCY) FREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPARED TO THE APPROPRIATE DEFICIENCY)			185028	B. WING			C 09/02/2021
F 600 Continued From page 28 F 600 Continued From page 28 F 600 Cantinued From page 28 F 600			IG HOME		2:	323 CONCRETE ROAD	
(anti-convulsive) and taped into the Roxicodone a week for two weeks, then weekl	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	O BE COMPLÉTION
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 fiffy (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 lipiury, serious harm or death to other residents in the facility. Immediate Jeopardy (IJ) and Substandard Quality of Care (SGC) 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 LI and SGC 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 #23 down, resulting in a hermatoma to Resident #35 shead. On 06/27/2021, Resident #21. The facility provided an acceptable Immediate Jeopardy, on 08/31/2021, The Salte Survey Agency validated removal of the Immediate Jeopardy, as alleged on 08/31/2021, prior to exit on 09/02/2021. The Salte Survey Agency validated removal of the Immediate Jeopardy, as alleged on 08/31/2021, prior to exit on 09/02/2021. The facility remaining	F 600	(anti-convulsive) and blister pack. Review of a Uniform dated 07/18/2021, with two (2) counts First Degree. LPN she switched out m (50) milligrams (mg would have on the action of the facility's failure prevent further abusensure all residents caused or is likely tharm or death to other immediate Jeopard of Care (SQC) were were determined to area of 42 CFR 48: F-600, Free from A of the IJ and SQC of the IJ and IJ a	in Citation (police report), revealed LPN #1 was charged of Wanton Endangerment, #1 admitted to the police that redications for Primidone fifty p), not caring what effects it residents. It to take immediate action to se and to follow their policy to swere free from abuse has o cause serious injury, serious ther residents in the facility. By (IJ) and Substandard Quality is identified on 08/20/2021, and exist on 07/18/2021, in the 3.12 Freedom from Abuse, buse. The facility was notified on 08/20/2021. determined the facility failed to om abuse for an additional Residents #21, #45, #28, and 21, Resident #28 pushed on, resulting in a hematoma to ad. On 06/27/2021, Resident #21, resulting in multiple asions to Resident #21. d an acceptable Immediate Plan on 09/01/2021, with the roval of the Immediate enoval	F	300	a week for two weeks for four weeks, then months, to ensure any abuse or misapproprize reported. Resident converse any concern more misappropriation where any concern more control of the consumer of the control	s, then weekly nonthly for two y allegation of ation was oncerns will be neeting to regarding abuse was reported to ensure the cted. On SDC, MDS es Director (AD) or gan on residents with y weekly for four for two months, no concerns eir controlled nistered. Abuse ontinue as per Data will be thly Quality nce Committee additional

CENTER	S FUR MEDICARE	E MEDICAID SEKVICES				SINITI 140	. 0000-0001
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MUI A. BUILD		INSTRUCTION		E SURVEY APLETED
ı		185028	B. WING			00	C (02/2021
		103020			ET ADDRESS, CITY, STATE, ZIP CODE	03	02/2021
NAME OF P	ROVIDER OR SUPPLIER		'				'
JOHNSO	N MATHERS NURSIN	NG HOME			CONCRETE ROAD		
				CARI	LISLE, KY 40311		
(X4) ID PREFIX TAG	(EACH DEFICIENC	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	IO PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X3) COMPLETION CATE
F 600		•	F	600			
		th three (3) empty packs; one					
	4:7 4	325 mg tablet; one (1)					
	10/325 ma tableter	ablet; two (2) Hydrocodone ; three (3) Gabapentin 600 mg :					
	tablets: five (5) Ga	bapentin 300 mg tablets; one					
}	(1) empty skid (a b	lister pack when full contained					
	thirty (30) tablets)	of Roxicodone labeled for					
	Resident #32; and	, one (1) pack of birth control					
	pills labeled for LP	N #1.					
		of the report, revealed LPN #1					
		medications from the facility, ig some narcotics out and					
		h Primidone 50 mg, without					
	regard for how this	s would affect the involved					
İ		I stated, if the police drug					
		ould have Hydrocodone,					
		entin, and Marijuana in her					
		eport, LPN #1 stated she did					
1		cotics removed from her					
		ntil the end of the shift and nurses					
		erefore, the medication could be	1				
	missing and even	taken by the resident but not	-				
	yet signed out on	the narcotic record. The report					
	stated LPN #1 wa	is charged with two (2) counts o	f				
		rment in the First Degree;					
	thirteen (13) coun	its of Theft by Unlawful Taking					
		ed Substance; three (3) counts	_				
		a Controlled Substance; and tw	Ū				
	(2) counts of Abus	se and Neglect of an Adult					
	F613011.						
	Interview with the	Registered Nurse (RN) Facility	,				
		7/27/2021 at 1:15 PM, and again	n,				
		2:32 PM, revealed she had					
1		rom corporate as a result of the	1				
	TERMINOR ICCHAR IN	Nazzanne en ni neneun ici					

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

PRINTED: 10/11/2021 FORM APPROVED OMB NO. 0938-0391

		A			711111 TTO: 0000-0001
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILC	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		185028	B. WING		C 09/02/2021
NAME OF E	ROVIDER OR SUPPLIER			STDEET ADDRESS CITY STATE TO COSE	USIUZITUZ I
HAME OF F	MOVIDER ON SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
JOHNSO	N MATHERS NURSIN	IG HOME		2323 CONCRETE ROAD	1
				CARLISLE, KY 40311	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		D BE COMPLÉTION
F 600	Percocets was whe was missing, which an audit conducted she had reported it sent the information on 07/09/2021. Co when police came with them, the Adm pharmacy had delir (30) Percocet 50 m 06/28/2021; howevereceived two (2) sk thought there was was not on the trigineither LPN #1 nor Interview with the 3:15 PM, revealed following an incide of Percocet tablets stated, when aske implicated in drug DON replied she w (2) nurses was restated, when the D suspend both staff her shoulders. Continued intervie Consultant, on 07/10/18/2021, sh who informed her taped into a Roxic	e first she heard of missing on pharmacy determined a skid of belonged to Resident #17, in on 07/09/2021. She revealed his to the Administrator and in in a self-report to the police ontinued interview revealed to the facility, she never spoke ninistrator did. She stated evered three (3) skids of thirtying tablets for Resident #17, on er, LPN #1 stated she only stated she a trigger call that day, but she ger call. The DON stated in LPN #2 were suspended. Ombudsman, on 07/26/2021 at she interviewed the DON int, on 07/09/2021, after a skid is was reported missing. She diabout suspending staff diversion on 07/09/2021, the vas not sure which of the two sponsible. The Ombudsman DON was asked why she did not if members, the DON shrugged with the RN Facility 127/2021 at 1:15 PM, revealed, e was contacted by the DON, LPN #2 had found two (2) pills odone skid belonging to the were not Roxicodone.		600	
	also had two (2) p	and resident, Resident #84, who ills taped into a Roxicodone ot Roxicodone. She stated the)		

pills used to replace the Roxicodone were

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				O		0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUL A. BUILD		CONSTRUCTION		(X3) DATE	
		185028	B. WING	J			Date:	2/2021
NAME OF F	PROVIDER OR SUPPLIER			STI	REET ADDRESS, CITY, STATE, ZIP CODE	_	03/0	12/2021
JOHNSO	ON MATHERS NURSIN	IG HOME		232	23 CONCRETE ROAD ARLISLE, KY 40311	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD	BE	(XS) COMPLETION DATE
F 600	the narcotics sheet DON had taken the which tracked the n	, but the Administrator and Shift Change Count Sheet, number of controlled substance		600				
	skids in the cart. Li another sheet and i	PN #2 stated she started counted forty-two (42) sheets.						
	PM, revealed LPN: 07/18/2021, taped: #32 of two (2) Roxi replaced with some to that, she wanted narcotics in the dra #84 also had two (2 from a skid and rep He revealed LPN # and he knew they h while he was still or							
	AM, revealed she in the night of 07/18/2 LPN #2, stated that Resident #32's nari with other pills. She text, on 07/18/2021 she had found a se who had two (2) na pills. The DON sta Administrator. The trigger call, at 7:52	OON, on 08/04/2021 at 8:28 eceived a cell from LPN #2, on t021 at 7:30 PM. She stated is she had found two (2) of cotics that had been replaced e stated she also received a at 7:47 PM from LPN #2, that cond resident, Resident #84, rcotics replaced with other ted she alerted the Administrator then had a PM, with the Facility nical Director, and the Regional						
	at 8:28 AM, revealed came in a little after police and the SSC	with the DON, on 08/04/2021 and the Administrator r 9:00 PM on 07/18/2021; If were already present in the they did cart audits, and the						

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES					M APPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) D/	O. 0938-0391 NTE SURVEY OMPLETED
	_	185028	B. WING				C 9/02/2021
	PROVIDER OR SUPPLIER ON MATHERS NURSIN	IG HOME		232	LEET ADDRESS, CITY, STATE, ZIP CODE 3 CONCRETE ROAD RLISLE, KY 40311		310212021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(XS) COMPLETION DATE
F 600	Stage Renal Disease Diseases Classifler Disturbance, and D Record review reverses	ge 36 agnoses that included End se, Dementia in Other I Elsewhere without Behavioral ependence on Renal Dialysis, aled the facility assessed Quarterly Minimum Data Set	F 6	00			
	(MDS) Assessment fourteen (14) of fifter for Mental Status (Elimpairment. Continumedical record revedated 03/23/2021, fanti-selzure medical 100 mg at bedtime. Physician's Order, (Oxycodone) 5 mg needed for pain.	i, dated 04/26/2021, as ear (15) on the Brief Interview BIMS), indicating no cognitive nued review of Resident #84's ealed a Physician's Order, for Neurontin (Gabapentin, an also used for nerve pain). The record revealed another on 05/10/2021 for Roxicodone every eights (8) hours as					
	Count Record for R 06/10/2021, revealed with use twice a day #1 had signed out of	#84's Controlled Substance oxicodone 5 mg, delivered on ad frequent use once a day, on multiple occasions. LPN eight (8) tablets on the record, documented as replaced with /2021.					
	2:45 PM, revealed I medications on time experienced pain, s medications. Resid	dent #84, on 07/28/2021 at ne/she received his/her e, and whenever he/she taff provided him/her with pain lent #84 stated he/she had wrong medications, as far as					
	revealed she had of Medication Adminis	#6, on 08/10/2021 at 2:40 PM, bserved, on Resident #84's tration Record (MAR) that utinely receive pain					

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				D.		APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A BUILD		ONSTRUCTION		(X3) DAT	E SURVEY
		185028	B. WING	i			I	C
NAME OF	PROVIDER OR SUPPLIER		1	STRE	ET ADDRESS, CITY, STATE, ZIP	20005	09/	02/2021
JOHNSO	N MATHERS NURSIN	G HOME		2323 (CONCRETE ROAD LISLE, KY 40311	- 0002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ix	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD HE APPROPI	BE	(05) COMPLETION DATE
F 600	Count Record for R 06/15/2021, revealed	ge 38 #32's Controlled Substance oxicodone 5 mg, initiated on id the last two (2) medications in replaced with Primidone on	F	800	đ:			
	at 8:39 AM, reveale Resident #32 was r medication or gettin of it. She revealed pain medication ofte #32 had frequent U In Resident #32 by things, having delus	with LPN #6, on 08/19/2021 d there had been no evidence tot receiving his/her pain of another medication in place Resident #32 did not ask for en. LPN #6 stated Resident Ti's, which would be exhibited confusion, saying off-the-wall tions, and sometimes fatigue, are exhibited by Resident #32						
	revealed when Res would be confused,	#9, on 08/19/2021 at 8:50 AM, ident #32 had a UTI, he/she might not know where he/she I out. She revealed Resident hy as needed pain						
	it could lead to probresidents with pain untreated pain. Restated he had order concerned Residen overdosed but foun Medical Director stakeeping him Information and the problem of the problem in the pro	PM, revealed when ot administered as prescribed, lems; and, in the case of medications, it could lead to garding Resident #32, he ed lab work because he was t #32 might have been d that was not the case. The sted the DON had been ed on issues surrounding the tion at the facility, as well as						

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				FORM APPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE GURVEY
			A. BUILD	ING		COMPLETED
		185028	B. WING			C 09/02/2021
NAME OF	PROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE	1 03/02/2021
JOHNSO	N MATHERS NURSIN	IG HOME		232	3 CONCRETE ROAD	
(VA) ID	RI II MAA DV RTA	TELEVITOR		CA	RLISLE, KY 40311	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROV DEFICIENCY)	D.RE COMPLETION
F 600	Continued From pa allegations.	ge 40	Fe	5 00		
	Self-Reported Incid revealed, on 06/27// Resident #45 attack #21 tried to stop Re flowers in the courty revealed the facility and initiated an inveday follow-up revea assessed and treate placed and remaine supervision until her facility for psychiatri Review of Resident revealed the facility 03/12/2020, with dia Unspecified Demen Disturbance, Parant Psychotic Disorder Condition. The facilia a Quarterly MDS As as three (3) of fiftee severe cognitive impressonal space and quiet area during personal space and quiet area during	poid Personality Disorder, and due to Known Physiological lity assessed Resident #45, in assessment, dated 06/15/2021, in (15) on the BIMS, indicating pairment. #45's Comprehensive Care 020, revealed a care plan for ression with interventions for invading the resident's removing the resident to a				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MED

		& MEDICAID SERVICES					O. 0938-0391
STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILO		CONSTRUCTION	(X3) D	ATE SURVEY
		185028	B. WING				C organizado
NAME OF	PROVIDER OR SUPPLIER		1	975	REET ADDRESS, CITY, STATE, ZIP COD	1 0	9/02/2021
IOUNDO					3 CONCRETE ROAD	Æ	
JOHNSO	N MATHERS NURSIN	IG HOME					
/VALID	SUMMARY ST	TEMENT OF OCCUPANT		UM	RLISLE, KY 40311		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 600	Continued From pa	nge 42	E 4	500			
1		ecause Resident #45 thought		JUU			
	they were weeds. I	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	e 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					
ŀ	station after the inc	ident on 06/27/2021, and she					
	bandaged the resid	ent and called the doctor.					
	She stated Resider	nt #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 e	yes. LPN #3 stated the					
	residents were all o	ut in the courtyard and had					
	been making comm	nents to Resident #45 all day,					
	as lierane was pulli	ng up flowers. LPN #3 stated					
	and them if Periden	ed the residents to come and it #45 started pulling up					
	flowers again but to	nstead, per her interview with					
	Resident #21 Resi	dent #1 was making gestures					
	at Resident #45 In	ing 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	3 revealed Resident #45 had					
	exhibited aggressto	in toward staff before, but not					
	toward other reside	nts. She stated Resident #45					
	was placed on one-	to-one (1:1) supervision, and					
	she took care of Re	sident #21, calling the doctor					
	and the family. LPt	N #3 stated Resident #45's					
	nurse and the Assis	stant Director of Nursing					
	(ADON), took care	of initiating the investigation.					
	Further, she stated	the facility had transferred					
	Resident #45 to and	other facility, for psychiatric					
	care, and since his/	her return to the facility, the					
	resident had been v	vell behaved.					

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				FORM APPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		185028	B. WING			C
NAME OF F	PROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CODE	09/02/2021
JOHNSO	N MATHERS NURSIN	C Hotes	ļ		2323 CONCRETE ROAD	
	WIND CHAINE	G HOME	- 1		CARLISLE, KY 40311	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFE TAG	iX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROV DEFICIENCY)	D BE COMPLETION
	Assistant (PCA) wa and the CA told her nurse came out, she Resident #21 inside Resident #45 to his supervision, which sher shift ended. She Resident #45 calmed Interview with Regist O8/03/2021 at 3:33 dining room with a state of the Incident, feeding heard a commotion courtyard, and the State of the SRNA cat courtyard. She state who was upset, cryit she said she saw somembers in the courty and the saident #45 had goulling up flowers. The seident #45 to sto violent. RN #2 reverse #45 choked Resident #45 to sto violent. RN #2 reverse #45 choked Resident #45 to sto violent. RN #2 reverse #45 choked Resident #45 to sto violent. RN #2 reverse #45 choked Resident #45 to sto violent. RN #2 reverse #45 choked Resident #45 to sto violent. RN #2 reverse #45 choked Resident #45 to sto violent. RN #2 reverse #45 choked Resident #45 to sto violent. RN #2 reverse #45 choked Resident #45 to sto violent. RN #2 reverse #45 choked Resident #45 to sto violent. RN #2 reverse #45 choked Resident #21 residents out there winterview, RN #2 sail	stated a Personal Care is in the courtyard with her, to go get a nurse. When the e stated, the nurse took and told the CA to take (her room for one-to-one (1:1) she did until 11:00 PM, when e stated, after the incident, ed down. Stered Nurse (RN) #2, on PM, revealed she was in the State Registered Nurse on 06/27/2021, at the time of g residents. She stated, they at the inside door to the SRNA went out first. She me and got her to go to the ed she saw Resident #21, ng, and bloody. In addition, everal SRNA's and staff rityard, and she was told one to the courtyard and was Then, she stated, when other esidents, in the courtyard, told one to the courtyard and became aled she was told Resident on t #21, twisted his/her arm, She stated there was a esident #21's neck, multiple at arm, and a skin tear or the right or left leg. RN #2 was pretty upset, and other were also upset. Per the d she told CA #1 to take on his/her room, to senarate	F 6	300		

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

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				FORM APPROVED
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		185026	B. WING			С
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	ST	REET ADDRESS. CITY, STATE, ZIP CODE	09/02/2021
IOHNEC	M MATHERS MINNE				23 CONCRETE ROAD	
JOHNSC	N MATHERS NURSIN	IG HOME			ARLISLE, KY 40311	
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES				
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFU TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DEE COMPLETION
F 600	Continued From pa	ge 46	F6	00		
	Self-Reported Incid revealed on 05/18/2 unit, the DON witner Resident #63, caus Continued review or report revealed Resident #63 was it said some profanition before staff could in Resident #63, who his/her head on the Resident #28 was provision. Resident #28 was propertied to the Resident #28 was propertied for the Resident for the Resident for the Resident for the Resident for the Facility assesses MDS Assessment, of fifteen (15) on the Cognitive impairment Review of Resident 10/25/2019, revealed anxiety and anger we personal space. Interest in Intere	#28's care plan, dated ed a behavioral care plan for then others were in his/her				

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				FORM	APPROVED
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT		PLE CONSTRUCTION	(X3) DATI	0938-0391 E SURVEY PLETED
		185028	B. WING	_			C
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	09/	02/2021
JOHNSO	ON MATHERS NURSIN	10.110.20			2323 CONCRETE ROAD		
UC/III	M MAINERS MURSIN	IG HOME			CARLISLE, KY 40311		
(X4) ID PREFIX TAG	EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ıx	PROVIDERS PLAN OF CORRECTE (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	DRE	COMPLETION DATE
F 600	Continued From pa	ige 48	F 6	300		<u> </u>	
	AM, revealed she rounit and had been to five (5) months. She could "sometimes of	A #6, on 07/28/2021 at 11:20 outinely worked on the secure there consistently for the past are revealed Resident #28 get in a mood", but it was not Resident #28 to push s/her way.					
	observed Resident : observed Resident : 05/18/2021, resultin stated Resident #28 (1:1) supervision, wi fifteen (15) minute of	acility Consultant, on PM, revealed the ADON #28 push Resident #63, on a fall with injury. She was placed on one-to-one which gradually went to every checks and was finally \$104/2021, as there had been .					
	Jeopardy Removal I alleged removal of t	d an acceptable Immediate Plan, on 09/01/2021, that the Immediate Jeopardy (IJ) a facility Implemented the					
	Plan (PIP) was initial Narcotics which was Inspector General- [a Performance improvement ated related to Missing s reported to the Office of Division of Health Care (State 4:30 PM on 07/09/2021.					
	nurses audited narc medication carts as blister pack missing to match the numbe	the Unit Manager and MDS cotics in the remaining the North back hall had a p. All count sheets were found or of skids. Staff signing in the cart was expected on e check sheets.					

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CENTER	S FOR MEDICARE	& MEDICAID SERVICES				0		. 0938-0391	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE		ONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		185028	B. WING				00	C 102/2021	
NAME OF	ROVIDER OR SUPPLIER			STRI	ET ADDRESS, CITY, STAT	E. ZIP CODE	1 03	10212021	
JOHNSO	N MATHERS NURSIN	IG HOME		2323	CONCRETE ROAD				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES I' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION]	ID PREF TAG	lx	PROVIDER'S PLAN (EAGH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD TO THE APPROP	BE	(XS) COMPLETION DATE	
F 600	interdisciplinary tea comprised of the Admprovement Nurse Coordinator (SDC/C Nurse, Unit Manage Services Director, a agreed actions take abuse/neglect educemonitoring via progwith residents, and abuse/neglect. 9. On 07/19/2021, Administrator, Corp began reconciling the narcotics received. completed three of correct number of declining Any discrepancies to the DON and/or at the DON and/or assessing pain. For eight (8) or below, to observation of non-breathing, facial exconsolability. No consolability. No consolability. No consolability and 12. On 07/20/2021	onal action steps with the m (IDT). The IDT was dministrator, DON, Quality a/Staff Development DI), Minimum Data Set (MDS) or, Activity Director, Social and Dietary Manager. The IDT on would include action, abuse/neglect ress note review, safe surveys staff surveys regarding the DON, Unit Manager, orate RN, or a support RN he narcotic packing slips to the The reconcillation would be times per week to ensure the delivered narcotics were colle count book and the grount sheets were updated, would be reported immediately administration. I staff nurses performed residents, including or residents with a BIMS of the assessment included verbal signs of pain to include; pression, body language, and oncerns were identified.	F	500					
	LPN #2.	, ===							

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED C 185028 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 2323 CONCRETE ROAD CARLISLE, KY 40311 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PRECIX (SACH DEFICIENCY MUST BE DESCREED BY STATEMENT OF PROVIDER'S PLAN OF CORRECTION (X3) DATE SURVEY COMPLETED C 09/02/2021	CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NO ARREST
NAME OF PROVIDER OR SUPPLIER JOHNSON MATHERS NURSING HOME SUMMARY STATEMENT OF DEFICIENCIES (BACH DEFICIENCY MUST SEE PRECEDED BY FULL TAG. PREFIX (BACH DEFICIENCY MUST SEE PRECEDED BY FULL TAG. PREFIX (BACH DEFICIENCY MUST SEE PRECEDED BY FULL TAG. PREFIX (BACH DEFICIENCY MUST SEE PRECEDED BY FULL TAG. PREFIX (BACH DORNEST VERY OR TAG. DEFICIENCY)	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	l ' '		NSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED
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JOHNSON MATHERS NURSING HOME (CA) ID SUMMANY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 600 Continued From page 52 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) limes 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	NAME OF F	PROVIDER OR SUPPLIER			STREE	TADDRESS CITY STATE ZID CODE	UBIUZIZUZ
(A) ID SUMMARY STATEMENT OF DEPICIENCIES PRECEDED BY PULL PRECEDED BY PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 600 Continued From page \$2 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 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, SOC/OI, Weekend Supervisor, MDS Nurses, the Corporate RN, and/or a support RN would audit the storage and documentation or 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	JOHNSO	N MATHERS NURSIN	IG HOME		2323 0	CONCRETE ROAD	
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 OAPI committee determined frequency could be reduced. Any concern regarding documentation or storage of narcotic administration would be addressed at the time of	PREFIX	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	PREF	×	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI	ILD BE COMPLETION
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		sheets and found L #2) had recorded on number of sheets of documented four (4 previous shift. The explanation why the than the previous sithe nurse and report of the nurse and admission of the nurse with all residents were ask and when medicatic concerns, which incompain, were documented of the concerns, which incompain, were documented of the concerns, which incompain, were documented of the concerns	icensed Practical Nurse (LPN in the log sheet a reduced counted. The nurse (l) less sheets than the re was no documented are were four (4) less sheets hift. The facility suspended red the information to the otective Services), and police. to 07/21/2021, the Social slons Coordinator completed esidents with a BIMS above 8, teed about concerns with how ons were administered. Any cluded but was not limited to inted and reported to the weekend Supervisor, MDS ate RN, and/or a support RN rage and documentation of cking medication carts to be stored appropriately and a correct. The audits included: s, shift change count sheets, g count sheets, wasted to of narcotic medication skids, sted for, and/or pharmacy	F	IOD	MEF (GENET)	
Administrator, All gave engages would be		per week until the C frequency could be regarding documen administration woul the audit and report	API committee determined reduced. Any concern tation or storage of narcotic d be addressed at the time of ed to the DON or				

reviewed in the morning IDT meeting. Any

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING C (X3) DATE SURV COMPLETE: C (D9/02/20): NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	0938-0391
NAME OF PROVIDER OR SUPPLIER 185026 B. WING 09/02/200	SURVEY
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
JOHNSON MATHERS NURSING HOME 2323 CONCRETE ROAD CARLISLE, KY 40311	22021
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMP	(DIS) COMPLETION DATE
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 narcolics. 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 07/28/2021, the DON, Unit Manager, SDC, Nurse Supervisor, MDS Nurse, and Corporate RN consultants began administering a medication administration and physician notification and validated the 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.	

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CENTER	CENTERS FOR MEDICARE & MEDICAID SERVICES					D		APPROVED . 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER:	(X2) MUI A. BUILD	TIPLE C		(X3) DAT	E SURVEY	
		185028	8. WING					C
NAME OF	PROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE.	ZIP CODE	09/	02/2021
JOHNSO	N MATHERS NURSIN	IG HOME			CONCRETE ROAD			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD THE APPROPI	85	(XS) COMPLETION DATE
F 600	Continued From pa	ge 56	F	300				
	30. On 08/19/2021 Director update tele	the DON facilitated a Medical aphone call.						
	31. On 08/20/2021 Director of eight (8) were being worked	, the DON notified the Medical IJ tags and the PIP's that on.						
	SDC, and Corporat additional Code of in-service included included employees systems, when to make to find more were able to verbal	, the Administrator, DON, e Support staff began Conduct in-servicing. The a quiz. The quiz questions is following laws, reporting eport, who to report to, and information. The employees ize their role in protecting enting abuse, neglect, and						
	33. On 08/20/2021 rebilled and/or paid medications.	, the facility verified the facility for the misappropriated						
	announced the tran Administrator. The Interim Administrator, new Administrator, the tags F-600 Abu	, the Regional Vice President isition to the new Regional Vice President and or provided education to the including the requirements of se/Neglect/Exploitation and Prevent/Correct Alleged						
	Director update tele DON, Regional Vic Interim Administrate Consultant. The di immediate jeopardy	, the DON facilitated a Medical aphone meeting, including the e President, Medical Director, or, new Administrator, and RN scussion included the facility's y (IJ) status, including the tag Prevent/Correct Alleged						

CENTE	RS FUR MEDICARE	& MEDICAID SERVICES				CHEN	M APPROVED
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		CONSTRUCTION	(X3) D	O. 0938-0391 PATE SURVEY OMPLETED
		185028	B. WING				C
NAME OF	PROVIDER OR SUPPLIER			STR	IEET ADDRESS, CITY, STATE, ZIP CODE		9/02/2021
JOHNSO	ON MATHERS NURSIN	1G HOME		232:	3 CONCRETE ROAD RUSLE, KY 40311		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	ıx	PROVIDER'S PLAN OF CORRECTIVE ACTION SHIP CROSS-REFERENCED TO THE APP DEFICIENCY)	OUTDE	COMPLETION DATE
F 600	Continued From pa	uge 58	F (300			
	RN Nurses, and a Clinterviewed staff an medication carts, and documentation. No received. No new received, as resider their medications. It identified as missing 41. Starting 08/29/2 have a meeting five concerns. The Admidentify an Investigation. The Cutilized to track the	2021, the facility's IDT would 3 (5) times a week to review					
	facility at least mont	Consultant would visit the thly to validate narcotics were dounted per standard of					
	The State Survey Agimplementation of the Jeopardy Removal I	he facility's Immediate					
	07/09/2021, reveale blister pack of thirty pharmacy audit, the staff was signing for facility, and initiated substances, to inclu-	ality Assurance (PIP), dated ad, as a result of the missing (30) Percocet identified in a facility identified only one (1) representation on controlled ade having a second person ubstances arriving at the					

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		& MEDICAID SERVICES				OMB NO	0.0938-0391
	OF DEFICIENCIES IF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI		LE CONSTRUCTION		ITE SURVEY
		185028	B. WING			0.0	C 9/02/2021
NAME OF F	PROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CODE	1 08	3/UZJZUZ I
					2323 CONCRETE ROAD		
JOHNSO	N MATHERS NURSIN	IG HOME		Ι.	CARLISLE, KY 40311		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LO BE	(X5) COMPLETION DATE
F 600	staff providing care revealed she assess evidence of abuse. conducted chart revealed she had made at 2:00 AM, as well any resident concert following procedures. 5. Review of Compression	ge 60 Ills of the building, observing, and talking with staff. She ised and interviewed for She revealed she also views and validated the facility its and doing everything they be doing. The Clinical Director de surprise visits to the facility as on weekends, to determine this and ensure staff was estimated they had been educated on. It initiated staff education for aff and KMA's. Education the back of the MAR, (2) all in use must stay locked up in until they could be given to eclining count sheet must be numbers at the top of the and to one sized to staff the need to do menting the effectiveness of ministered to residents. It is of the been arrested and the counts of Theft by the (3) counts of Possession and was a size of the second to the factor of the f	F	600			
	of Controlled Subst	ances, two (2) counts of					

Wanton Endangerment, and two (2) counts of

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			O	MB NO. 0938-0391
	OF DEFICIENCIES IF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		185028	B. WING			C 09/02/2021
NAME OF F	PROVIDER OR SUPPLIER			ST	FREET ADDRESS, CITY, STATE, ZIP CODE	USIGEIZUZI
IOUNEO	N MATHERS NURSIN	10.110.40			323 CONCRETE ROAD	
3011130	M MATHERS NORSE	IG HUME		C	ARLISLE, KY 40311	
(X4) ID PREFIX TAG	(EACH DEFICIENC	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 600	AM, revealed when confirmed there we checked to ensure packing slips was a she would initial the reviewed them. 10. Review of Pair Assessments were residents on 07/19 identified. Addition Medication Adminis with no concerns in Interview with the DAM, revealed no reidentified through the conducted on 07/1. 11. Review of Amb confirmed APRN # 07/19/2021. No coassessment of Reserview of the physolirector (MD) with revealed possible in oplates had been redocumentation reviewed with Reside	DON, on 09/02/2021 at 9:10 in reviewing packing slips, she are two (2) signatures and everything listed on the conthe medication cart; then a packing slips to show she in Assessments revealed Pain a completed for all facility (2021. No concerns were reviewed, dentified. DON, on 09/02/2021 at 9:10 away or untreated pain was the pain assessments (9/2021). The pain assessments (9/2021) at 10 and 10 a	F	600		
	Self-Reported Incid	ong Term Care Facility - dent Form, dated 07/20/2021, had been suspended from the				

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				FORM APPROVE OMB NO. 0938-039	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(XZ) MUL A. BUILO		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	31
		185028	B. WING	;		C	
NAME OF F	ROVIDER OR SUPPLIER			5	TREET ADDRESS, CITY, STATE, ZIP CODE	09/02/2021	_
DSMHOL	N MATHERS NURSIN	IC HOME			323 CONCRETE ROAD		
				C	CARLISLE, KY 40311		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETIO	IN
F 600	Continued From pa	ne 64	E 4	200			
	•	ional Vice President by the	rt	600			
	Social Services Dire	ector or the Admissions					
	Coordinator about v	vhether or not they had					
	medications. If resi	administration of their dents indicated concerns, this					
	was explored further	r, to include to whom the					
	residents reported o	concerns and when. No ed during documentation					
	review.	ed during documentation					
	46 Deview of Man-	and a Constant of the Constant					
	07/21/2021 confirm	otic Cart Audit forms, dated ed the DON audited the					
	storage and docum	entation of all facility					
	medication carts. C	Continued review of audits					
	times each week. I	e occurring five (5) or more Review of Narcotic Cart Audit					
	forms revealed requ	ired education was given, on					
	07/22/2021, for a KI	MA who had pulled narcotics ne time the narcotics were					
	given.	ie time the harcotics were					
	17 Intendess with 4	ha Basisani Vies Decisi					
	on 09/02/2021 at 7:	he Regional Vice President, 07 PM, confirmed the					
	previous Administra	tor had been suspended on					
	07/21/2021, as a re	sult of concerns regarding the					
	vay the Administrat	or handled the drug diversion al Vice President stated he					
\	present at the t	acility acting in the capacity of					
1	intrator from (07/21/2021 through					
1	'1, With an	Interim Administrator present ning 07/27/2021, until a new					
	starte	d on 08/26/2021.					
	_	elete le Condo Z. 1.1					
	٦	plete In-Service Training nding, with a start date of					
1		'aff was educated on the					
1		d Misappropriation of					
		vised 03/10/2017.					

ared to be on

CENTER	RS FOR MEDICARE	E & MEDICAID SERVICES					0.0938-0391
STATEMENT	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		LE CONSTRUCTION	(X3) DA	U. 0938-0391 ATE SURVEY EMPLETED
		185026	B. WING				C
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	US	9/02/2021
LOWNER					2323 CONCRETE ROAD		
	N MATHERS NURSIN				CARLISLE, KY 40311		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	FIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	11006	(XS) COMPLETION DATE
F 600	Continued From pa		F	600			
	PM, and RN #3 at 3 been educated on to count at shift change to the number of count at shift change to the number of count at shift change to the number of count and wasting medication room also covered the important completing pain assembled medication was in count of the coun	2/2021 with LPN #11, at 3:03 3:14 PM, revealed both had the proper way to do a narcotic ge, counting skids, comparing ontrolled substance sheets, atlons, with another nurse ning, in the Drug Buster kept in ms. Both stated education aportance of signing and sessments on the back of the needed) medications and er nurse when narcotics also stated, if a skid was to the DON, and if a danger of falling out of a as to be wasted with another as to be wasted with another not signing. LPN #11 revealed experienced management DON, going around doing dits, and she stayed with her ite was being audited. A #20, on 09/02/2021 at 3:39					
	education nursing s had received multip stated the education signing out narcotic walting until the end revealed he signed given, and if a resid as a refusal and had the medication as w skid was compromi- tampered with, he w could assess and di	ed he received the same staff received. He revealed he cole educations. The KMA on included the importance of as when he gave them and not dof shift to sign them out. He them out right after they were dent refused, he would mark it ave a nurse witness and sign wasted. He stated, if a pill or ised, or if anything looked would alert the DON so she letermine if medications and. He revealed corporate					

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

A 20111 Pc	ALCONOLOGY	WINEDIGHID OF IANGED				140. 0830-039 I
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILC		ONSTRUCTION	(X3) DATE SURVEY COMPLETED
		185028	B. WING			C 09/02/2021
NAME OF F	ROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE	
					CONCRETE ROAD	
JOHNSO	N MATHERS NURSIN	IG HOME	i	_	RLISLE, KY 40311	
				CAL	-	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRICIENCY)	D BE COMPLETION
E 600	0		_			
F 600	Continued From pa	-	F	500		
		of a sign in sheet, dated				
		ed the Medical Director was In				
	attendance at the n	neeling.				
		Medical Director, on				
		PM, revealed the DON had h him two (2) to three (3) times				
	oeen in contact wit	ovided him all the PIP's that				
		out. The Medical Director				
		dremely pleased at the			•	
		y had made addressing their				
	problems.	The med add ossing their				
		Narcotic Cart Audit sheets				
}		cotic cart audits revealed staff sure (1) All staff were signing				
	the Controlled Sub	stance Count Sheet (CSCS) at				
İ		I narcotic sheets had been				
		imber of narcotic count sheets				
}		er of skids on the cart, (4)				
		id not have tape on their				
	backs, (5) Skids w	ere chacked to ensure there				
	were no missing si	kids, (6) CSCS were being				
		of the cart on the Shift Change				
		ice Count Check form as the				
1		er changed (new skids arrived,				
		ited), and (6) All narcotics were				
	signed out and acc	counted for.				
1	Baulau of a Nassa	No Cost Avidit consoleted				
		tic Cart Audit completed, on				
		2 AM, by the DON revealed the				
		ed with no issues noted or				
		equired or taken. The				
- 2		sultant noted the front-north ad a screw sticking out that				
}		thed holes in the back of				
		kids: The screw was covered.				
	·					
1	27 Review of Na	cotic Cart Audit completed on				

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES					M APPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DA	<u>0. 0938-0391</u> TE SURVEY MPLETED
		185028	B. WING				С
NAME OF F	PROVIDER OR SUPPLIER		3		SET ADDRESS AND ADDRESS	09	3/02/2021
JOHNSO	N MATHERS NURSIN	IG HOME		2323	EET ADDRESS, CITY, STATE, ZIP CODE DI CONCRETE ROAD RLISLE, KY 40311		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDERS PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(XS) COMPLETION DATE
	feel like it was being contact the DON ar call or fax the Corport of the DON are call or fax the Corport of the DON are call or fax the Corport of the DON are call or fax the Corport of the DON are controlled on the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the Corport of the	to their supervisor and did not graddressed, they could ad Administrator, as well as brate Compliance line. Ity documentation, not labeled a total of one hundred and is were documented as uded three (3) skids of thirty ach that were missing, and led medications that were sing. The document listed along with discrepancies each individual dose, resident all cost of all medications was three hundred and four even (\$304.97) cents. It is appointment of a new 3/26/2021, with an escription, reporting to the ident, who also signed the limited and signed the limited and signed the limited and signed the limited and signed the limited and signed the limited and signed the limited and signed the spoke with the Interimance Regional Vice President 108/25/2021, and they wanted to make sure he truation he would be coming Regional Vice President had ance of reporting allegations	F 6	00			
	35. Review of the d	locument Communication with					

Medical Director, signed by the Medical Director

CENTER	S FUK MEDICARE	& MEDICAID SERVICES			0	<u> MB NO. 0938</u>	-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		CONSTRUCTION	(X3) DATE SURV COMPLETED	
		185028	9. WING			C 09/02/20:	21
NAME OF P	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE	03.42.20	
	** ** * * * * * * * * * * * * * * * * *				23 CONCRETE ROAD		
TOKNZO	N MATHERS NURSIN	IG HOME		1	RLISLE, KY 40311		
	E1154144 EN ET			0,1			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED DEFICIENCY)	BE COMP	KS) LIETION ATE
F 600	facility nurse went to 08/28/2021 at shift and went through the medication cart state documentation and process was repeature from a different there had been not 39. Interview with the 09/02/2021 at 6:32 Director had thorour eporting and investing and investing and investigation file with 08/29/2021. She investigation file with 08/29/2021. She investigation file with the 0 at 9:10 AM, reveals investigation file with 08/29/2021. She investigation file with the 0 at 0. The Clinical Administrator mad needed to do and of time. The Clinical Administrator had investigation 40. Review of the dated 08/28/2021, and a support RN investigation administration administra	ed she, the SDC, and a sister o each medication cart, on change with their audit tools, he packet of audit tools with ff, asking questions about reporting. She revealed this ted on 08/29/2021 with a ent sister facility. She revealed concerns with the audits. The Administrator, on PM, confirmed the Clinical ughly reviewed with him abuse stigating. Clinical Director, on 09/02/2021 at she reviewed an the Administrator on evealed they went down the eviewed the process, and the en what he could do at that Director stated the interviewed residents, called attatives, and was very thorough of misappropriation. facility's Weekend Audits, confirmed the Administrator interviewed staff and residents tode of conduct, and stration. Staff members were estions accurately, and express any concerns during r, nursing staff conducted an ocumentation and did not		600	JEPICIENCT)		
	41. Review of the	Cardinal IDT Meeting minutes					

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CENTERS FOR MEDICAR	E & MEDICAID SERVICES			OMB NO. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI	LTIPLE CONST	TRUCTION	(X3) DATE SURVEY COMPLETED
	185028	B. WING			C 09/02/2021
NAME OF PROVIDER OR SUPPLIES	3		STREET A	DORESS, CITY, STATE, ZIP CODE	
JOHNSON MATHERS NURS	NG HOME			NCRETE ROAD LE, KY 40311	
PREFIX (EACH DEFICIENT	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU ROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
On 07/09/2021, to (LPN #1 and #2) is skid of thirty (30). Percocet (a narco 5/325 milligram (no was suspended property) take other misappropriation. On 07/18/2021, a residents had con (Residents had con (Residents #1, #8 #71, and #79); and controlled medical non-prescribed in Resident #84). On 07/20/2021, it had a missing sk Percocet. LPN # investigation. The facility's failure property; and failing caused or is likely harm or death to Immediate Jeopa of Care (SQC) were determined area of 42 CFR 4 F-602 Free from	44) sampled residents. vo Licensed Practical Nurses were implicated in stealing a lablets of Resident #17's stic opioid used to treat pain) ng). Despite this, neither nurse ending investigation, nor did the action to prevent	·	0 02	2. On 7/19/21, staff numpain assessments or with no concerns idea 7/21/21, corporate by staff audited stimulus. Any additional reside have had stimulus mitems the facility show provided had the more Residents were allow items purchased. 3. On 07/09/21, 07/12/2/2/21, 07/23/212, 07/22/21, 07/23/212, 07/25/21 the DON, sconsultants and corporations and reconcultations, and readministration, docure conciliation. (See a for details). On 07/2 consultant educated investigation process checklists to ensure actions are taken whis misappropriation/expanding orientation, as approprientation, s approprientation, as approprientation.	all residents intified. On usiness office is monies spent. Into found to onles spent on onles refunded. Interest refunded. Interest refunded. Into found to keep any or found for the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the cont

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

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NO	0. 0938-0391	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTI	ON	CO:	(X3) DATE SURVEY COMPLETED	
		185028	B. WING			09	C 0/02/2021	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRES	SS, CITY, STATE, ZIP CODE			
JOHNSO	N MATHERS NURSIN	IG HOME		2323 CONCRET				
					VIDER'S PLAN OF CORRECT	TION	(XS)	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREF TAG	X (EACH	CORRECTIVE ACTION SHO CORRECTIVE ACTION SHO CORRECTIVE APPL CORRECTIVE CONTROL OF THE APPL CONTROL OF THE APPL C	JULD BE	COMPLETION	
F 602	Continued From pa	age 76	F	302				
	(DFWP), revised 1 recognized the need environment free from and alcohol. The produced safety, security the company. The for Registered Nur Nurse (LPN), or Mosubmit a urine same employment. The Conduct as possedrug or alcohol who work, or during woo Conduct, per the product, per the product, per the product, or failing a administered in accomplete or failing and Alcohol in the DFWP, reveasked to submit to alcohol, and include employees in situation, a workplace in resulted in an inverseident abuse or time at the sole dipolicy required en Free Workplace from a DFWP Acknowledgement and the sole of the employees of the employees of the employees of the employees of the employees of the employees of the employees of the employees of the employees of the employees of the employees of the employees of the employees of the employees of the employees of the employees of the employees of the employees of the employees of the employees of the employees of the employees of the employees of the employees of the employees of the employees of the employees of the employees of the employees of the employees of the employees of the employees of the employees of the employees of the employees of the employees of the employees of the employees of the employees of the employees of the employees of the employees of the employees of the employees of the employees of the employees of the employees of the employees of the employees of the employees of the employees of the employees of the employees of the employees of the employees of the employees of the employees of the employees of the employees of the employees of the employees of the employees of the employees of the employees of the employees of the employees of the employees of the employees of the employees of the employees of the employees of the employees of the employees of the employees of the employees of the employees of the employees of the employees of the employees of the employees of the employees of the employees of the employees of the employees of the employees of	ty Drug Free Workplace Policy 2/2018, revealed the company of for a safe and healthy work from the use of prohibited drugs colley stated employees who could be policy revealed all applicants se (RN), Licensed Practical edication Aide were required to a policy defined Prohibited ssing or using any prohibited sile at the workplace, while at a the workplace, while at a the workplace, while at a the workplace, while at a the workplace, while at a the workplace, while at a the workplace, while at a the workplace, while at a the workplace, while at a the workplace, while at a the workplace, while at a the workplace, while at a the workplace, while at a the workplace, while at a the workplace, while at a the workplace, while at a the workplace, while at a the workplace, while at a the workplace, while at a the workplace, while at a the workplace, while at a the workplace, while at a the workplace, while at a the workplace, while at a the workplace, while at a the workplace, while at a the workplace, while at the workplace, while at the workplace, while at the workplace, while at the workplace, while at the workplace, while at the workplace, while at the workplace, while at the workplace, while at the workplace, while at the workplace, while at the workplace, while at the workplace, while at the workplace, while at the workplace, while at the workplace, while at the workplace, while at the workplace, while at the workplace, while at the workplace, while at the workplace, while at the workplace, while at the workplace, while at the workplace, while at the workplace, while at the workplace, while at the workplace, while at the workplace, while at the workplace, while at the workplace, while at the workplace, while at the workplace, while at the workplace, while at the workplace, while at the workplace, while at the workplace, while at the workplace, while at the workplace, while at the workplace, while at the workplace, while at the workplace, while at the workplace, while at the workplace, while at the workplace, while						

Facility ID: 100349

CENTE	KS FUR MEDICARE	& MEDICAID SERVICES				MIR MO.	0930-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI		ONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		185026	B. WING	I		1	C 02/2021	
	PROVIDER OR SUPPLIER ON MATHERS NURSIN	IG HOME		2323	EET ADDRESS, CITY, STATE, ZIP CODE CONCRETE ROAD RLISLE, KY 40311			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX.	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	.O BE	(X5) COMPLETION DATE	
F 602	provided that information report. Review of a Packing revealed LPN #2 so 5/325 mg tablets, to #17. Interview with LPN revealed, on the night approached her return the pharmacy arrive LPN #2 was working South Unit nurse with deliveries from phasigned for three (3 each of Percocet 5 the night of 06/28/was informed, after the port of the pharmacy arrive with the pharmacy arrive the pharmacy arrive the pharmacy arrive the night of 06/28/was informed, after the port of the pharmacy arrive the pharmacy arrive the pharmacy arrive the pharmacy arrive the pharmacy arrive the pharmacy arrive the pharmacy arrive the pharmacy arrive the pharmacy arrive the pharmacy arrive the pharmacy arrive the pharmacy arrive the pharmacy arrive the pharmacy arrive the pharmacy arrive the pharmacy arrive the pharmacy arrive the pharmacy arrive the pharmacy arrive the pharmacy arrive the pharmacy arrive the pharmacy arrive the pharmacy arrive the pharmacy arrive the pharmacy arrive the pharmacy arrive the pharmacy arrive the pharmacy arrive the pharmacy arrive the pharmacy arrive the pharmacy arrive the pharmacy arrive the pharmacy arrive the pharmacy arrive the pharmacy arrive the pharmacy arrive the pharmacy arrive the pharmacy arrive the pharmacy arrive the pharmacy arrive the pharmacy arrive the pharmacy arrive the pharmacy arrive the pharmacy arrive the pharmacy arrive the pharmacy arrive the pharmacy arrive the pharmacy arrive the pharmacy arrive the pharmacy arrive the pharmacy arrive the pharmacy arrive the pharmacy arrive the pharmacy arrive the pharmacy arrive the pharmacy arrive the pharmacy arrive the pharmacy arrive the pharmacy arrive the pharmacy arrive the pharmacy arrive the pharmacy arrive the pharmacy arrive the pharmacy arrive the pharmacy arrive the pharmacy arrive the pharmacy arrive the pharmacy arrive the pharmacy arrive the pharmacy arrive the pharmacy arrive the pharmacy arrive the pharmacy arrive the pharmacy arrive the pharmacy arrive the pharmacy arrive the pharmacy arrive the pharmacy arrive the pharmacy ar	missing for Resident #17 and nation to the facility in her ag Slip, dated 06/28/2021, igned for ninety (90) Percocet hree (3) skids, for Resident #2, on 07/29/2021 at 4:29 PM, ght of 06/28/2021, LPN #1 had peatedly to let her know when red to deliver medications, as ng on the South Unit, and the was responsible for signing for armacy. LPN #2 stated she skids of thirty (30) tablets 6/325 mg for Resident #17, on 2021. However, she stated she or the discovery of a missing 1, that LPN #1 alleged only		602				
	Count Record for sheet, 2 of 3, delivereceiving signature. Despite repeated to provide either substance Count covering the time 07/08/2021. Sheet as identified by phof sheet 2 of 3 revitablet out, at 12:01 #7 replacing her comorning of 07/09/ #17's MAR for 07/09/	nt #17's Controlled Substance Percocet 5/325 mg revealed a rered on 06/28/2021, with a e and date on the sheet. requests, the facility was unable heet 1 of 3, or a Controlled Record for Percocet 5/325 mg frame 06/19/2021 through et 3 of 3 was the sheet missing larmacy on 07/09/2021. Review realed LPN #1 signed the first 0 AM on 07/09/2021, with LPN on the medication cart on the 2021. Review of Resident /2021 revealed eighty-two (82) t 5/325 mg had been						

		& MEDICAID SERVICES			C	MB NO.	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		185028	B.WING	i		l l	C
NAME OF I	PROVIDER OR SUPPLIER			CTC	REET ADDRESS, CITY, STATE, ZIP CODE	09/	02/2021
JOHNSO	N MATHERS NURSIN	IG HOME		ļ	3 CONCRETE ROAD		
(24.1) 15	CINIMATMOTA			- CA	RLISLE, KY 40311	-	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE	(75) COMPLETION DATE
F 602	Continued From pa	ge 82	E 4	302			
		dication carts were audited by	1. (JUZ			
	2:00 AM on 07/19/2	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	g of 07/19/2021.					
	Interview with RN #	4, on 07/28/2021 at 1:20 PM,					
	revealed she was c	alled to the facility, on the					
	night of 07/18/2021	by the DON to help audit					
	medication carts. S	She revealed several narcotics					
		the cart belonging to LPN #1.					
	Interview with LPN	#12, on 08/13/2021 at 8:21					
	AM, revealed she w	vas working, on the night of					
	07/18/2021, when a	another nurse and the SSCI					
	came around check	king medication carts. She ad no problems, and the only					
	cart she thought ha	d an Issue was LPN #1's cart.					
	revealed the facility	ient #65's medical record assessed Resident #65, in a					
	Ouarterly MDS Ass	essment, dated 06/29/2021.					
	as fifteen (15) of fift	teen (15) on the BIMS,					
	indicating no cognit	ive impairment. Continued					
	review revealed ord	lers for Neurontin					
	(Gabapentin) 200 n	ng three times per day, dated					
	06/04/2021; and Ro	oxicodone 5 mg every six (6)					
	hours, dated 06/21/	/2021.					
		#65's Controlled Substance					
	Count Record for R	loxicodone 5 mg revealed a					
	missing (not docum	rented) tablet on 07/18/2021.					
	B) Review of Resid	dent #34's medical record					
	revealed Resident	#34 was admitted by the					
	facility, on 12/09/20	19, and was assessed in a					
	QUARTERIY MUS Ass	essment, dated 06/29/2021,					
	indication no const	teen (15) on the BIMS, ive impairment. Continued					
	moreanny no cognit	ive impairment. Continuéd					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SUR COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLE		OLLINE	& MEDICAID SERVICES				MB NO.	0938-0391
185028 B. WING						(X3) DATE SURVEY COMPLETED		
			185028	B. WING			1	
1 STREET ADDRESS, CITY, STATE, ZIP CODE	NAME OF PROVIDER	VIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE	[03/0	2021
JOHNSON MATHERS NURSING HOME 2323 CONCRETE ROAD CARLISLE, KY 40311	JOHNSON MATH	ATHERS NURSIN	IG HOME	İ	232	CONCRETE ROAD		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM	PRÉFIX (EA	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFI	·	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	(KS) COMPLETION DATE
#1 signed out eight (8) tablets on the record, with two (2) tablets documented as replaced with Primidone on 07/16/2021. 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 (8) documented on the back of the MAR. Review of the 08/2021 MAR revealed, of Newth-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 #8, 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 #3 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 fifieen (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 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 Roxicodones 5 mg documented as given for 07/03/2021; however, the back of the MAR only itsited on (1) dose was	#1 sign two (2) Primid 07/202 was as docum Record docum the MA back or reveals only six MAR. was, o Interview reveals on trouworkin E) Re reveals on 04/6 Quarte as a six indicat review every of Review Count 06/15/6 on the Review reveals docum	signed out eight of (2) tablets documented on 07/18/2021 revealed as administered of cumented on the cord. Further recumented administered of the MAR, with only ok of the MAR. If yealed, of twenty by six (6) were down of the last dos is, on 07/18/2021 review with LPN yealed she had one of the marked of the resident #84 did row of the with LPN received with LPN yealed the receiver with LPN received the reside of the reside of the reside of the reside of the reside of the reside of the reside of the reside of the reside of the reside of the reside of the reside of the the skid had been the skid had been the skid had been the skid had been the skid had been the skid had been the skid had been the skid had been the skid had been the skid had been the skid had been the skid had been the skid had been the skid had been the skid had been the skid had been the skid had been the skid had been the skid had been the skid had been the skid had been the skid had been the skid had been the skid had been the skid had been the skid had been the skid had been the skid had been the skid had been the skid had been the skid had been the skid had been the skid had been the skid had been the skid had been the skid had been the skid had been the skid had been the skid had been the skid had been the skid had been the skid had been the skid had been the skid had been the skid had been the skid had been the skid had been the skid had been the skid had been the skid had been the skid had been the skid had been the skid had been the skid had been the skid had been the skid had been the skid had been the skid had been the skid had been the skid had been the skid had been the skid had been the skid had been the skid had been the skid had been the skid had been the skid had been the skid had been the skid had been the skid had been the skid had been the skid had been the skid had been the skid had been the skid had been the skid had been the skid had been the skid had been the skid had been the skid had been the skid had been the skid had be	(8) tablets on the record, with imented as replaced with 1/2021. Review of the MAR for dose of Roxicodone 5 mg in 07/08/2021, but not econtrolled Substance Count view revealed ten (10) distrations during 07/2021 on six (8) documented on the Review of the 06/2021 MAR deview of the 06/2021 MAR deview of the 06/2021 MAR deview of the back of the elemented on the MAR deview of the back of the elemented on the MAR deview of the MAR deview of the MAR deview of the back of the elemented on the MAR deview of the MAR deview of the MAR, that outlinely receive pain PN #1 at night, although he did elemented them when LPN #6 was day. I was assessed in the essment, dated 06/01/2021, fleen (15) on the BIMS, impaired cognition. Continued order for Roxicodone 5 mg rs PRN, dated 04/01/2020. It #32's Controlled Substance doxicodone 5 mg, initiated on the last two (2) medications are replaced with Primidone. It #32's MAR for 07/2021 dese of Roxicodone 5 mg en for 07/03/2021; however,	F 6	002			

PRINTED: 10/11/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AREA PLAN OF CORRECTION (X1) PROVIDER ON SUMPLIER 185028 (X3) AND STATEMENT OF DEFICIENCIES	CENTER	S FOR MEDICARE	& MEDICAID SERVICES					OMB N	O. 0938-0391
NAME OF PROVIDER OR SUPPLIER JOHNSON MATHERS NURSING HOME [XA) D. SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL FACE). TAG PREFIX FACE IN CONTROLL FROM THE PROPERTY FLAN OF CORRECTION (EACH CORRECTION FOR ACTION SHOULD BE DEFICIENCY). TAG PREFIX FACE IN CONTROLL FOR ACTION FROULD BE DEFICIENCY OR IS GIGHTIFYNS INFORMATION). TAG PREFIX TAG CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY). F 602 Continued From page 85 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 revealed one (1) dose missing, on 07/18/2021, and not documented as given. 1) Review of Resident #47's medical record revealed the resident was readmitted by the facility, on 09/12/2020, 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 05/15/2021, 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 06/12/2021, as six (6) of fifteen (15) on the BIMS, indicating severe cognitive impairment. Continued review revealed an order for Percent was admitted by the facility, on 11/25/2013 and was assessed in the Quarterly MDS Assessment, dated 06/12/2021, as six (6) of fifteen (15) on the BIMS, indicating severe cognitive impairment. Continued review revealed an order go Percent 10/1328 mg every four (4)			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				Y		
NAME OF PROVIDER OR SUPPLIER JOHNSON MATHERS NURSING HOME (X) D SUMMANY STATELEAY OF DEFICIANCES (EACH DEFOLIATION) MATTER PROCEED BY FULL REGULATORY OR LSC (DENTIFYING INFORMATION) FROM REGULATORY OR LSC (DENTIFYING INFORMATION) F 602 F 602 Conlinued From page 86 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 revealed one (1) dose missing, on 07/18/2021, and not documented as given. 1) 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 06/18/2021, 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 06/18/2021. Review of Resident #47's Controlled Substance Count Record 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 senditted by the facility, on 11/25/2013 and was assessed in the Quarterly MDS Assessment, dated 08/28/2021, as six (6) of fifteen (15) on the BIMS, indicating severe cognitive impairment. Continued review revealed an order government of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process			495029	B MINIT	,				
JOHNSON MATHERS NURSING HOME (X4) D. SUMMARY STATEMENT OF DEFICIENCIES EACH DEFICIENCY MUST BE PRECEDED BY FULL FREGULATORY OR LIST IDENTIFYING INFORMATION FREGULATORY OR LIST IDENTIFYING INFORMATION FROUZ Continued From page 88 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 revealed one (1) dose missing, on 07/18/2021, and not documented as given. 1) Review of Resident #47's medical record revealed the resident was readmitted by the facility, on 09/12/2020, and was assessed in a Quarterly MDS Assessment, dated 06/28/2021. Review of Resident #47's medical record revealed the resident was readmitted by the facility, on 09/01/2202, and was assessed in a Quarterly MDS Assessment, dated 06/16/2021, 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 06/28/2021. Review of Resident #47's Controlled Substance Count Record for Ultram (Tramadol) 50 mg every eight (8) hours PRN, dated 06/28/2021. 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 Percected 10/325 mg every four (4)	NAME OF F	BOVIDED OF CHARLIER	103025	B. WING				0	9/02/2021
(X4) D. SUMMARY STATEMENT OF DEFICIENCIES (EACH OPPROPRIATE (EACH CORRECTION SHOULD BE (EACH OPPROPRIATE MEDITARY OR LISC IDENTIFY NA WPORMANTOM) F 602 Continued From page 86 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 revealed one (1) dose missing, on 07/18/2021, and not documented as given. 1) Review of Resident #47's medical record revealed the resident was readmitted by the facility, on 09/01/2020, and was assessed in the Gacility, on 11/25/2013 and was assessed in the Gacility, on 11/25/2013 and was assessed in the Gacility, on 11/25/2013 and was assessed in the Gacility, on 11/25/2013 and was assessed in the Gacility, on 11/25/2013 and was assessed in the Gacility, on 11/25/2013 and was assessed in the Gacility, on 11/25/2013 and was assessed in the Gacility, on 11/25/2013 and was assessed in the Gacility, on 11/25/2013 and was assessed in the Gacility, on 11/25/2013 and was assessed in the Gacility, on 11/25/2013 and was assessed in the Gacility, on 11/25/2013 and was assessed in the Gacility, on 11/25/2013 and was assessed in the Gacility, on 11/25/2013 and was assessed in the Gacility, on 11/25/2013 and was assessed in the Gacility, on 11/25/2	NAME OF F	TOVIDER OR SUPPLIER			1	,			
PREFIX TAG REQULATORY OR LSC IDENTIFYING INFORMATION) F 602 Continued From page 88 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 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 06/18/2021, 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 06/18/2021, Review of Resident #47's Controlled Substance Count Record for Ultram (Tramadol) 50 mg every eight (8) hours PRN, dated 06/18/2021. 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 as admitted by the facility, on 11/25/2013 and was assessed in the Quarterly MDS Assessment, dated 06/18/2021, as six (5) of fifteen (15) on the BIMS, indicating severe cognitive impairment. Continued review revealed an order for Percocat 10/325 gm every four (4)	JOHNSO	N MATHERS NURSIN	IG HOME		1				
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. 1) 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 50 mg revealed one (1) dose missing, on 07/18/2021. 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 (5) of fifteen (15) on the BIMS, indicating severe cognitive impairment. Continued review revealed an order for Percocet 10/28/5 mg every four (4)	PREFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREF		(EACH CO	PRRECTIVE ACTION SHOP FERENCED TO THE APPR	ILD BE	COMPLETION
hours PRN, dated 04/19/2021.	F 602	H) Review of Residence on 03/12/2020, and Significant Change 05/05/2021, as three BIMS, indicating set Continued review of Hydrocodone 5 mg 05/26/2021. Review of Residence Count Record for Hone (1) dose missing documented as given 1) Review of Residence of the revealed the residence facility, on 09/01/20 Quarterly MDS Assas four (4) of fifteensevere cognitive in revealed an order revery eight (8) hour Review of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Residence of Resid	dent #8's medical record and was admitted by the facility, if was assessed in the of Status Assessment, dated set (3) of fifteen (15) on the overe cognitive impairment, evealed an order for a four (4) times per day, dated at #8's Controlled Substance dydrocodone 5 mg revealed and, on 07/18/2021, and not even. Bent #47's medical record and was assessed in a deassment, dated 08/15/2021, in (15) on the BIMS, indicating an pairment. Continued review for Ultram (Tramadol) 50 mg are PRN, dated 05/28/2021. If #47's Controlled Substance Ultram 50 mg revealed one (1) 17/18/2021, and not even. Ident #56's medical record and was admitted by the facility, and was assessed in the Quarterly dated 08/28/2021, as six (6) of BIMS, indicating severe ent. Continued review revealed cet 10/325 mg every four (4)		502				

Review of Resident #56's Controlled Substance

		& MEDICAID SERVICES				OMB NO	0.0938-0391
STATEMENT AND PLAN C	r of deficiencies of correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILC		CONSTRUCTION	(X3) DA1	TE SURVEY MPLETED
		185028	B. WING				C
NAME OF I	PROVIDER OR SUPPLIER			STE	REET ADDRESS, CITY, STATE, ZIP CODE	1 09	/02/2021
IOHNSO	N MATHERS NURSIN	to More			S CONCRETE ROAD		
 					RLISLE, KY 40311		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DSE	(XS) COMPLETION DATE
F 602	Admission MDS As as a fifteen (15) of indicating no cognit review of Resident an order for Klonop twice a day PRN, d changed to twice a for Neurontin (Gaba aday, dated, 05/05 Percocet 7.5/325 m dated 05/27/2021 (on 07/12/2021). Interview with Resident	221, and was assessed in the sessment, dated 05/09/2021, fifteen (15) on the BIMS, tive impairment. Continued #9's medical record revealed oin (a nerve pain reliever) 1 mg ated 05/05/2021 (was day, on 07/08/2021); an order apentin) 600 mg four (4) times 1/2021; and an order for ng every eight (8) hours PRN, was changed to twice a day, dent #9, on 07/28/2021 at 3:01	Fe	302			
	PM, revealed one in pain medication, an could not provide it administered at 2:3 he/she had not recount and that LPN # the medication was Resident #9 stated medication signed when LPN #1 works had reported it to or reporting it to SRNA	norning he/she had asked for and staff informed him/her they					
	PM, revealed Resid Percocet and one (medication. She st Instance in which R getting a medication check the MAR, and had not received so	A #9, on 08/02/2021 at 2:55 dent #9 had one (1) scheduled 1) scheduled as a PRN pain ated she did not recall any desident #9 shared with her not in, but if he/she had, she would d if Resident #9 stated he/she benething documented on the lare this information with her					

CENTER	(2 FOR MEDICARE	& MEDICAID SERVICES			(<u>JMB NO</u>	0.0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		DNSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185026	B. WING			09	C /02/2021
NAME OF F	ROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
1011110				2323	CONCRETE ROAD		
JOHNSO	N MATHERS NURSIN	IG HOME		CAR	LISLE, KY 40311		
/VA) ID	ELIMANARY CTA	TEMENT OF DEFICIENCIES	- 15			ON1	
(X4) ID PREFIX TAG	(EACH DEFICIENCS	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
F 602	Continued From pa	nge 90	F	502			
	· ·	vered on 07/15/2021.		702,			
	Count Check form revealed an incomp signing in on form at 6:30 PM, which is sheets remaining, bottom of the sheet Review of the followindicated the sheet two sheets on the texts.	change Controlled Substance for resident rooms 136 to 149 plete form with LPN #2 not next to LPN #6 on 07/18/2021 indicated forty-six (46) count There was still room at the t for two more changes of shift. wing form revealed LPN #2 to count was 42, and completed 07/18/2021 at 7 PM to 4 shift, bringing the count to 40					
	revealed when she 07/20/2021, the D0 through a med car noted a narcotic sk (2) for a medication week before for Rewas also a discrep Sheets, however, I not have known the Change Count Shecart. She revealed Change Count Shedetermined there we	#5 on 08/03/2021 at 4:20 PM came in on the morning of DN had asked her to go t with her. She stated they tid was on skid two (2) of two in that had just been delivered a esident #9. She revealed there ancy in the Shift Change Count ooking at the cart she would at, as the previous Shift set had been removed from the dafter the previous Shift set had been located, it was was a discrepancy of four (4) if for. She revealed one (1) skid esident #9.		3			
	following the arrive Administrator, the skids with tape on medications on the the morning of 07/	w with LPN #2 revealed, at of the DON and y identified multiple narcotic them, and were busy wasting a night of 07/18/2021 through /19/2021. She revealed some over them, and had to be					

OFILL	KO I OIY INCOICAINE	A MEDICAID SEKVICES			<u> </u>	MB NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILO		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		185028	B. WING			C 09/02/2021
	PROVIDER OR SUPPLIER IN MATHERS NURSIN	IG HOME		232	REET ADDRESS, CITY, STATE, ZIP CODE 23 CONCRETE ROAD ARLISLE, KY 40311	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 602	Continued From papain.	nge 92	F	602		1.0
	Practitioner (ARNP AM, revealed her c receiving their cont	nced Registered Nurse) #1, on 08/11/2021 at 11:44 oncern with residents not rolled pain medication would wing their pain controlled.				
	during the course of	nistrator was not available of the survey, and did not t of which was attempted on AM.				
	o8/20/2021 at 10:2 was the facility wou program, a good at count program for they come in to the of drug diversion of misappropriation of 4. Review of the far Fund Management that each resident opportunity to estal (RTA). There was deposit to open the the convenience of stated to protect the minimize the risk of division of duties in was the primary cholirector of Nursing Office Manager (Bibalance report morecipient whose badollars (\$200) of the					
	Review of 42 CFR	483.10(f)(11) revealed the				

STATEMEN	C C C C C C C C C C C C C C C C C C C	G WEDICAID SERVICES				OMB NO. 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		185028	B. WING			C
NAME OF	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	09/02/2021
JOHNSO	ON MATHERS NURSIN	IG HOME		23:	23 CONCRETE ROAD ARLISLE, KY 40311	
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES				
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DIE COMPLETION
F 602	Continued From pa	ao 04	_			
			F 6	502		
	have been supplied	minutes, the Regional				
	Business Office (RE	PO) and Cornerate				
	Compliance (CC) co	onducted an investigation and				
	audits of accounts	and items purchased. Items				
	identified that the fa	cility should have paid for				
	were to be reimburs	sed by 07/27/2021. RBO and				
	CC would conduct r	nonthly audits of RTA's for				
	two (2) months to vi	alldate purchases met				
	regulations. On 07/	23/2021 a QAPI meeting was				
	held to discuss the	process improvement plan				
	(PIP) of self-identific	ed issuesand all actions				
	taken. The investig	ation Summary dated				
	0//21/2021 revealed	d that facility staff, in good				
	taith, was assisting	residents to "spend down"				
	Continued and order to	maintain Medicaid eligibility.				
	provided in May 201	20 to assist facilities with				J
	understanding the c	current guidelines for spending				1
	down the RTA The	Summary stated the facility				
	believed they were t	following the guidance				(2.0
	correctly.	and goldened				
	Review of the Stimu	ilus Payment Tracking Report,				
	dated 01/01/2021 th	rough the present, revealed				
	all four (4) sampled	residents received Stimulus				
	money that was add	led to their RTA's. Continued				
	thora was lased that	t at various times in 2021,				
	dishused from their	ms of money authorized to be				
	items.	RTA to pay for personal				
	1. Review of Reside	ent #77's RTA revealed				
	ne/she received Stir	mulus money, on 05/28/2020				
	tor \$1200, 01/04/20	21 for \$600, and 04/07/2021				
	for \$1400. On 02/0	8/2021, authorization for				
	miscellaneous payn	nents from patient trust				
	accounts revealed ti	he facility, as Resident/Legal				
	representative, aut	horized payment of \$3,334.74				

STATEMENT	T OF DEFICIENCIES	WANTED CAID SERVICES				OMB NO. 0938-0391
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MU A. BUIL(CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		185028	B. WING			C ,
NAME OF	PROVIDER OR SUPPLIER			STD	SET ADDRESS SET	09/02/2021
ľ					EET ADORESS, CITY, STATE, ZIP CODE	
JOHNSC	N MATHERS NURSIN	IG HOME		232	CONCRETE ROAD	
				CAI	RLISLE, KY 40311	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DIRE COMPLETION
F 602	Continued From	00				
1 002	Continued From pa		F	502		
	television for \$299.9	99 and a microAIR MA500				
	alternating pressure	low air loss mattress system				
	for \$894.99; that au	thorization form was signed				
	by the previous Adn	ninistrator.				
	Interview with Resid	lent #36, on 08/17/2021 at				
	8:48 AM, revealed I	ne/she was resting in bed,				
	winged mattress ob	served, head of bed elevated,				
	when asked about t	he previous mattress (air				
	mattress), the resid	ent stated he/she had told				
	them he/she did not	want the mattress. Resident				
	#36 stated he/she w	as unable to remember who				
	he/she told, just "the	one that brought it." The				
	resident also stated	the winged mattress was				
	comfortable, Residence	ent #36, per the interview				
	stated there had not	been the need for a new				
	television, and he/sl	ne 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 dau	ghter.				
	Information and the first					
	THE COUNTY WITH LICENS	sed Practical Nurse (LPN)				
	#1, OR US/14/2021 a	t 10:29 AM, revealed she did				
	the min matters of Ch	a it was to get Resident #36				
	as to why because t	e stated she was confused				
	as to why because (he resident had a winged				
	mattess to prevent	falling out of bed, and an air				
	E8 1 Anethor ceamon	sier to slide out of bed. The				
	air mathrase was evi	s taken off the bed, and the				
	Resident #28 clid -	on the bed. LPN #7 stated of the bed three (3) times				
	that night with sees	erious injuries, and night shift				
	staff took it upon the	arous injuries, and night shift imselves to remove the air				
	mattress and nut the	winged mattress back on				
	the hed Per I DN #	7, Resident #36 never				
	complained that the	winged mattress was				
	uncomfortable.	wingeu materess was				
	Interview with the Mi	inimum Data Set (MOS)				

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				MB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		185028	B. WING	·		C 09/02/2021
NAME OF	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	T COTOLDEDE !
IONNEO	M MATUEOE MICON	to Lour		:	2323 CONCRETE ROAD	
JURNSU	N MATHERS NURSIN			i .	CARLISLE, KY 40311	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROV DEFICIENCY)	D BE COMPLETION
F 602	Continued From pa	ige 98	F	602)	
		orization, dated 06/09/2021,			•	
		ous Administrator and				
	co-signed by Resid	ent #30, revealed an order for				
	a floor lamp, top of case of pillow cove	the line bedside table, and a				
	Interview with Resid	dent #30, on 08/10/2021 at				
	3:50 PM, revealed	when the resident was asked				
	about the RTA and	who bought items such as				
	did not need south	r, the resident stated he/she ing. Resident #30 seemed a				
ı	little confused.	ng. Nesident #30 Seemed a				100
	at 11:52 AM, was u ignored the State S Surveyor's convers	v Resident #30, on 08/19/2021 insuccessful. Resident #30 Survey Agency (SSA) sation and stared blankly,				
	Resident #30 would not want to talk. O	sident #30's roommate stated d ignore someone if he/she did bservation of Resident #30's revealed the floor lamp, lift				
	chair, television, and in the room.	nd top of the line bedside table				
		t #30's financial statements.				
		revealed a total of \$507.61 esident #30's RTA account.				
		dent #34's RTA revealed				
		imulus monles on 04/29/2020 4/2021 for \$600, and on				
	04/02/2021 for \$14	00. On 02/10/2021, an				
	authorization for m	Iscellaneous payments from				
	patient trust accour	nts revealed Resident #34 as				
		egal Representative, with				
	his/her signature,	and it was co-signed by the				
		or. Further review revealed the for payment of \$3639.85, for				
	personal items that	or payment or \$3839.85, for tincluded a forty inch television				

						<u>יט . טאן מוען.</u>	<u> 970-078 l</u>	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPL IDENTIFICATION N		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILC		ONSTRUCTION	(XI) DATE SURVEY COMPLETED		
		185028	B. WING		<u> </u>	09/02	/2021	
NAME OF F	PROVIDER OR SUPPLIER	<u> </u>		STRE	ET ADDRESS, CITY, STATE, ZIP CODE	1 00102	32021	
JOHNSO	IN MATHERS NURSIN	IG HOME			CONCRETE ROAD			
				CAR	LISLE, KY 40311			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE ((XS) COMPLETION DATE	
F 602	Continued From pa	ge 100	E :	602				
			17.1	XUZ				
	Salo She would take	care of making it right, and						
	the bed trame was	still in the Maintenance						
	storage area. The	Maintenance Director stated						
		trator acted alone when						
	ordering the resider	nt items.						
	Review of Resident	l #34's financial statements.						
	Asiad 07/22/2021	revealed a total of \$3238.88						
	uated 07/23/2021, 1	esident #34's RTA account.						
	Mas reminded to Me	sident #34 \$ KTA account.						
	5 Telephone inten	view with Resident #246's						
	development interv	New With Resident #240'S						
	daughter/POA, on t	08/19/2021 at 10:36 AM,						
	revealed the reside	nt had been a patient at the						
	facility but was now	deceased. She stated the						
	facility said they ha	d to do something with the						
	resident's Stimulus	money and had to spend						
	down the RTA withi	n the year, and several items						
j	were purchased. F	urther, she stated, after						
	Resident #246 pass	sed away, his/her sister did						
	pick up the television	on that had been purchased,						
	but the resident ain	eady had one, and she did not						
	know why the facilli	ty bought a new one.						
	Additionally, she sta	ated the family was able to						
	take home the light	weight wheelchair (\$129.31)						
	that was used to ta	ke Resident #246 out of the						
	facility for visite an	d she did not know about						
	RoHo cushion /975	i.00) purchase. She stated the						
	lift chair (\$£17 pg)	and the Panacea Reclining						
	- mic Gridii (3017.00) (and the Panacea Reclining						
	vyneeichair (\$363.9	99), which had been						
	hricuszed, were le	It at the facility because they						
	were too neavy for	the family to move. She						
	stated the family wa	as not reimbursed for the						
\$1700 spent. The interview ended by Resident		Interview ended by Resident						
	#246's daughter sta	ating that if facility staff felt like						
	the resident neede	d those items, that was fine.						
	but she did not siar	anything nor was the RTA						
1	reimbursed any mo	onies. She stated the facility						
		eral items had been						

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				0		. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		DNSTRUCTION		(X3) DA	E SURVEY
· 		185028	B. WING				no	C /02/2021
NAME OF F	PROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZII	P CODE	0.3	I DELEGE I
JOHNSO	N MATHERS NURSIN	IG HOME		2323	CONCRETE ROAD			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO TI OFFICIENCY	ION SHOULD HE APPROPI	BE	(XS) COMPLETION DATE
F 602	Continued From pareimbursed.	ge 102 PON, on 08/13/2021 at 4:20	F6	i02				
	PM, revealed she his Stimulus purchases remember, In a dail remember when, for Administrator talked to buy residents spifacility should suppliformer Administrator allowed to do that, so kay as long as a middle pool of the anything with resided did not report this to been notified of the regarding Stimulus.	and no direct knowledge of a or reimbursements. She did by morning meeting (unable to ormal notes not taken), the diabout using Stimulus monies ecial air mattresses that the by. The DON stated when the or was questioned if she was the Administrator stated it was esident would be using it. The dinot question her again about ent financials. She stated she or anyone because she had not Principal (Corporate) directive checks, and therefore, did not orate Compliance or the						
	on 08/16/2021 at 2: unaware of what sy that caught the DM Administrator state	ON and Interim Administrator, 30 PM, revealed they were stem or process was in place E purchases. The Interim d he did not arrive at facility d that was one reason he did						
	08/20/2021 at 10:24 Administrator did no money or access the Administrators coul move money aroun resident trust. He se President (RVP) was Administrator. He se	nterim Administrator, on 4 AM, revealed the of have any ability to move se general accounting ledger. It do not do rake money out of a stated the Regional Vice as oversight manager for the stated, until July, there was no ner Administrator had used						

		& MEDICAID SERVICES					MB NO	. 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		185028	B. WING	i				C	
NAME OF I	PROVIDER OR SUPPLIER			_	STREET ADDRESS, CITY, STATE,	710 0005	1 094	02/2021	
				t t	2323 CONCRETE ROAD	ZIP COUE			
JOHNSO	IN MATHERS NURSIN	G HOME			CARLISLE, KY 40311				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN O (EACH CORRECTIVE AI CROSS-REFERENCED TO DEFICIE	THE APPROP	BE	(X5) COMPLETION DATE	
F 602	Continued From pa	ge 104	E	602					
	worked her way arc		1. (JUZ	4				
	Jeopardy Removal alleged removal of	d an acceptable Immediate Plan, on 09/01/2021, that the Immediate Jeopardy (IJ) a facility implemented the						1	
	Plan (PIP) was initial Narcotics which wa Inspector General-	a Performance Improvement ated related to Missing s reported to the Office of Division of Health Care (State 4:30 PM on 07/09/2021.							
	Nurses audited nar- medication carts as blister pack missing to match the number	the Unit Manager and MDS cotics in the remaining the North back hall had a p. All count sheets were founder of skids. Staff signing in the cart was expected on the check sheets.							
	Coordinator (SDC) topics included nare added and subtract	the Staff Development Initiated staff education. The cotic count, counting sheets ed, signing packing slips, and to the narcotic books.							
*	07/22/2021, 07/24/2 08/22/2021 to 08/29 (Facility) Consultan Corporate Nurse we facility five (5) days 2021, ensuring resi abuse, neglect, and procedures were for plan of correction.	07/13/2021, 07/20/2021 to 2021 to 08/13/2021, and 20/2021, an RN Corporate It worked in the facility. An RN could continue to be at the a week through September dents remained free from It exploitation, and policy and Ilowed, including the active An RN Corporate Nurse could in place of the assigned							

		G MEDIONIO CENTICES				MB NO. 0938-0391
AND PLAN O	OF DEF CIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		185028	B. WING			C 09/02/2021
	ROVIDER OR SUPPLIER N MATHERS NURSIN	G HOME		2323	EET ADDRESS, CITY, STATE, ZIP CODE 3 CONCRETE ROAD RLISLE, KY 40311	1 00/02/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DE COMPLETION
F 602	correct number of clogged into the name number of declining Any discrepancies to the DON and/or: 10. On 07/19/2021 assessments on all assessing pain. For eight (8) or below, to observation of non-breathing, facial exconsolability. No consolability. No consolabili	I times per week to ensure the telivered narcotics were colic count book and the grount sheets were updated, would be reported immediately administration. I staff nurses performed residents, including or residents with a BIMS of the assessment included verbal signs of pain to include: pression, body language, and oncerns were identified. I the APRN assessed	F	502		

		& MEDICAID SERVICES				O). 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL		CONSTRUCTION		(X3) DAT	TE SURVEY MPLETED
		185028	B. WING					С
NAME OF	PROVIDER OR SUPPLIER	10000	0. 7			!	09/	/02/2021
	ON MATHERS NURSIN	IG HOME		232	REET ADDRESS, CITY, STATE ZIP COD 3 CONCRETE ROAD RLISLE, KY 40311	•		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	ıx	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	ioui n	AF.	COMPLETION DATE
F 602	Manager, SDC/QI, Nurses, the Corpora would audit the stornarcotics when che ensure narcotics we documentation was locking carts, MAR' signatures, declininarcotics, back side skid cards in numer all narcotics accourpacking silps. Audii per week until the Cfrequency could be regarding documen administration would the audit and report Administrator. All in reviewed in the more	the DON, ADON, Unit Weekend Supervisor, MDS ate RN, and/or a support RN rage and documentation of ecking medication carts to ere stored appropriately and a correct. The audits included: s, shift change count sheets, ag count sheets, wasted e of narcotic medication skids, rical order, no missing skids, ated for, and/or pharmacy its would occur five (5) times DAPI committee determined reduced. Any concern station or storage of narcotic id be addressed at the time of ted to the DON or new concerns would be ming IDT meeting. Any ling would be reviewed and	F	602				
	17. On 07/21/2021 interviewed and sus Administrator.	, the Regional Vice President spended the facility's						
8	Corporate Nurses p Neglect, and the Mi Property Policy. Th screening of employ prevention, identific and reporting/respo of one hundred eighthe education at tha	through 07/25/2021, the RN provided education on Abuse, isappropriation of Resident the education included: yees, training of employees, action, investigation, protection, onse. One hundred five (105) and (108) employees completed at time. The three (3) es have since received the						

		& MEDICAID SERVICES					O	MB NO.	0938-0391
STATEMENT OF DEFIC AND PLAN OF CORRE	CTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	V		(XJ) DATE	SURVEY PLETED
		185028	8. WING					1	C 02/2021
NAME OF PROVIDER	OR SUPPLIER			S	TREET ADDRESS,	CITY, STATE, ZIP CI	ODE	0.01	DE/EUE I
JOHNSON MATH	ERS NURSIN	NG HOME	:	١.	323 CONCRETE CARLISLE, KY				
(X4) ID PREFIX (EA TAG REG	CH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	IX.	PROVID (EACH CO	DER'S PLAN OF COR PRECTIVE ACTION FERENCED TO THE DEFICIENCY)	ISHOULD	BE	(XS) COMPLETION DATE
F 602 Continu	ued From pa	age 110	F	502					
SDC, N Corpor medica nurses medica notifica the KM form. one-hu receive 21. Or abuse/ note re nursing for any 22. Or Manag facilitie safe su regard 23. Or Directo 24. Or narcoti Directo 25. Or Comm preser survey Review conclu	sturse Super ate RN constition administration administration and Valida Any licensed additional examples and RN (any licensed additional examples additional examples and RN (any licensed additional examples and RN (any licensed additional examples were indication on 07/27/2021 er, RN's, and RN (arveys, with any abuse/net in 08/01/2021 or Update tell and 08/01/2021 or Update tell and 08/01/2021 or Update tell and 08/01/2021 or Update tell and 08/01/2021 or Update tell and 08/01/2021 or Update tell and 08/01/2021 or Update tell and 08/10/2021	I, the DON and SDC began iitoring via nursing progress last twenty-four (24) hours of printed off and read, looking f abuse/neglect/exploitation. I, the DON, SDC, Unit d Administrators from "sister Corporate nurses continued residents, and staff surveys							

		& MICHICAID SERVICES			(OMB NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILO		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		185028	8, WING			C 09/02/2021
	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE 23 CONCRETE ROAD	05/02/2021
	N MATHERS NURSIN		ļ		ARLISLE, KY 40311	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPLETION
F 602	Continued From pa exploitation.	ge 112	F	602		
	33. On 08/20/2021 rebilled and/or paid medications.	, the facility verified the facility for the misappropriated				
	announced the tran Administrator. The Interim Administrator, new Administrator, the tags F-600 Abu	, the Regional Vice President sition to the new Regional Vice President and or provided education to the including the requirements of se/Neglect/Exploitation and brevent/Correct Alleged				
	Director update tele DON, Regional Vice Interim Administrate Consultant. The dis Immediate jeopardy F-610 Investigate/P Violation. Review or results concluded in	the DON facilitated a Medical aphone meeting, including the President, Medical Director, or, new Administrator, and RN scussion included the facility's (IJ) status, including the tag trevent/Correct Alleged of actions taken and audit in the recommendation for the e continued education and 2)				
	Nurse provided edu employees, includir	, the SDC and RN Corporate relation to three (3) new dietary ng abuse/ neglect, and //Correct Alleged Violation if				
	audited the north-fr verbally quizzed the to preventing and p further misappropri	, the SDC monitored and ont medication cart and a medication cart nurse related rotecting residents from ation of property (controlled medication cart nurse passed				

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			C	MB NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		185028	B. WING			C 09/02/2021
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ОЕИНОС	N MATHERS NURSIN	IG HOME	!		23 CONCRETE ROAD ARLISLE, KY 40311	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE COMPLETION
F 602	thoroughly. 42. The Pharmacy facility at least mon	ompleted timely and Consultant would visit the thly to validate narcotics were	F	602		
:	practice. The State Survey A	d counted per standard of				·
!	Jeopardy Removal 1. Review of a Qua	ality Assurance (PIP), dated				
6	blister pack of thirty pharmacy audit, the staff was signing fo facility, and initiated substances, to inclu-	ed, as a result of the missing (30) Percocet identified in a efacility identified only one (1) or narcotics arriving at the deducation on controlled ude having a second person substances arriving at the				
	confirmed the facili- misappropriation to	lent Form, dated 07/09/2021, ty reported the incident of all appropriate parties, to if Inspector General (State				
	staff audited narcol	mentation confirmed facility lics in all medication carts on w of audits revealed no other				
	Report with Staff All confirmed the SDC attended by license	mplete In-Service Training Itending, dated 07/09/2021, initiated staff education, ad nursing staff and KMA's, the need for both the off going				

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CENTER	IS FUR MEDICARE	: & MEDICAID SERVICES				MIB NU.	0820-0381
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		185028	B. WING			1	2/2021
NAME OF F	PROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
JOHNSO	N MATHERS NURSIN	IG HOME	İ		CONCRETE ROAD LISLE, KY 40311		
(X4) ID PREFIX TAG	(EACH DEFICIENC	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROV DEFICIENCY)	DBE	COMPLETION DATE
	Continued From parmust be signed on narcotics no longer the medication can the DON, and (3) of labeled with room is sheet. Interview with the I AM, reveated it has everything was sig back of the MAR, 107/12/2021, emphthis, including door pain medication at 6. Review of a Ke Reporting System 07/18/2021, revea and charged with 10 Unlawful Taking, to of Controlled Subs Wanton Endanger Abuse and Neglet Review of LPN #1 #1 had been term 07/18/2021. 7. Review of the interview of th	age 116 the back of the MAR, (2) all r in use must stay locked up in t until they could be given to declining count sheet must be numbers at the top of the DON, on 09/02/2021 at 9:10 dispendent on the december of the description of the so the education initiated, on asized to staff the need to downenting the effectiveness of dministered to residents. Antucky Incident Based (KYIBRS) Report, dated led LPN #1 had been arrested thirteen (13) counts of Theft by hree (3) counts of Possession stances, two (2) counts of the december of the december of the december of the december of the december of the december of the december of the december of the december of the december of the december of the december of the december of the december of the december of the december of the december of the december of the december of the december of the december of the december of the december of the december of the december of the december of the december of the december of the december of the december of the december of the december of the december of the december of the december of the december of the december of the december of the december of the december of the december of the december of the december of the december of the december of the december of the december of the december of the december of the december of the december of the december of the december of the december of the december of the december of the december of the december of the december of the december of the december of the december of the december of the december of the december of the december of the december of the december of the december of the december of the december of the december of the december of the december of the december of the december of the december of the december of the december of the december of the december of the december of the december of the december of the december of the december of the december of the december of the december of the december of the december of the december of the december of the december of the december of the de	F	602	DEFICIENCY}		
	residents had nar non-prescribed m was in place to id- affected, as well a	8/2021 incident in which two (2) cotics replaced with edications, a PIP addendum entify the scope of residents as further staff education on nees and monitoring by f.					
	8. Review of me	eting minutes, dated					

07/18/2021, confirmed the IDT met and were in

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		& MEDICAID SERVICES					MB NO	. 0938-0391
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NAME OF B	PROVIDER OR SUPPLIER	10000	0. 1140				09	/02/2021
natitain mi. t	WANDEN ON GOLLEGEN				TREET ADDRESS, CITY, STATI	E, ZIP CODE		
OSNHOL	N MATHERS NURSIN	IG HOME			2323 CONCRETE ROAD			
				_ (CARLISLE, KY 40311			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOU TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)		ACTION SHOULD TO THE APPROP	BE	(KS) COMPLETION DATE	
F 602	Continued From pa	an 140	_					
1 002			F	502				
	conducted on 07/18	ne pain assessments 9/2021.						
	confirmed APRN #	ulatory Nursing Home Report I assessed Resident #84 on ncerns were identified with the ident #84.						
	Director (MD) with I revealed possible in opiates had been redocumentation reveils improving at the time documentation furtile.	ician visit by the Medical Resident #32, on 07/20/2021, adicators Resident #32's eplaced with Primidone. MD ealed Resident #32's condition the of documentation. MD ther revealed APRN #2 had at #32 on 07/19/2021.						
	Self-Reported Incid	ng Term Care Facility - lent Form, dated 07/20/2021, had been suspended from the						
	Administration conf three (3) or more re on 07/20/2021 rega medication adminis	ident Interview Medication irmed facility staff interviewed esidents each week beginning urding any concerns with stration, and if so who they en. No concerns were noted at interviews.						
	also used to docum regarding narcotics forms had been con	ange Narcotic Review sheets, tent nurse and KMA concerns administration, revealed no mpleted, indicating no reported as of the review date						
	Interview with the D	ON, on 09/02/2021 at 9:10						

AM, revealed she frequently interviewed residents

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILO		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE	1 09/02/2021	
				l .	3 CONCRETE ROAD		
JOHNSO	N MATHERS NURSIN	IG HOME		i	RLISLE, KY 40311		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DIE COMPLETION	
	Continued From pa 07/22/2021, for a K but did not sign at ti given.	ige 120 MA who had pulled narcotics he time the narcotics were	Fŧ	502			
	17. Interview with ton 09/02/2021 at 7: previous Administration 7/21/2021, as a reway the Administratissue. The Regions was present at the Administrator from 07/23/2021, with an at the facility, begin Administrator started 18. Review of ComReport with Staff At 07/20/20/2021, revealed facility Abuse, Neglia Resident Property of The focus of the transporting and follow reporting if the situation of commemployee's supervix Administrator, and Compliance line or The training also not Compliance line cosign in sheets for the employee complete Interviews, on 09/02 at 2:27 PM; the Administrator at 3:14 PM, revealed they at 3:14 PM, revealed they at 3:14 PM, revealed they at 3:14 PM, revealed they at 3:14 PM, revealed they at 3:14 PM, revealed they at 3:14 PM, revealed they at 3:14 PM, revealed they at 3:14 PM, revealed they at 3:14 PM, revealed they at 3:14 PM, revealed they at 3:14 PM, revealed they at 3:14 PM, revealed they at 3:14 PM, revealed they at 3:14 PM, revealed they at 3:14 PM, revealed they at 3:14 PM, revealed they at 3:14 PM, revealed they at 3:14 PM, revealed they at 3:14 PM, revealed they at 3:14 PM, revealed they at 3:14 PM, revealed they at 3:14 PM, revealed they at 3:14 PM, revealed they at 3:14 PM, revealed they at 3:14 PM, revealed they at 3:14 PM, revealed they at 3:14 PM, revealed they at 3:14 PM, revealed they at 3:14 PM, revealed they at 3:14 PM, revealed they at 3:14 PM, revealed they at 3:14 PM, revealed they at 3:14 PM, revealed they at 3:14 PM, revealed they at 3:14 PM, revealed they at 3:14 PM, revealed they at 3:14 PM, revealed they at 3:14 PM, revealed they at 3:14 PM, revealed they at 3:14 PM, revealed they at 3:14 PM, revealed they at 3:14 PM, revealed they at 3:14 PM, revealed they at 3:14 PM, revealed they at 3:14 PM, revealed they at 3:14 PM, revealed they at 3:14 PM, revealed they at 3:14 PM, revealed they at 3:14 PM, revealed they at 3:14 PM, revealed they at 3:14 PM, revealed they at 3:14 PM, revealed they at 3:14 PM, revealed they at 3:14 PM, revealed they at 3:14 PM, revealed t	aplete In-Service Training stending, with a start date of ead staff was educated on the ect, and Misappropriation of Policy, revised 03/10/2017. Sining appeared to be on wing the chain of command in ation had not been addressed and consisted of the isor, the DON, the followed by the Corporate the Regional Vice President. Since Calls to the Corporate and the anonymous. Review of alning revealed the last ed the training, on 08/10/2021. 2/2021, with Housekeeper #4, missions Coordinator, at 2:48 PM; and SRNA #23, at 3:21 all had received education on					
	abuse/neglect and	misappropriation. In addition, entify their immediate					

CENTER	S FOR MEDICARE	& MEDICAID SERVICES				OMB NO	D. 0938-0391_
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		LE CONSTRUCTION		ATE SURVEY
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					2323 CONCRETE ROAD		
JOHNSO	N MATHERS NURSIN	IG HOME		1	CARLISLE, KY 40311		ļ
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 602	Continued From pa	ge 122	Fe	302	2		
	*	as to be wasted with another			-		
	nurse witnessing a	nd signing. LPN #11 revealed					
	she had seen and	experienced management					
	staff, including the	DON, going around doing					į
	medication cart aud	lits, and she stayed with her					
	medication cart wh	ile was being audited.					
	Interview with SRN	A #20, on 09/02/2021 at 3:39					
	PM, a KMA, reveal	ed he received the same					
	education nursing :	staff received. He revealed he					
	had received multip	ole educations. The KMA					
	stated the education	n included the importance of					
	signing out narcotic	s when he gave them and not					
	waiting until the en	d of shift to sign them out. He					
	revealed he signed	them out right after they were					
		dent refused, he would mark it ive a nurse witness and sign					
	the medication as	wasted. He stated, if a pill or					
	skid was comprom	Ised, or if anything looked					
	tampered with, he	would alert the DON so she					
	could assess and o	determine if medications					
		ed. He revealed corporate					
		I his drug cart recently.					
	20. Review of the	facility's Narcotic					
		z revealed licensed nurses and					
		written quizzes, beginning on					
		responses reviewed were					
	appropriate, with n	o concerns identified during					
	review of them.	· ·					
	21. Interview with	the DON, on 09/02/2021 at					
		the DON and the SDC printed					
		esident progress notes.					
		ng potentially indicative of					
	abuse or neglect.	She revealed, in addition to					
	reviewing any incid	lents and accidents, they					
		umentation of resident injuries					
		stated this was an ongoing					

CTATCACAL	OF OF THE BIOTIFE	G MCDICAID SEKVICES				OMB NO. 0938-0391		
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		ONSTRUCTION	(XI) DATE SURVEY COMPLETED		
		185028	B: WING			C 09/02/2021		
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F 602	counted, (3) the numeratched the number Skids on the cart dispacks, (5) Skids was were no missing skidgged in and out of Controlled Substansheet count number signed out and according to the signed out and according to the signed out and according to the signed out and according to the signed out and according to the signed out and according to the signed out and according to the signed out and according to the signed out and according to the signed out and according to the signed out and according to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to the signed to	narcotic sheets had been mber of narcotic count sheets or of skids on the cart, (4) do not have tape on their are checked to ensure there ids, (6) CSCS were being of the cart on the Shift Change or Count Check form as the rehanged (new skids arrived, ed), and (6) All narcotics were bunted for. In Cart Audit completed, on the AM, by the DON revealed the downward with no issues noted or quired or taken. The sultant noted the front-north is a screw sticking out that sed holes in the back of ids: The screw was covered. In Cart Audit completed, on PM, by the DON revealed the downth no issues noted or quired or taken. It is contic Cart Audit completed, 25 PM, by the DON revealed iteled with no issues noted or quired or taken. It is contic Cart Audit completed, 25 PM, by the DON revealed iteled with no issues noted or quired or taken. It is contic Cart Audit completed, 25 PM, by the DON revealed iteled with no issues noted or quired or taken.	F€	802				
	provided the Medica 08/19/2021.	Director an update call on						

PRINTED: 10/11/2021

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			-	FORM APPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	LTIPL	E CONSTRUCTION	MB NO. 0938-0391 (X3) DATE SURVEY
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NAME OF F	PROVIDER OR SUPPLIER			5	TREET ADDRESS, CITY, STATE, ZIP CODE	09/02/2021
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(X4) ID	SUMMARY STA	NTEMENT OF DEFICIENCIES		C	CARLISLE, KY 40311	
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F 602	Continued From pa	ge 126	F€	802	-	
	Administrator revea Administrator, on 08 Administrator, on 08 Administrator job de Regional Vice Presiletter on 08/26/2021 Interview with the Administrator and the over the phone, on discussed with him been cited, to includ tags. He stated the was aware of the sit into. He stated the instrused the important keeping him info 35. Review of the dimension of the discussed with info 35. Review of the dimension of the discussed the important keeping him info 35. Review of the dimension of the discussion of the discus	escription, reporting to the Ident, who also signed the 1. Ident, who also signed the 1. Ident, who also signed the 1. Ident, who also signed the 1. Ident, who also signed the 1. Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Ident Id				
	discussing issues as address issues.	down each one of the tags, nd what was being done to				

36. Review of three (3) Employee Affirmation

CENTERS FOR MEDICARI	& MEDICAID SERVICES				OMB	JRM APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION		NO, 0938-0391 DATE SURVEY COMPLETED
	185028	B. WING				С
NAME OF PROVIDER OR SUPPLIER JOHNSON MATHERS NURSII	IC LONE			REET ADORESS, CITY, STATE, ZIP CO	DDE	09/02/2021
				RLISLE, KY 40311		
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08/29/2021. She re Action Checklist, re Administrator made needed to do and other. The Clinical I Administrator had in residents' represent in his investigation. 40. Review of the feated 08/28/2021, and a support RN in regarding abuse, comedication administration administration administration administration. Further, audit of narcotic documents are conducted an arcotic documents. Further, audit of narcotic documents are visited evidence to the feater with the confirmed she visited conducted an arcotic visits. Interview with the Dam, confirmed the Conducted monthly conducted a medical She stated the only Pharmacist was not	th the Administrator on avealed they went down the eviewed the process, and the enotes to himself on what he enotes to himself on what he enotes to himself on what he enotes to himself on what he enotes to himself on what he enotes to himself on what he could do at that Director stated the interviewed residents, called tatives, and was very thorough of misappropriation. Tacility's Weekend Audits, confirmed the Administrator interviewed staff and residents ode of conduct, and tration. Staff members were stlons accurately, and press any concerns during in nursing staff conducted an cumentation and did not terms. Tardinal IDT Meeting minutes at 1/2021, and 09/01/2021 he facility had initiated five (5) eetings. The Consultant Pharmacist and the facility monthly and cs audit during her monthly The Consultant Pharmacist wisits, reviewed charts, and attion administration audit. Itime the Consultant coming were times, during the facility was in lock-down	F 6	602			

CENTERS FOR MEDICARE						MB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/BUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CO	JCTION	(X3) DATE SURVEY COMPLETED	
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made allegations of and that staff were fifteen (15) of forty-The residents affect #17, #32, #34, #47, #82, and #84. On 08/25/2021, Resignation medications do Licensed Practical I of Nursing (DON) is her to monitor and i regarding PRN contivated a thorougallegation. On 07/08/2021, Resignation allegation. On 07/08/2021, Resignation allegation. On 07/08/2021, Resignation allegation. On 07/08/2021, a plantistic process and the sallegation. On 07/09/2021, a plantistic process and the sallegation allegation. On 07/09/2021, a plantistic process and the sallegation and the sallegation allegation. On 07/09/2021, a plantistic process and the sallegation and the sallegation allegation are total of Resident #17, on 06 allegation allegation allegation are total of Resident #17, on 06 allegation allegation allegation allegation are total of Resident #17, on 06 allegation allegation allegation allegation are total of Resident #17, and 06 allegation allegation allegation allegation allegation allegation allegation allegation allegation allegation allegation allegation allegation allegation allegation allegation allegation allegation allegation allegation allegation allegation allegation allegation allegation allegation allegation allegation allegation allegation allegation allegation allegation allegation allegation allegation allegation allegation allegation allegation allegation allegation allegation allegation allegation allegation allegation allegation allegation allegation allegation allegation allegation allegation allegation allegation allegation allegation allegation allegation allegation allegation allegation allegation allegation allegation allegation allegation allegation allegation allegation allegation allegation allegation allegation allegation allegation allegation allegation allegation allegation allegation allegation allegation allegation allegation allegation allegation allegation allegation allegation allegation allegation allegation allegation allegation allegation allegation allegation allegation	medications), after residents in not receiving medications taking the medications for four (44) sampled residents. ted were: Resident #1, #8, #9, #48, #56, #60, #65, #71, #79. sident #82 alleged in a written he had not received controlled ocumented as given by Nurse (LPN) #1. The Director tated the Administrator asked investigate for any concerns trolled pain medications; there is evidence the facility gh investigation into the sident #9 confronted LPN #1; is stealing his/her controlled hal grievance was initiated; as not investigated as result in armacy audit revealed a (30) Percocet (Scheduled II to Resident #17. LPN #2 skids of thirty (30) Percocet inety (90) Percocet for 1/28/2021; however, LPN #1 ag two (2) skids of thirty (30) a total of sixty (60) Percocet.	F6	310	4.	misappropriation is all Refer to the abatemer facility's systemic char Beginning 11/1/21, co investigations will be rIDT meeting, weekly fithen monthly for two mensure the investigation complete and followed appropriate. Abuse an audits continue as per abatement plan. Refer abatement plan for fact change. Data will be requality Assurance Per Improvement (QAPI) monthly for additional recommendations. Compliance Date: 11/2	nt plan for the inge. Impleted reviewed in the or four weeks, months, to on was a checklists as and narcotic the reviewed at the cility's systemic eviewed at the rformance meeting

<u>CENTER</u>	RS FOR MEDICARE	& MEDICAID SERVICES					. 0938-0391	
	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUI A. BUILL		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		185028	B. WING				C /0 2/2021	
NAME OF F	PROVIDER OR SUPPLIER			5T/	REET ADDRESS. CITY, STATE, ZIP CODE			
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F 610	610 Continued From page 132 a Plan of Correction and the facility's Quality Assurance (QA) monitors to ensure compliance with systemic changes. The findings include:		F	510				
					20			
	Neglect, or Misappi Policy," last revised facility would do wh prevent abuse and property. The polic responsible to ensu- investigated and to appropriate agencie Prevention, the poli- investigate allegation develop corrective in the section on Investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigate and investigat	ly's policy titled, "Abuse, repriation of Resident Property 103/10/2017, revealed the atever was in its control to misappropriation of resident y stated the Administrator was in e complaints were report allegations to the est. Under the section on cy stated staff would one in a timely manner and measures as indicated. Under stigation, the policy stated the responsible to direct the ensure appropriate agencies						
	on 07/27/2021 at 16 07/29/2021 at 3:45 allegations to their reported to the Admidid the reporting to investigation. The investigations was facility residents an follow up interviews Regarding grievance or resident could conditionally department of the resident could conditionally department of the resident could conditionally department of the resident could conditionally department of the resident could be resident could be resident could be resident could be resident could be resident could be resident could be resident could be resident could be resident could be resident could be resident could be resident could be resident could be resident could be resident could be resident could be resident could be resident could be resident could be resident could be resident could be resident could be resident could be resident could be resident could be resident could be resident could be resident could be resident could be resident could be resident could be resident could be resident could be resident could be resident could be resident could be resident could be resident could be resident could be resident could be resident could be resident could be resident could be resident could be resident could be resident could be resident could be resident could be resident could be resident could be resident could be resident could be resident could be resident could be resident could be resident could be resident could be resident could be resident could be resident could be resident could be resident could be resident could be resident could be resident could be resident could be resident could be resident could be resident could be resident could be resident could be resident could be resident could be resident could be resident could be resident could be resident could be resident could be resident could be resident could be resident could be resident could be resident could be resident could be resident could be resident could be resident could be resident could be resident could be resident could be resident could	social Services Director (SSD), D:29 AM, and again, on PM, revealed staff reported supervisor, which were then ninistrator. The Administrator state agencies and initiated an SSD revealed her role in typically interviewing other d sometimes conducting with the residents involved. The SSD shared any staff omplete one, with the mining which ent would receive the SSD logging them in the revealed some staff and						

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

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F 610	Continued From page	ge 134		510			
		re on consecutive days.	г	HU			
	TOUT (4) OF WHICH WE	re on consecutive days.					
	o8/02/2021 at 3:52 I reported to the Adm concern over narcot Resident #82 how he revealed he/she was couple of nurses the because he/she had over the weekend woccur. Resident #82 hurting and had not in a few days. RN # Resident #82's narchad signed out for the and two (2) pain pills #82 stated he/she he revealed she sent a Administrator regard with narcotics. She Administrator the M. stated "this was bec Resident #9 had aim She revealed the Ad #82 for about twenty Resident #82 stated him/her she would ghe/she had heard the going to do crap" ab with RN #1 revealed with RN #1 revealed with RN #1 revealed with resident RN #1 revealed with RN #1 revealed with RN #1 revealed with RN #1 revealed with RN #1 revealed with RN #1 revealed with RN #1 revealed with RN #1 revealed with RN #1 revealed with RN #1 revealed with RN #1 revealed with RN #1 revealed Resident RN #1 revealed Resident RN #1 revealed RN #1 revealed RN #1 revealed RN #1 revealed RN #1 revealed RN #1 revealed RN #1 revealed RN #1 revealed RN #1 revealed RN #1 revealed RN #1 revealed RN #1 revealed RN #1 revealed RN #1 revealed RN #1 revealed RN #1 revealed RN #1 revealed RN #1 revealed RN #1 revealed RN #1 revealed RN #1 revealed RN #1 RN #1 revealed RN #1 revealed RN #1 revealed RN #1 revealed RN #1 revealed RN #1 revealed RN #1 revealed RN #1 revealed RN #1 revealed RN #1 revealed RN #1 revealed RN #1 revealed RN #1 revealed RN RN #1 revealed RN RN #1 revealed RN RN #1 revealed RN RN #1 revealed RN RN #1 revealed RN RN #1 revealed RN RN #1 revealed RN RN #1 revealed RN RN #1 revealed RN RN #1 revealed RN RN #1 revealed RN RN #1 revealed RN RN #1 revealed RN RN #1 revealed RN RN #1 revealed RN RN #1 revealed RN RN #1 revealed RN RN #1 revealed RN RN #1 revealed RN RN #1 revealed RN RN #1 revealed RN RN #1 revealed RN RN #1 revealed RN RN #1 revealed RN RN #1 revealed RN RN #1 revealed RN RN RN #1 revealed RN RN RN #1 revealed RN RN #1 revealed RN RN RN #1 revealed RN RN RN #1 revealed RN RN RN RN RN RN #1 revealed RN RN RN RN RN RN RN RN RN RN RN RN RN	stered Nurse (RN) #1, on PM, revealed she had Inistrator, on 06/21/2021, a state. She stated she asked telshe was doing, the resident is doing well, but told her a bught he/she was dying if received a lot of narcotics which the resident said did not 2 reported he/she was not needed any pain medications at stated she examined otic sheet and found LPN #1 wo (2) pain pills on Saturday is for Sunday, which Resident ad not received. She text to the previous ling Resident #82's concern revealed she showed the AR, and the Administrator oming a problem" and that eady "called state on us." Iministrator met with Resident (20) minutes, after which the Administrator told let to the bottom of it, but as at before, knew they "weren't out it. Continued interview Resident #82 typically took pain pills a month for					
	dated 06/25/2021, in RN #1 who received uncertainty voiced by	Concern/Grievance Form, illiated by Resident #82 with the grievance, revealed y the resident if he/she had ation over the weekend. RN					

CTATCACAC						<u> </u>	91
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILL		ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185028	B. WING			C 09/02/2021	
NAME OF I	PROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE	USIGZIZGZ	
огинос	N MATHERS NURSIN	IG HOME		2323	CONCRETE ROAD		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID.		PROVIDER'S PLAN OF CORRECTI	7N	
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F 610	Continued From pa	ige 136	F	810			
		SDC/QI, on 08/05/2021 at	•	,,,			-
	12:22 PM, revealed	she was uncertain when					
	Resident #82 first id	dentified an issue, although					
	she thought it was o	early to mid-July. She					
	revealed no one rep	ported anything directly to her					
	about Resident #82	, although there had been a					
	grievance regarding	him/her believing he/she was					
	not getting pain me	dications that had been signed					
	out during the night	. She stated if someone had					
	It to the DOM She	her, she would have reported					
	suspicion of days di	stated, if a nurse had a iversion, he/she should					
	contact the DON in	mediately and initiate a					
	orievance form. Th	ie SDC/QI shared she would					
	expect staff to follow	w the chain of command in					
	reporting concerns.	which would be nursing staff,					
	herself, and the DC	N, as there was currently (as					
	of the date of this in	nterview) no Assistant Director					
	of Nursing (ADON)						
	Interview with the D	ON, on 08/04/2021 at 8:28					
	AM, and again, on (08/05/2021 at 12:35 PM.					
	revealed the Admin	istrator approached her, after					
	the grievance by Re	esident #82, and told her that					
	Resident #82 might	not have received his/her					
	medication. She st	ated the Administrator told her					
	she needed to start	watching LPN #1. The DON					
	revealed, in her rev	lew of MAR's, she was unable					
	to identify LPN #1 v	vas signing out more PRN					
	medications than of	ther night shift staff. The DON					
		ot document her review of the					
	residents' MAR's.						
	2. Review of Resid	lent #9's medical record					
	revealed the reside	nt was readmitted to the					
	facility, on 05/03/20	21, with diagnoses to include					
	Paraplegia Unspeci	ified, Nicotine Dependence					
	Unspecified Uncom	plicated, Other Specified					
	Anxiety Disorders, and Other Chronic Pain. The						

1		& MEDICAID SERVICES			Oi	MB NO. 0938-0391
STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED
		185028	B. WING			C 09/02/2021
NAME OF F	ROVIDER OR SUPPLIER			STE	REET ADDRESS, CITY, STATE, ZIP CODE	03/02/2021
				l .	3 CONCRETE ROAD	
	N MATHERS NURSIN			l	RLISLE, KY 40311	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHC TAG CROSS-REFERENCED TO THE APPL DEFICIENCY)			BE COMPLETION
F810	did not appreciate r when the nurse said continued interview at 8:28 AM, revealed 07/08/2021, to speashe had been giving residents to ensure DON staled she insured interview with LPN revealed, on 07/06/indicated to her that his/her medications wanted his/her pain unable to give it as been signed out the revealed she alerte message of Resident #9 was not however, she state receive his/her PRh morning. Interview with Reside PM, revealed one in paln medication, and could not provide it administered at 2:3 he/she had not receive AM, and LPN #1 had medication was altered the state of the paln medication was altered the state of the posterior was altered the state of the posterior was altered the state of the posterior was altered the posterior was altered the posterior was altered the posterior was altered the posterior was altered the posterior was altered the posterior was altered the posterior was altered the posterior was altered the posterior was altered the posterior was altered the posterior was altered the posterior was altered the posterior was altered the posterior was altered the posterior was altered the posterior was altered the posterior was altered the posterior was altered the posterior was altered the posterior was altered the posterior was altered the posterior was altered the posterior was altered the posterior was altered the posterior was altered to the posterior was altered to the posterior was altered to the posterior was altered to the posterior was altered to the posterior was altered to the posterior was altered to the posterior was altered to the posterior was altered to the posterior was altered to the posterior was altered to the posterior was altered to the posterior was altered to the posterior was altered to the posterior was altered to the posterior was altered to the posterior was altered to the posterior was altered to the posterior was altered to the posterior was altered to the posterior was altered to the posterior was altered to the posterior was altered to the posterior was a	nted LPN #1, saying he/she not getting his/her medication d he/she did receive them. with the DON, on 08/04/2021 at she stayed late, on ak with LPN #1, who revealed g PRN pain medications to they were able to sleep. The structed LPN #1 not to do that. #5, on 08/03/2021 at 4:20 PM, 12021, Resident #9 had the/she was not receiving at She revealed Resident #9 in medication, but she was Resident #9's pain pill had be previous evening. She at the DON at that time via text ent #9's allegation. She stated at in any pain that morning, and Resident #9's routine was to N pain medication in the	F	310		
	Medication Aide (K	MA) and able to administer				

CENTER	13 FUR MEDICARE	& MEDICAID SERVICES			(<u> MB NO</u>	<u>. 0938-0391</u>	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		ONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		185028	B. WING		·	1	C /02/2021	
NAME OF F	ROVIDER OR SUPPLIER			STOR	ET ADDRESS, CITY, STATE, ZIP CODE	1 991	ORIZOZ I	
JOHNSO	N MATHERS NURSIN	IG HOME		2323	CONCRETE ROAD			
				CAF	RLISLE, KY 40311			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT: (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(XS) COMPLETION DATE	
F 610	and responded to the taken, which include interviewed nurses reviewed MAR's, at facility and law enforced as resolved on 07/09/2021. The initiate an investigation of the taken and investigation of the taken and investigation of the taken and investigation reveal tablets each of Perdelivered by pharmal tablets each of Perdelivered by pharmal tablets each of Perdelivered by pharmal tablets each of Perdelivered by pharmal tablets each of Perdelivered by pharmal tablets each of Perdelivered by pharmal tablets each of Perdelivered by pharmal tablets each of Perdelivered by pharmal tablets each of Perdelivered by pharmal tablets each of Perdelivered by pharmal tablets each of Perdelivered by pharmal tablets each of Perdelivered by pharmal tablets each of Percocet 5/325 mg. Interview with the CO8/13/2021 at 10:3 noted a concern or attention, she included a concern or attention, she included a concern or attention, she included a concern or attention, she included a concern or attention, she included a concern or attention, she included a concern or attention and included a concern or attention and included a concern or attention and included a concern or attention and included a concern or attention and included a concern or attention and included a concern or attention and included a concern or attention and included a concern or attention and included a concern or attention and included a concern or attention and included a concern or attention and included a concern or attention and included a concern or attention and included a concern or attention and included a concern or attention and included a concern or attention and included a concern or attention and included a concern or attention and included a concern or attention and included a concern or attention attention and included a concern or attention and included a concern or attention and included a concern or attention and included a concern or attention and included a concern or attention and included a concern or attention and included a concern or atten	ous Administrator received he grievance, with action led: interviewed Resident #9, (did not indicate who), and ongoing investigation with process. The form was by the previous Administrator is information was not used to ation into misappropriation. The Facility Consultant, on PM, and again, on 08/18/2021 at she had been brought in a result of facility issues that assed. She revealed there had 07/09/2021, by pharmacy which was a missing skid of Percocet g to Resident #17. The led three (3) skids of thirty (30) trocet 5/325 mg had been lacy, on 08/28/2021 as rensed Practical Nurse (LPN) #1 stated she had received of thirty (30) tablets each of thirty (30) tablets each of thirty (30) tablets each of thirty (30), and the pharmacist, on anything that raised her ided it in her pharmacy report. 7/09/2021, she noted a skid of and provided that information in instrative staff.		510	DEFICIENCY)			
	a total of ninety (90 Resident #17.	ach of Percocet 5/325 mg, for 0) Percocet 5/325 mg for						

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				Ol		. 0938-0391	
STATEMENT AND PLAN O	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUI A. BUILD		CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
	;	185028	B. WING	i				C	
NAME OF F	PROVIDER OR SUPPLIER		<u>. </u>	STE	REET ADDRESS, CITY, STATE, ZIP	CODE	na	/02/2021	
IOUNGO	N MATUES AND AND AND AND AND AND AND AND AND AND	(A. 1. a. a. a. a. a. a. a. a. a. a. a. a. a.		1	3 CONCRETE ROAD	0000			
	N MATHERS NURSIN	IG HOME		I	RLISLE, KY 40311				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	PREF TAG		PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD IE APPROPF	8E	(XS) COMPLETION DATE	
F 610	Percocet tablets, be signed out by LPN is this to the SDC/QI, and did not say any the DON was audit and the DON told hecause a whole signature and date repeated requests, provide either shee Controlled Substam 5/325 mg covering through 07/08/2021 the missing sheet, is 07/09/2021. Sheet signed the first table on 07/09/2021, with cart on the morning Resident #17's MAI eighty-two (82) dos mg had been admit the back of the MAI signed, Indicating a medication on the roll of the missing single as reported by LPN SDC/QI, was investigated.	ontained twenty-nine (29) at only one (1) had been #1. She stated she reported but was uncertain of the date, whing to LPN #1. She stated ing her medication cart later, were she was doing the audit kid of Percocet was missing. I #17's Controlled Substance aled a sheet two (2) of three 6/28/2021, with a receiving on the sheet. Despite the facility was unable to the one (1) of three (3), or a ce Count Record for Percocet the time frame of 06/19/2021. Sheet three (3) of (3) was as identified by pharmacy on 2 of 3 revealed LPN #1 et of Percocet out at midnight a LPN #7 replacing her on the 1 of 07/09/2021. Review of R for 07/2021 revealed es (tablets) of Percocet 5/325 histered. However, review of R revealed no staff had dministration or results of the esident's pain level. The proceed of the tablet of Percocet 5/325 mg, 1 #7 on 07/08/21 to the tigated.	F	510	DEFICIENCY	87			
	AM, and again, on (EDC/QI, on 08/03/2021 at 9:29 08/13/2021 at 4:00 PM, suspicions about LPN #1, and							

she and the DON had interviewed her on a

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CENTER	CENTERS FOR MEDICARE & MEDICAID SERVICES					O	MB NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		DISTRUCTION		(X3) DATE SURVEY COMPLETED
		185028	B. WING				C 09/02/2021
	N MATHERS NURSIN	IG HOME		2323	ET ADDRESS, CITY, STATE, ZIP CO CONCRETE ROAD LISLE, KY 40311	OE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDERS PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERÊNCED TO THE AL DEFICIENCY)	SHOULD	BE COMPLETION
F 610	without a doubt son influence, and she and staff had never under the influence made as a team by to suspend or drug she agreed on the to prevent further p interview with the C 3:15 PM, revealed following the 07/09 diversion and aske address the issue, were unable to deturn was guilty of drug of both were not susp	ed she would have to suspect neone was under the had never suspected LPN #1, reported to her LPN #1 was. She stated the decision was corporate and administration test an employee. She stated importance of suspending staff otential drug diversion. Ombudsman, on 07/26/2021 at she interviewed the DON /2021 incident with drug d what the facility had done to She stated the DON said they ermine which of two (2) nurses liversion. When asked why ended, the Ombudsman rugged her shoulders,	F	310			
	(DFWP), revised 1: recognized the need environment free from and alcohol. The produced abused drugs or all the safety, security the company. The for Registered Nurse (LPN), or Michael a urine same employment. The Conduct as possed drug or alcohol which work, or during work Conduct, per the programment of the conduct, per the programment of the conduct, per the programment of the conduct, per the programment of the conduct, per the programment of the conduct, per the programment of the conduct of the conduct of the conduct of the conduct of the conduct of the conduct of the conduct of the conduct of the conduct of the conduct of the conduct of the conduct of the conduct of the conduct of the conduct of the conduct of the conduct of the conduct of the conduct of the conduct of the conduct of the conduct of the conduct of the conduct of the conduct of the conduct of the conduct of the conduct of the conduct of the conduct of the conduct of the conduct of the conduct of the conduct of the conduct of the conduct of the conduct of the conduct of the conduct of the conduct of the conduct of the conduct of the conduct of the conduct of the conduct of the conduct of the conduct of the conduct of the conduct of the conduct of the conduct of the conduct of the conduct of the conduct of the conduct of the conduct of the conduct of the conduct of the conduct of the conduct of the conduct of the conduct of the conduct of the conduct of the conduct of the conduct of the conduct of the conduct of the conduct of the conduct of the conduct of the conduct of the conduct of the conduct of the conduct of the conduct of the conduct of the conduct of the conduct of the conduct of the conduct of the conduct of the conduct of the conduct of the conduct of the conduct of the conduct of the conduct of the conduct of the conduct of the conduct of the conduct of the conduct of the conduct of the conduct of the conduct of the conduct of the conduct of the conduct of the conduct of the conduct of the conduct of the conduct of the conduct of	ty Drug Free Workplace Pollcy 2/2018, revealed the company of for a safe and healthy work om the use of prohibited drugs solicy stated employees who cohol posed a serious risk to and welfare of residents and policy revealed all applicants are (RN). Licensed Practical edication Aide were required to sple as a condition of policy defined Prohibited asing or using any prohibited le at the workplace, while at thing hours. Further Prohibited olicy, included refusing to alcohol test required by the					

policy, or failing a drug or alcohol test

		& MEDICAID SERVICES					0.0938-0391
STATEMENT AND PLAN O	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		LE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		185028	8. WING			00	C 1/02/2021
NAME OF F	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	US	10212021
JOHNSO	N MATHERS NURSIN	IG HOME		2	323 CONCRETE ROAD		
47444.47	5.4.4.4.5.5.5				CARLISLE, KY 40311		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(XS) COMPLETION DATE
F 610	Continued From pa	ge 146	Fε	510			
	revealed she was w 07/18/2021, and wa when she noted Re tape on it, and the re thicker than the oth She revealed she commended she commended the medication cart medications taped in arcotics. She stat Protective Services Clinician I witness her medica any narcotics, which and SRNA #20 with Continued interview at 4:29 PM, revealed identified multiple in them and were bus night of 07/18/2021 07/19/2021. She stover them and had had pills removed continued interview at 8:28 AM, revealed the narcotics sheet. Continued Interview at 8:28 AM, revealed LPN #2, on the night who revealed she in the medical sheet.	is administering medications sident #32's narcotic skid had nedications taped inside were er medications in the skid. Ontacted the DON and had as she searched the rest of and found two more in place of Resident #84's ed she contacted Adult, and was advised by Social (SSCI) to have other staff the staff that it is administration involving in she did by having SRNA #8 ess every narcotic pulled. If with LPN #2, on 07/29/2021 if the DON and Administrator arcotic skids with tape on a y wasting medications on the through the morning of the ated some skids had tape all to be wasted, while others just use to tape. She stated when taken from her medication on the removing staff signed on					
	from LPN #2 that si resident, #84, also	received a text, at 7:47 PM, ne had found a second had two (2) narcotics replaced ne DON stated she alerted the					

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				QM	B NO. 0938-03	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		PLE CONSTRUCTION	-	X3) DATE SURVEY COMPLETED	
		185028	B. WING	·			C 09/02/2021	
NAME OF	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		09/02/2021	_
JOHNSO	N MATHERS NURSIN	IG HOME		2	2323 CONCRETE ROAD CARLISLE, KY 40311			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	L	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD B	(XS) JE COMPLET! ATE DATE	ON.
F 610	08/20/2021 at 10:24 the facility would haprogram, a good at count program for rithey came to the fadrug diversion occur. The previous Admiration of the previous Admiration of the previous Admiration of the previous Admiration of the course of calls, the last of who 08/20/2021 at 9:48 Interview with the For 08/20/2021 at 3: of the trigger call the stated the facilities of the trigger call the stated the facilities of the previous of the trigger call the stated the facilities of the trigger call the stated the facilities of the trigger call the stated the facilities of the trigger call the trigger call the stated the facilities of the trigger call the stated the facilities of the trigger call the stated the facilities of the stated the facility were unable to nurse might have taken of the stated the facility provided Jeopardy Removal alleged removal of	s started. Interim Administrator, on 4 AM, revealed his expectation are a good investigation adit program, and a good narcotics that started when cility, to limit the possibility of urring. Inistrator was not available of the survey and did not return ich was attempted on AM. Regional Vice President (RVP), 103 PM, revealed he was part at occurred on 07/09/2021. By reported the incident and of the missing skid of thirty occet. However, he stated, as a determine which specific asken the medications, neither lied at that time. He stated he ned of any prior allegations, but have expected to be	F	310				
	Plan (PIP) was initi	a Performance Improvement ated related to Missing as reported to the Office of						

Inspector General- Division of Health Care (State

		& MEDICAID SERVICES				OMB NO. 0938-0391		
STATEMENT AND PLAN C	OF DEFICIENCES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		LE CONSTRUCTION	(X3) DAT	TE SURVEY MPLETED	
		185028	B. WING			00	C /02/2021	
NAME OF F	ROYIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	1 03	102/2021	
IOUNG	31 51 5 3 1 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3				1323 CONCRETE ROAD			
JOHNSU	N MATHERS NURSIN	IG HOME			CARLISLE, KY 40311			
(X4) ID	SI ILIMADV STA	TEMENT OF DEFICIENCIES		<u></u>				
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(XS) COMPLETION DATE	
F 610	Continued From pa	20 150	_					
			F 6	510	1			
	arrested by Police. suspended.	ved from the facility and LPN #1 was automatically						
	7. On 07/18/2021,	an Addendum was added to						
	the PIP due to finding	ngs that Percocet tablets were						
	Resident #32 medic	done on Resident #84 and cations.						
	8. On 07/18/2021,	an ad hoc meeting was held						
	to review the addition	onal action steps with the m (IDT). The IDT was						
	comprised of the Ad	iministrator, DON, Quality						
	Improvement Nurse	e/Staff Development						
	Coordinator (SDC/0	QI), Minimum Data Set (MDS)						
	Services Director a	er, Activity Director, Social and Dietary Manager. The IDT						
	agreed actions take	en would include						
	abuse/neglect educ	ation, abuse/neglect						
	monitoring via prog	ress note review, safe surveys						
	abuse/neglect.	staff surveys regarding						
	9. On 07/19/2021,	the DON, Unit Manager,						
	began reconcilled to	orate RN, or a support RN he narcotic packing slips to the					i	
	narcotics received.	The reconciliation would be						
	completed three (3)	times per week to ensure the						
	correct number of d	lelivered narcotics were colic count book and the						
		court sheets were updated.						
	Any discrepancies v	would be reported immediately						
	to the DON and/or a	administration.						
	10. On 07/19/2021	, staff nurses performed						
	assessments on all	residents, including residents with a BIMS of						
		he 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 A. BUILDING	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED C
	_
185028 B. WING	nologional
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	09/02/2021

COMPONE MATHERS HORSING HOME	
CARLISLE, KY 40311	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOUTAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE COMPLETION
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 QAP! 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/CI, 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 vas correct. The audits included: locking carts, MAR's, shift change count sheets, signatures, declining count sheets, signatures, declining count sheets, wasted	

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		& MEDICAID SERVICES					OMB NO	0.0938-0391
STATEMENT AND PLAN O	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		CONSTRUCTION		(X3) DA	TE SURVEY IMPLETED
		185028	B, WING				Of	C 3/02/2021
NAME OF F	PROVIDER OR SUPPLIER			STR	EET ADDRESS, CI	TY, STATE, ZIP CODE		J. OLI L OL I
JOHNSO	N MATHERS NURSIN	G HOME		l	CONCRETE RO			
				CAF	RLISLE, KY 40	1311		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORE	R'S PLAN OF CORRECTED SHOWN SHOWN THE RENCED TO THE APPRECIENCY]	JLD BE	(XS) COMPLETION DATE
F 610	Medical Leave Act (FMLA. This educat nurse should have to actual narcotics seemember. Narcotics time they were remained witness destruit narcotic before sign could not be the seement witness for a nurcould not tape a mean anarcotic came loo two (2) signatures and education also included that the signafilmation that the signifilmation that the signafilmation and when could be signed when could be signed when could be signed when could be signed when could be signed when could be signed when could be signed when could be signed when could be signed when could be signed when could be signed when could be signed when could be signed when could be signed when could be signed when could be signed when could be signed when could be signed when could be signed when could be signed when could be signed when could be signed when could be signed when could be signed when could be signed when could be signed when could be signed when could be signed when could be signed when could be signed when could be signed when could be signed when could be signed when could be signed when could be signed when could be signed when could be signed when could be signed when could be signed when could be signed when could be signed when could be signed when could be signed when could be signed when could be signed when could be signed when could be signed when could be signed when could be signed when could be signed when could be signed when could be signed when could be signed when could be signed when could be signed when could be signed when could be signed when could be signed when could be signed when could be signed when could be signed when could be signed when could be signed when could be signed when could be signed when could be signed when could be signed when could be signed when could be signed when could be signed when could be signed when could be signed when could be signed when	One (1) nurse was on Family FMLA) and remained on ion included the off-going the record for comparison to an by the on-coming staff is should be signed out at the oved from the packet; a nurse action of a dropped or refused sing as a witness. KMA's cond signature. (A KMA could res.) Nurses and KMA's adication to hold it in a card. If se, it must be wasted, and must be present. This ided signing the Shift Change ce Count Check sheet at the of the shift. This education gnature was the nurse's count was correct and must unting. It could not be signed as and KMA's were also deliveries of multiple cards of a receiving the narcolles and edication cart would hold the sign for the receipt. If the th receiving and had the econd nurse must sign also. The DON, Unit Manager, issor, MDS Nurse, and ultants began administering a tration post-test to all licensed. The quiz covered both tration and physician dated the licensed nurses and discompetency in a written nurse or KMA not scoring.	F	310				
	one-hundred percer	nt (100%) on the gulz would						

receive additional education.

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

CTATCHEL						CIND	140. 0936-0381
	OF DEFICIENCIES IF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		ONSTRUCTION	(X3) DATE SURVEY COMPLETED
		185028	B. WING				C
NAME OF F	PROVIDER OR SUPPLIER			OTOGI	TT I DOGGOO AND I THE TO THE	Щ,	09/02/2021
ОВИНОС	N MATHERS NURSIN	G HOME		2323 (ET ADDRESS, CITY, STATE, ZIP CODE CONCRETE ROAD LISLE, KY 40311		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES AUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	COMPLETION DATE
F 610	Continued From pa	of the five medication carts.	F	10			
	Audit result: no issu	195.					
	28. On 08/13/2021 cart audits on each carts. Audit result:	, the SDC completed narcotic of the five (5) medication no issues.					
	29. On 08/18/2021 cart audits on each Audit result: no issu	, the SDC completed narcotic of the five medication carts. ees.					
	30. On 08/19/2021 Director update tele	the DON facilitated a Medical phone call.					
	31. On 08/20/2021 Director of eight (8) were being worked	, the DON notified the Medical IJ tags and the PIP's that on.					
	SDC, and Corporate additional Code of Cin-service included included employees systems, when to rewhere to find more were able to verball	the Administrator, DON, as Support staff began Conduct in-servicing. The aquiz, The quiz questions of following laws, reporting aport, who to report to, and information. The employees at their role in protecting enting abuse, neglect, and					
	33. On 08/20/2021 rebilled and/or paid medications.	, the facility verified the facility for the misappropriated					
	Administrator. The Interim Administrator, in ew Administrator, in ew Administrator, in ew Administrator, in ew Administrator, in ew Administrator, in experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimental experimenta	the Regional Vice President sition to the new Regional Vice President and provided education to the including the requirements of se/Neglect/Exploitation and					

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

	NOT OIT INCOIDAILE	A MICHICAID SERVICES				ON BMC	0.0938-0391
STATEMENT AND PLAN (OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILO		LE CONSTRUCTION	(X3) DA	TE SURVEY
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NAMEOF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 08	0/02/2021
l			- 1				
I JOHNSC	N MATHERS NURSIN	IG HOME		ľ	1323 CONCRETE ROAD		
				C	CARLISLE, KY 40311		
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F 610	Continued From pa	ige 158	E 6	310			
			г	טוג			
	alleged violations, for abuse/neglect w continued on 08/29/Administrator was a importance of, and allegation of misapp Administrator also a protect, thoroughly alleged violations.	enting, and correcting any Review of the Action Checklist vas also included. This //2021, at which time the able to verbalize the timeline for, reporting any propriation of property. The articulated corrective actions to investigate, and resolve					
	RN Nurses, and a C interviewed staff an medication carts, at documentation. No received. No new received, as resider	, the DON, four (4) Support Corporate RN Nurse of residents, inspected and reviewed narcotic a new staff concerns were resident concerns were attent they were receiving No narcotic medications were g.					
	have a meeting five concerns. The Adm identify an investiga investigation. The (utilized to track the	2021, the facility's IDT would (5) times a week to review ninistrator or DON would ator to conduct the Cardinal IDT tool would be investigation and ensure the completed timely and					
	facility at least mont	Consultant would visit the thly to validate narcotics were d counted per standard of					
	The State Survey Agimplementation of the Jeopardy Removal	he facility's Immediate					

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NO	. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILO		LE CONSTRUCTION	(X3) DAT	TE SURVEY MPLETED
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NAME OF I	PROVIDER OR SUPPLIER			-	STREET ADDRESS, CITY, STATE, ZIP CODE	1 09	10212021
10111100				1	2323 CONCRETE ROAD		
	N MATHERS NURSIN				CARLISLE, KY 40311		
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F 610	Continued From pa	ige 160	Ff	610	}		
	a packet of educati				,		
	administration as w for delivery of narce	ell as having each nurse sign					
	4. Interview, on 09	/02/2021 at 9:10 AM, with the					
	arrival, the Facility	realed that she, prior to her Consultant, had been in the					
	Removal Plan. She	documented in the IJ revealed her daily routine					
	consisted of talking	to residents on both the					
		alls of the building, observing , and talking with staff. She					
	revealed she asses	ssed and interviewed for					
		She revealed she also					
	was continuing aud	views and validated the facility lits and doing everything they					
	were supposed to I	oe doing. The Clinical Director					
	at 2:00 AM, as well	de surprise visits to the facility as on weekends, to determine					
	any resident conce	rns and ensure staff was					
		es they had been educated on.					
	5. Review of Comp	plete In-Service Training Itending, dated 07/12/2021,					
	confirmed the DON	lightiated staff education for					
	licensed nursing st	aff and KMA's. Education					
	covered (1) All PRI	N (as needed) medications the back of the MAR, (2) all					
	narcotics no longer	In use must stay locked up in					
		until they could be given to					
	labeled with room	eclining count sheet must be numbers at the top of the					
	sheet.						
		ON, on 09/02/2021 at 9:10					
		I been determined riot ned out consistently on the					
	back of the MAR, s	o the education initiated, on					
	07/12/2021, empha	asized to staff the need to do					

PRINTED: 10/11/2021 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES					O. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) O/	ATE SURVEY OMPLETED
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NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		WOLLEGE !
JOHNSO	N MATHERS NURSIN	IG HOME			323 CONCRETE ROAD CARLISLE, KY 40311		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES I MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(XS) COMPLETION DATE
F 610	the DON, Unit Man Corporate RN, or a One (1) packing slip signed for by one (1) determined this nur reeducation by the the need for two (2). Interview with the EAM, revealed when confirmed there we checked to ensure packing slips was on the she would initial the reviewed them. 10. Review of Pain Assessments were residents on 07/19/identified. Addition Medication Administ with no concerns identified through the conducted on 07/19/11. Review of Amb confirmed APRN # 07/19/2021. No consistency of the physical control of the physical control of the physical control of the physical control of the physical control of the physical control of the physical control of the physical control of the physical control of the physical control of the physical control of the physical control of the physical control of the physical control of the physical control of the physical control of the physical control of the physical control of the physical control of the physical control of the physical control of the physical control of the physical control of the physical control of the physical control of the physical control of the physical control of the physical control of the physical control of the physical control of the physical control of the physical control of the physical control of the physical control of the physical control of the physical control of the physical control of the physical control of the physical control of the physical control of the physical control of the physical control of the physical control of the physical control of the physical control of the physical control of the physical control of the physical control of the physical control of the physical control of the physical control of the physical control of the physical control of the physical control of the physical control of the physical control of the physical control of the physical control of the physical control of the physical control of the physical control of the physical control of the physical control of the physical control of the physica	thad been reviewed by either ager, Administrator, a Support RN. p, dated 07/22/2021, was 1) nurse. Further review received consultation and Facility Consultant regarding) signatures always. 20N, on 09/02/2021 at 9:10 reviewing packing slips, she are two (2) signatures and everything listed on the packing slips to show she at the medication cart; then a packing slips to show she at Assessments revealed Pain completed for all facility 2021. No concerns were ally, Resident Interview stration papers were reviewed, itentified. 20N, on 09/02/2021 at 9:10 aw or untreated pain was ne pain assessments 8/2021. Pulatory Nursing Home Report 1 assessed Resident #84 on neerns were identified with the	F	310			
	revealed possible is	ndicators Resident #32's					

opiates had been replaced with Primidone. MD

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

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NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	09	9/02/2021
JOHNSO	N MATHERS NURSIN	IG HOME			2323 CONCRETE ROAD		
					CARLISLE, KY 40311		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDERS PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	0.85	(XS) COMPLETION DATE
	missing skid four (4 narcotic pain medic Change Controlled sheets confirmed or (46), while the follow (42). 15. Resident Intervidocumentation was questioned the Reg Social Services Directordinator about we concerns regarding medications. If residents reported or issues were identified review. 16. Review of Narco 17/21/2021 confirmed storage and document medication carts. Or revealed audits were times each week. From servealed requipation of the confirmation of	ge 164 cet and Resident #76 was) of four (4) for Norco (a ation). Review of Shift Substance Count Check ne (1) sheet ended at forty-six wing sheet started at forty-two iew Medication Administration reviewed. Residents were lonal Vice President by the ector or the Admissions whether or not they had administration of their dents indicated concerns, this r, to include to whom the concerns and when. No ed during documentation outic Cart Audit forms, dated ad the DON audited the entation of all facility ontinued review of audits e occurring five (5) or more deview of Narcotic Cart Audit irred education was given, on MA who had pulled narcotics te time the narcotics were the Regional Vice President, or PM, confirmed the for had been suspended on sult of concerns regarding the or handled the drug diversion I Vice President stated he acility acting in the capacity of	F6	510			
	was present at the fi Administrator from 0	Printy acting in the capacity of					

		& MEDICAID SERVICES				OMB NO). 0938-0391
AND PLAN	COF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		E CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
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	PROVIDER OR SUPPLIER N MATHERS NURSIA	IG HOME		23	TREET ADDRESS, CITY, STATE, ZIP CODE 223 CONGRETE ROAD ARLISLE, KY 40311	1 03	10272021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	IO PREFI TAG	IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(75) COMPLETION DATE
F 610	AM, revealed education to be taped, and dispersion of a KMA to waste could not sign for a all to be wasted in the chemical container disposal. She state requirement for two narcotics. Interviews, on 09/02 PM, and RN #3 at 3 been educated on the count at shift change to the number of count at shift change to the number of count at shift change to the number of count at shift change to the number of count at shift change to the number of count at shift change to the number of count at shift change to the number of count at shift change and significant wasting medication room also covered the imcompleting pain asset MAR for PRN (as misgring with another arrived. LPN #11 at damaged, to report medication was in diamaged skid, it was nurse witnessing and she had seen and e staff, including the Emedication cart and medication cart whill interview with SRNA PM, a KMA, reveale education nursing signal received multiple had received multiple and received multiple states.	ge 168 20N, on 09/02/2021 at 9:10 atton emphasized skids could liscussed the proper way to the revealed a nurse could sign narcotics, however, a KMA nurse. She stated drugs were the Drug Buster, which was a that drugs were placed in for the staff was educated on the (2) staff to sign for receipt of 2/2021 with LPN #11, at 3:03 2:14 PM, revealed both had the proper way to do a narcotic the, counting skids, comparing nitrolled substance sheets, attons, with another nurse ing, in the Drug Buster kept in thes. Both stated education portance of signing and the stated education portance of signing and the stated in a skid was it to the DON, and if a anger of falling out of a is to be wasted with another and signing. LPN #11 revealed experienced management DON, going around doing its, and she stayed with her the was being audited. A #20, on 09/02/2021 at 3:39 and he received the same that received. He revealed he the educations. The KMA to included the importance of	F	310			

PRINTED: 10/11/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION 185028 XIII PROVIDER OF SUPPLIER 185028 XIVING	CENTER	S FOR MEDICARE	& MEDICAID SERVICES					M APPROVED 0. 0938-0381
AMAME OF PROVIDER OR SUPPLIER JOHNSON MATHERS NURSING HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PILL.) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 610 Continued From page 168 for Abuse and Narcolics and ongoing audits on 07/29/2021. 24. Review of an email, with the Abuse PIP and Narcolic PIP attached, confirmed it was sent to the Medical Director, on 08/01/2021, 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 08/01/2021 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, (6) Skids were checked to ensure there were no missing skids, (6) CSCS were been on their backs, (6) Skids were checked to ensure there were no missing skids, (6) CSCS were been on their backs, (6) Skids were checked to ensure there were no missing skids, (6) CSCS were been on the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of t	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	9		ONSTRUCTION	(X3) D	ATE SURVEY
JOHNSON MATHERS NURSING HOME (X4)10 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 610 Continued From page 168 for Abuse and Narcolics and ongoing audits on 07/29/2021. 24. Review of an email, with the Abuse PIP and Narcolle PIP attached, confirmed it was sent to the Medical Director, on 08/10/2021, revealed the Abuse PIP was in the 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, 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. 28. Review of the Narcotic Cart Audit sheets used for facility narcotic cart audits revealed staff were audiling 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 skids on the cart, (4) Skids on the cart did not have tape on their backs, (6) Skids were checked to ensure there were no missing skids, (6) CSCS were being			185028	B. WING				_
(A)ID SLIMMARY STATEMENT OF DESCRIBENCES PREFER (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 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					STRE 2323	CONCRETE ROAD		9/02/2021
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 agends, 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 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	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREF	x	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE AP	HOULD BE	(X5) COMPLETION DATE
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.	F 610	for Abuse and Narco 07/29/2021. 24. Review of an elemant of Narcotle PIP attach the Medical Director of a Q/agenda, from 08/10/2021, reveals attendance at the minterview with the Mo8/10/2021 at 4:11 been in contact with a week and had prohad been planned or revealed he was exprogress the facility problems. 26. Review of the trusted of the American of the number of the number of the number of the controlled Substantial of the number of the controlled Substantial of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the number of the num	mail, with the Abuse PIP and ed, confirmed it was sent to r, on 08/01/2021. API Committee meeting b/2021, revealed the Abuse itoring phase, with monitoring of a sign in sheet, dated ed the Medical Director was inneeting. Idedical Director, on PM, revealed the DON had in him two (2) to three (3) times evided him all the PIP's that but. The Medical Director tremely pleased at the rhad made addressing their was made addressing their was cotic cart audits revealed staff sure (1) All staff were signing stance Count Sheet (CSCS) at narcotic sheets had been miber of narcotic count sheets ar of skids on the cart, (4) d not have tape on their are checked to ensure there ids, (6) CSCS were being if the cart on the Shift Change ce Count Check form as the r changed (new skids arrived, ed), and (6) Ali narcotics were	F	110			

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES					O. 0938-0391
STATEMENT	OF CEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) D	ATE SURVEY OMPLETED
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NAME OF	PROVIDER OR SUPPLIER	n and a second		STE	REET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	9/02/2021
JOHNSO	N MATHERS NURSIN	IG HOME		232	23 CONCRETE ROAD ARLISLE, KY 40311		,
(X4) ID PREFIX TAG	(EACH DEFICIENC	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 610	with the goal of enswere reported and Interview with SRN Therapist, on 09/02 both had received I Conduct, which inc misappropriation, wand when to report report an allegation feel like it was bein contact the DON at call or fax the Corp 33. Review of facil or dated, revealed eight (108) narcotic missing, which included in the contact the DON at call or fax the Corp 34. Review of facil or dated, revealed eight (108) narcotic missing, which included in the control occumented as mis residents by name, noted, the cost for payors, and the total reimbursed, which dollars and ninety-sale. Review of an Analmistrator, on 0 Administrator, on 0 Administrator, on 0 Regional Vice Presidetter on 08/26/202	anonymous reports if desired, suring all potential violations addressed. A #24 and the Occupational £/2021 at 3:30 PM, revealed raining on the Code of buded abuse, neglect, what to report, who to report to, both revealed if they were to it to their supervisor and did not graderessed, they could not Administrator, as well as crate Compliance line. A #24 and the Occupational did not graderessed, resident as addressed, they could not graderessed, they could not administrator, as well as crate Compliance line. A were documented and its were documented as a total of one hundred and sever document listed along with discrepancies along with discrepancies each individual dose, residential cost of all medications was three hundred and four seven (\$304.97) cents. Appointment Letter as facility alled appointment of a new 8/26/2021, with an escription, reporting to the ident, who also signed the 1.	F 6	610			
	6:32 PM, confirmed Administrator and t	the spoke with the Interim he Regional Vice President 08/25/2021, and they					

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

		A MEDICAID SERVICES					OMB NO	O. 0938-0391
AND PLAN C	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(XZ) MUL A. BUILD		PLE CONSTRUCTION		עם (בא)	ATE SURVEY OMPLETED
NAMEOFI	PROVIDER OR SUPPLIER	185028	B. WING				0,	C 9/02/2021
	ON MATHERS NURSIN	IG HOME			STREET ADDRESS, C 2323 CONCRETE R CARLISLE, KY 4		-	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH COR	ER'S PLAN OF CORRECTIVE ACTION SHE ERENCED TO THE APP DEFICIENCY)	OUILD BE	(XS) COMPLETION DATE
F 610	Continued From pa	~	Fé	310	0	No.		
	sheets, completed to corporate RN's, revinarcottc documenta	Change Narcotic Review by the SDC, support RN's, and realed medication carts and ation were monitored on 2021, and 08/30/2021, with no						
	at 9:10 AM, revealed facility nurse went to 08/28/2021 at shift of and went through the medication cart staff documentation and process was repeat nurse from a different facility.	dinical Director, on 09/02/2021 deshe, the SDC, and a sister to each medication cart, on change with their audit tools, the packet of audit tools with fit, asking questions about reporting. She revealed this teed on 08/29/2021 with a cent sister facility. She revealed concerns with the audits.						
	09/02/2021 at 6:32 (he Administrator, on PM, confirmed the Clinical ghly revlewed with him abuse ligating.						
	at 9:10 AM, revealed investigation file with 08/29/2021. She re Action Checklist, revealed to do and or time. The Clinical D Administrator had in residents' represent in his investigation of	th the Administrator on evealed they went down the viewed the process, and the notes to himself on what he what he could do at that Director stated the attribute residents, called eatives, and was very thorough of misappropriation.						
	40. Review of the fa dated 08/28/2021, c	acility's Weekend Audits, confirmed the Administrator						

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				C	FORM APPROVED MB NO. 0938-0391
STATEMENT AND PLAN (OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE		CONSTRI		(X3) DATE SURVEY COMPLETED
		185028	B. WING				C 09/02/2021
NAME OF	PROVIDER OR SUPPLIER			STR	EETADD	RESS, CITY, STATE, ZIP CODE	08/02/2021
JOHNSO	N MATHERS NURSIN	IG HOME		2323			
				CAF			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		(EA	PROVIDER'S PLAN OF CORRECTION CHICAGO SHOULD SHOULD SHOULD SHOULD SHOULD TO THE APPROPRIEST OF THE APPROPRIEST OF THE APPROPRIEST OF THE APPROPRIEST OF THE APPROPRIEST OF THE APPROPRIEST OF THE APPROPRIEST OF THE APPROPRIEST OF THE APPROPRIEST OF THE APPROPRIEST OF THE APPROPRIEST OF THE APPROPRIEST OF THE APPROPRIEST OF THE APPROPRIEST OF THE APPROPRIEST OF THE APPROPRIEST OF THE APPROPRIEST OF THE APPROPRIEST OF THE APPROPRIEST OF THE APPROPRIEST OF THE APPROPRIEST OF THE APPROPRIEST OF THE APPROPRIEST OF THE APPROPRIEST OF THE APPROPRIEST OF THE APPROPRIEST OF THE APPROPRIEST OF THE APPROPRIEST OF THE APPROPRIEST OF THE APPROPRIEST OF THE APPROPRIEST OF THE APPROPRIEST OF THE APPROPRIEST OF THE APPROPRIEST OF THE APPROPRIEST OF THE APPROPRIEST OF THE APPROPRIEST OF THE APPROPRIEST OF THE APPROPRIEST OF THE APPROPRIEST OF THE APPROPRIEST OF THE APPROPRIEST OF THE APPROPRIEST OF THE APPROPRIEST OF THE APPROPRIEST OF THE APPROPRIEST OF THE APPROPRIEST OF THE APPROPRIEST OF THE APPROPRIEST OF THE APPROPRIEST OF THE APPROPRIEST OF THE APPROPRIEST OF THE APPROPRIEST OF THE APPROPRIEST OF THE APPROPRIEST OF THE APPROPRIEST OF THE APPROPRIEST OF THE APPROPRIEST OF THE APPROPRIEST OF THE APPROPRIEST OF THE APPROPRIEST OF THE APPROPRIEST OF THE APPROPRIEST OF THE APPROPRIEST OF THE APPROPRIEST OF THE APPROPRIEST OF THE APPROPRIEST OF THE APPROPRIEST OF THE APPROPRIEST OF THE APPROPRIEST OF THE APPROPRIEST OF THE APPROPRIEST OF THE APPROPRIEST OF THE APPROPRIEST OF THE APPROPRIEST OF THE APPROPRIEST OF THE APPROPRIEST OF THE APPROPRIEST OF THE APPROPRIEST OF THE APPROPRIEST OF THE APPROPRIEST OF THE APPROPRIEST OF THE APPROPRIEST OF THE APPROPRIEST OF THE APPROPRIEST OF THE APPROPRIEST OF THE APPROPRIEST OF THE APPROPRIEST OF THE APPROPRIEST OF THE APPROPRIEST OF THE APPROPRIEST OF THE APPROPRIEST OF THE APPROPRIEST OF THE APPROPRIEST OF THE APPROPRIEST OF THE APPROPRIEST OF THE APPROPRIEST OF THE APPROPRIEST OF THE APPROPRIEST OF THE APPROPRIEST OF THE APPROPRIEST OF THE APPROPRIEST OF THE APPROPRIEST OF THE APPROPRIE	DE COMPLETION
F 641	Continued From pa	ge 174 enters for Medicare and	F	641		resident assessment on 09/03/21 thru 09/03	
	Medicaid Services.	"Resident Assessment				additional resident ass	
	Instrument (RAI) M.	anual 3.0°, it was determined				were resubmitted with	
	the facility falled to	ensure the Minimum Data Set				information. On 10/18	
ĺ	(WDS) Assessment	t accurately reflected the r two (2) of forty-four (44)				nurse, and MDS Cons	•
1	residents (Resident	s #13 and #245).				reviewed 100% of res	
	Observation of Res 08/10/2021, and 08 had functional limits extremities: hips an was dependent on that addressed mot	ident #13, on 08/09/2021, i/12/2021 revealed the resident ations in bilateral lower and knees and his/her mobility an "Evolution" chair (a chair billty and positioning needs).			3.	ensure ROM and limit correctly coded. No coidentified. The MDS consultant of MDS nurses on 9/3/20 the accurate coding or	ations were oncerns were educated the l, regarding falls and on
	Minimum Data Set 08/10/2021, reveals functional limitation for lower bilateral emobility device.	Resident #13's Quarterly (MDS) Assessment, dated ed the resident did not have s in Range of Motion (ROM) xtremitles and did not use a				9/29/21 on the accura of ROM and limitation Resident Assessment Manual. The RAI manutilized as a reference	s utilizing the Instrument ual will be
	Progress Notes rev falls on 02/19/2021 Quarterly MDS Ass which only reflected				4.	coding. Beginning 9/6/21, the consultant or an RN Caudit MDS submission weeks, then monthly	Consultant will ns weekly for 4 for two months,
	The findings Include	9;				to ensure falls, ROM were coded correctly.	
	Interview with the M	IDS Coordinator, on				an ongoing basis the	

08/13/2021 at 2:51 PM, revealed the facility

assessments. Additionally, she stated the

members, face-to-face observations and assessment of residents, and review of the

utilized the Resident Assessment Instrument (RAI) Manual 3.0, as a guideline for accuracy of

Assessment process included communication

with licensed and non-licensed direct care staff

Nursing will audit two MDS

assessments weekly to ensure

accuracy of the assessments. This

collected will be taken to the monthly

will be an ongoing practice. Data

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

OCITICI	O I OIT MEDICAILE	A MEDICAID SERVICES			(<u>IMB NO.</u>	. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		ONSTRUCTION	COM	E SURVEY PLETED
		185028	B. WING				C 02/2021
	ROVIDER OR SUPPLIER N MATHERS NURSIN	IG HOME		2323	EET ADDRESS, CITY, STATE, ZIP CODE CONCRETE ROAD RLISLE, KY 40311		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTING (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(XS) COMPLETION DATE
F 641	addressed mobility Review of Resident MDS Assessment, Cognitive Pattern, short and long term moderately impaire decision making. A Functional Status, a occur, and the resid device. Further, th assistance of two (a mobility, transfer, to dressing, and eatin the resident had no for upper or lower to Observation of Res 4:11 PM, revealed was noted that at re lower extremities we resident's left leg re observation of Res 11:58 AM, revealed Additionally, at resident bent greater than th calf touched the left revealed the resider sident's right leg. Observation of Res 3:06 PM, with Regi revealed the resider	volution chair (a device that and positioning needs). I #13's most current Quarterly dated 08/10/2021, Section C: revealed the resident had memory problems; d cognitive skills for dally additional review of Section G: revealed ambulation did not dent did not use a mobility a resident required extensive 2) staff with ADL's such as bed bileting, personal hygiene, g. Continued review revealed of functional limitations in ROM bilateral extremities. Sident #13, on 08/09/2021 at the resident lying in bed. It est, the resident's bilateral vere bent at the knees and the ested on the right leg. Further ed an Evolution chair at the sident #13, on 08/10/2021 at the resident was lying in bed. It the resident was lying in bed. It the resident was lying in bed. It the resident was lying in bed. It the resident was lying in bed. It the resident was lying in bed. It the resident was lying in bed. It the resident was lying in bed. It the resident was lying in bed. It the resident was lying in bed. It the resident was lying in bed. It the resident was lying in bed. It the resident was lying in bed. It the resident was lying in bed. It the resident was lying in bed. It the resident was lying in bed. It the resident was lying in bed. It the resident was lying in bed. It the resident was lying in bed. It the resident was lying in bed. It the resident was lying in bed. It the resident was lying in bed. It the resident was lying in bed. It the resident was lying in bed. It the resident was lying in bed. It the resident was lying in bed. It the resident was lying in bed. It the resident was lying in bed. It the resident was lying in bed. It the resident was lying in bed. It the resident was lying in bed. It the resident was lying in bed. It the resident was lying in bed. It the resident was lying in bed. It the resident was lying in bed. It the resident was lying in bed. It the resident was lying in bed. It the resident was lying in the life was lying in the life was lying in the life was lying in the life was lying in the life was	F	641			
	knees. The reside	nt's right knee was bent at					

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

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(XZ) MUI	TIPLE CO	(X3) DATE SURVEY	
AND FLANC	PCORRECTION	IDENTIFICATION NUMBER:	A, BUILC	ING		COMPLETED
		185028	B. WING			C 09/02/2021
NAME OF	PROVIDER OR SUPPLIER			l .	ET ADDRESS, CITY, STATE, ZIP CODE	1 0010012001
JOHNSO	N MATHERS NURSIN	IG HOME			CONCRETE ROAD LISLE, KY 40311	
(X4) ID	SUMMARY STA	ITEMENT OF DEFICIENCIES	ID	47.11	PROVIDER'S PLAN OF CORRECTION	N (XS)
PRÉFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE COMPLETION
F 641	Continued From pa	ge 178	F	541		
		Registered Nurse Alde				
		ed at the facility for twelve (12) 121 at 11:00 AM, revealed she				
	was often assigned	to provide care to Resident				
		iew, the resident was not able sown 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 s	he provided passive ROM to and legs for one (1) hour a				
	day during care. Fi	urther, she stated Resident				
	#13 had an Evolution assisted to daily.	on chair that he/she was				
	assisted to daily.					
		the Quarterly MDS				
	assessment did no	08/10/2021, revealed the tapture Resident #13's				
	functional limitation	is In ROM, bilateral lower				
	extremities, or the	mobility device used daily.				
		Resident #13's nurse aide care				
	plan (Kardex), date resident was denot	ed 08/13/2021, revealed the ndent on an Evolution chair for				
	mobility.	TO SHE CAN BUT LANGUIGH CHAIL IN				
	Interview with Lieu-	nsed Practical Nurse (LPN)				
		itor and Registered Nurse (RN)				
	#7/MDS Coordinate	or (at the facility for seven (7)				
	years), on 08/13/20 used the RAI milds	021 at 2:51 PM, revealed they elines to ensure accurate MDS				
	Assessments. Per	the interview, when collecting				
		IDS Assessments, they				
		nd the resident, completed a sment of the resident, and				
ļ	reviewed the medic	cal record in its entirety. In				
		d it was important to ensure				
	reflected the currer	were accurate and that they				
		Assessment helped develop				

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				O	MB NO	. 0938-0391
STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(XZ) MUI A. BUILL		CONSTRUCTION		(X3) DAT	E SURVEY
			l					c
		185028	B. WING				09	/02/2021
NAME OF F	PROVIDER OR SUPPLIER			STA	REET ADDRESS, CITY, STATE	, ZIP CODE		
JOHNSO	N MATHERS NURSIN	IG HOME		232	IJ CONCRETE ROAD			
				CA	RLISLE, KY 40311			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION	IO PREF TAG		PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TI DEFICIE	CTION SHOULD O THE APPROPI	BE	(XS) COMPLETION DATE
E 841	Castleway Francis	400						
1 1 041	Continued From pa		F	341				
	revealed the facility	admitted the resident, on						
}	Disease Major Do	agnoses including Parkinson's pression, Dementia, and						
	Diabetes Mellitus T	vne 2						
į		, po E.						
ĺ	Review of Resident	t #245's Quarterly Minimum						
	Data Set (MDS) As	sessment, dated 02/26/2021.						
ļ	revealed the facility	assessed the resident with						
	the Brief Interview (or Mental Status (BIMS)						
1	of lifteen (15) which	dent #245 scored four (4) out hindicated severe cognitive						
1	Impairment, Contin	nued review revealed in						
	Section G: the resid	dent was a one (1) person						
	assist for bed mobi	lity and self-transfers. The						
	resident used mobil	lity devices, walker and						
	wheelchair. Furthe	r review of Section G revealed						
	the resident was no	at steady for moving from						
	seated to standing	position, walking, turning e-to-surface transfers between						
	the had and wheeld	e-to-surface transfers between thair. Further review of this						
		revealed Resident #245's fall,						
1		ch occurred during the look						
	back period, prior to	o the assessment, was not						
	noted on the MDS.							
	Doulous of Destates	MOJEL COD Jakes						
	01/18/2021 residen	t #245's CCP, dated ed the resident had an area of						
		Interventions listed. Further						
	review revealed the	Focus area did not address						
1	the falls on 02/19/2	021 or 02/23/2021 and						
	revealed no revisio	n of interventions after these						
	falls. (see F-657)							
	Raview of the incid	ient reports for falls revealed						
	Resident #245 had	falls, on 02/19/2021 and						
	02/23/2021. Revie	w of Resident #245's fall						
		rogress Notes revealed the						
1		V falls on (12/10/2021 and						

02/23/2021, prior to the Quarterly MDS

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

		THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE S					MB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE	LTIPLE COI DING	NSTRU	CTION	(X3) DATE SURVEY COMPLETED
		185028	B. WING	s			C
NAME OF	PROVIDER OR SUPPLIER				* 4000		09/02/2021
	N MATHERS NURSIN			2323 0	ONCR	IESS, CITY, STATE, ZIP CODE ETE ROAD KY 40311	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREF TAG	TIX.	(EA	ROVIDER'S PLAN OF CORRECTIO CH CORRECTIVE ACTION SHOULD S-REFERENCED TO THE APPROP DEFICIENCY)	DE COMPLETION
F 656	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 182 Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §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			656 656	1. 2. 3.	Residents # 13, #36, #240, care plans were the MDS nurses and consultants on 9/29/2 were completed as id MDS nurses and MD completed a review of care plans needing user resolved, or amended corrected. On 10/19/21 the MDS educated the MDS nurses and when care plans and when care plans and when care plans and when to interplan. Beginning 10/25/21, new orders or changing care plan updates with by the IDT, five times two weeks, then monthly	#64, #77 and e reviewed by MDS 21. Updates lentified. S consultant of all resident 10/05/21. Any pdated, d were S consultant urses, UM, and nce of updating to initiate a es, UM, and ensed nurses updating care itiate a care residents with es requiring Il be reviewed s a week for lokly for four for two
	future discharge. F whether the resider community was as:	acilities must document nt's desire to return to the				months, to ensure ca updated/revised/deve needed. Any concer will be corrected at the	eloped as ns identified

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES					C	MB NO	. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUI		LE CONSTRUCTIO	IN		(X3) DA	TE SURVEY MPLETED
		185028	B. WING					00	C /02/2021
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS	CITY, STAT	E. ZIP CODE	1 03	TOBLET
JOHNSO	N MATHERS NURSIN	IG HOME		2	2323 CONCRETE CARLISLE, KY	ROAD			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH C	ORRECTIVE	OF CORRECTION SHOULD TO THE APPROPENCY)	DBE	(X5) COMPLETION DATE
F 856	#240 suffered a fall 01/27/2021. 2. The CCP for Re to include bilateral in Restorative Care with treatment to maintain prevent a decrease. 3. The CCP for Re implemented consisting care interventions, palmar splint) to maintain status or prevent a. 4. The CCP for Re to include the air mather resident. The findings include Review of the Cent Services, "Resident Manual 3.0", dated Comprehensive Cainterdisciplinary cor include measurable and must describe attain or maintain the practicable physical well-being. Addition responsible for assistant in the control of the cent services and must describe attain or maintain the practicable physical well-being. Addition responsible for assistant in the cent services and must describe attain or maintain the practicable physical well-being. Addition responsible for assistant in the cent services are controlled to the cent services and must describe attain or maintain the practicable physical well-being. Addition responsible for assistant can be controlled to the cent services are controlled to the cent services are controlled to the cent services are controlled to the cent services are controlled to the cent services are controlled to the cent services are controlled to the cent services are controlled to the cent services are controlled to the cent services are controlled to the cent services are controlled to the cent services are controlled to the cent services are controlled to the cent services are controlled to the cent services are controlled to the cent services are controlled to the cent services are controlled to the cent services are controlled to the cent services are controlled to the cent services are controlled to the cent services are controlled to the cent services are controlled to the cent services are controlled to the cent services are controlled to the cent services are controlled to the cent services are controlled to the cent services are controlled to the cent services are controlled to the cent services are controlled to the cent services are con	aff member present. Resident with serious injury on sident #13 was not developed lower extremity contractures or lith interventions, services, or ain current functional status or in function. Isolant #77 was not stently related to Restorative services, or treatment (left aintain current functional decrease in function. Isolant #36 was not developed attress that was purchased for attress that instrument (RAI) October 2019, revealed the	F	55 6					
	regardless of wheth by the RAI, including condition and response	nevant to individual residents, ner or not they were covered ig monitoring each resident's anding with appropriate her review revealed the							

services provided or arranged must be consistent

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES					B NO. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		ONSTRUCTION		K3) DATE SURVEY COMPLETED
		185028	B. WING				С
NAME OF F	PROVIDER OR SUPPLIER				ET ADDOTOR ATTY OTHER		09/02/2021
	N MATHERS NURSIN	IG HOME	i		EET ADDRESS, CITY, STATE, ZIP C CONCRETE ROAD	300E	
				CAR	ILISLE, KY 40311		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	K	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD B	
F 656	pelvis, and left shot site that day. Furth results were returned with abnormal resu- ordered to be trans Resident #240 returns	ge 186 as ordered of bilateral hips, ulder, which was completed on er review revealed X-ray ad at 1:35 PM on 01/27/2021, its, and Resident #240 was ferred to the hospital, med from the local hospital, 30 PM, with a diagnosis of left	F6	56			
	resident's mobility of had not been devel assistance required tolleting. However, Assessment, on 01 07/01/2020, and 05 resident as requirin mobility, transfers, the resident's CCP person assist with the second control of the resident to the resident to the resident's CCP person assist with the second control of the resident's CCP person assist with the second control of the resident's CCP person assist with the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the sec	#240's CCP revealed the care plan, prior to 01/27/2021, oped to indicate the lifer bed mobility, transfers, or all four (4) previous MDS /05/2021, 10/08/2020, /29/2020, assessed the gran assist of two (2) with bed and toileting. On 01/27/2021, was updated for two (2) pred mobility.					
	Care Assistant (PC revealed PCA #2 w Resident #240 whe off the rail, resulting	A) #2, dated 01/27/2021, as providing Incontinence care in the resident's hand slipped in a fall. PCA #2 revealed se to come and help as soon					
	revealed she was c room, on 01/27/202 on the floor on his/h LPN #17's stateme said "I couldn't hold revealed she comp	ess Statement from LPN #17 alled into Resident #240's 11, and noted Resident #240 ner back between the beds. nt revealed Resident #240 on." LPN #17's statement leted a head-to-toe resident and noted a skin tear					

to the right lower arm, a skin tear to the right inner

		& MEDICAID SERVICES				MB NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
' 		185028	B. WING	_		С
NAME OF	PROVIDER OR SUPPLIER			-	STREET ADDRESS, CITY, STATE, ZIP CODE	09/02/2021
JOHNSO	N MATHERS NURSIN	IC HOME			2323 CONCRETE ROAD	
			- 1	l .	CARLISLE, KY 40311	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE COMPLETION
F 656	would not have bee care plan prior to 0. Interview with the D AM, revealed care a which was a reflecti	the CCP, so this information	F6	356		
	at 10:48 AM, reveal RAI manual in develorants. She reveale required during the was coded, and state care than the care provide less care. 2. Review of Reside revealed the facility 07/28/2017, with dia Major Depressive Discontinuous Chizoaffective Discontinuous Review of Resident Data Set (MDS) Astrevealed the facility a Brief Interview for of three (3) of fifteen	#13's Admission Minimum sessment, dated 08/04/2017, assessed the resident to have Mental Status (BIMS) score n (15), indicating severe				
	cognitive impairment the resident had no Range of Molion (R bilateral extremities resident was ambul mobility device. Fur extensive assistance	nt. Additional review revealed functional limitations in (OM) for upper or lower. Per the Assessment, the atory and did not use a rther, the resident required se of one (1) staff with bed ressing, tolleting, and personal				

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES					O. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILO		ONSTRUCTION	(X3) D	ATE SURVEY DMPLETED
		185028	B. WING				С
NAME OF F	PROVIDER OR SUPPLIER		0	STRE	EET ADDRESS, CITY, STATE, ZIP COD		9/02/2021
JOHNSO	N MATHERS NURSIN	G HOME		2323	CONCRETE ROAD RLISLE, KY 40311	E	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	ĸ	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	10ULD BE	(XS) COMPLETION DATE
F 656	function. Further observation 08/12/2021 at 3:06 (RN) #6, revealed the limitations in billater knees. The resider approximately a ninger resident was not abknee past the restifuted was bent less than the resident was the left knee beyond.	ge 190 to prevent a decrease in of Resident #13, on PM, with Registered Nurse he resident had functional al lower extremities: hips and ht's right knee was bent at ety (90) degree angle, and the ete of flex or extend the right tan forty-five (45) degrees, is not able to flex or extend d restling position. Per the sident's legs touched each	Fe	56	DEFICIENCY		
	other, and the left le nurse stated the bill and there was resistent's knees and resident's legs aparattempted to move right leg, the resident grab the nurse's ha at rest, the resident over the right leg, a	eg crossed the right leg. The aleral quadriceps were tight stance when trying to move the d when trying to move the t. Further, when RN #6 the resident's left leg off the nt moaned and attempted to nds. When the resident was s left leg rolled to the right nd Resident #13 was not able lignment of his/her legs.					
	revealed Resident a contracted. Per the decline in December ambulatory since the it was important to meet their needs as Further, RN #6 stat developed to include	6, on 08/12/2021 at 3:06 PM, #13's legs were severely interview, the resident had a er of 2020 and had not been ien. Additionally, RN #6 stated provide care to residents to ind ensure quality care, ed the CCP should have been e the bilateral lower extremity oppopriate interventions to					

assist the resident.

		& MEDICAID SERVICES				OMB NO	0.0038-0391
AND PLAN (OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		ONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		185020	B. WING		·	na	C /02/2021
NAME OF	PROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE	1 08	10212021
IOSINICO					CONCRETE ROAD		
JUHNSU	N MATHERS NURSIN	IG HOME			LISLE, KY 40311		
(X4) ID	SIBBARDVETA	TEMENT OF DEFICIENCIES		OAK			
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 656	Continued From pa	ge 192	EI	356			<u></u>
		ins included to encourage the	1 1	100			
	resident to particlos	ite in passive ROM, dated					
	05/20/2020. Additl	onal interventions included					
	hand hygiene for the	e resident, prior to donning the					
	left palmar orthotic	(splint); donning of the splint					
	for the resident to w	ear three (3) to four (4) hours					
	before removing; ar	nd checking skin prior to and					
	after removing the	splint, for six (6) days a week					
	for twelve (12) weel	ks, dated 03/18/2020.					
	Further intervention	s included, if the resident did					
	not participate in the	e splint/brace program,					
	occument the teast	on, dated 03/18/2020.					
	However, there was	no documented evidence the implemented the Restorative					
	Care regimen with i	nterventions, services, or					
	treatment to mainta	in current functional status or					
	to prevent a decrea	se in function for Resident					
	#77.						
	Review of Resident	#77's RNP Restorative Alde					
	task, dated 05/23/2	021 through 08/18/2021,					
	revealed no docum	ented evidence the resident					
	devices (6) days a	int three (3) to four (4) hours a					
	(12) weeks Addition	week, for six (6) of the twelve					,
	documented adder	onal review revealed no ice passive ROM had been					
	ncovided since 01/2	6/2021. Further review					
	revealed to docum	ented evidence the resident					
	received splint skin	integrity checks before and					
	after donning of the	left palmar hand splint for					
	twelve (12) of the tv	velve (12) weeks.					
	Review of Resident	#77's Annual MDS					
	Assessment, dated	07/14/2021, revealed the					
	racility assessed the	resident to have a BIMS					
	score of seven (7) (of fifteen (15), indicating					
	severe cognitive im	pairment. Additional review					
	revealed the reside:	nt had functional limitations in					

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

	NOT ON MEDICARE	A MEDICAID SERVICES				MB NO.	0938-0391
STATEMENT AND PLAN (T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		PLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		185028	8. WING	<u>. </u>			C 02/2024
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	UBIT	02/2021
					2323 CONCRETE ROAD		
JOHNSO	ON MATHERS NURSIN	IG HOME	1	1			
194110	CHAMAGNAT			'	CARLISLE, KY 40311		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	3 BE	(XS) COMPLETION DATE
F 656	Continued From pa	ng 10 <i>4</i>	= (
		however, there was no	۲,	658	3		
	documented pulder	nowever, there was no nce of passive ROM, or skin					
	integrity checks with	h the soliot					
	manual anadira and	it tild apriitt.					
	Interview with SRN	A #5 (had worked at the facility					
	for thirty-four (34) y	ears), on 08/12/2021 at 11:24					
	AM, revealed she h	lad been a RNP alde for eight					
	(8) years. Per the id	interview, she used the CCP					
	as a guide to know	how to care for residents.					
	 Also, she stated Re 	esident # 77 required a brace					
	to his/her left hand (for four (4) to five (5) hours a					
	day. She stated the	e resident also needed his/her					
	hand washed and n	nis/her fingers moved around					
	before applying the	brace. SRNA #5 stated					
	Turtner care anound	be provided to residents per					
	Their CCP to ensure	safe care and to ensure their					
	not always work as	lowever, she revealed she did a RNP aide, and all aides					
	were responsible to	implement the Restorative					
	care per the CCP.	mibiement me restorative					
	•						
	Interview with RN#	4, on 08/12/2021 at 3:45 PM,					
	revealed nursing sta	aff followed the CCP to ensure					
	care was provided a	appropriately to individualized					
	residents. Per the in	interview, Resident #77's					
	Restorative interver	ntions should be applied per					
	his/her RNP Care P	Plan. In addition, she stated it					
	was important to en	COURAGE DASSIVE ROM.					
	provide skin integrit	ly checks, and to apply the					
	brace per the RNP (Care Plan to decrease risk for					
	worsening contractu	ure, pain, and skin					
	impairment. Additio	onally, she stated nurses					
	should spot check the	he resident and ensure aides					
	had provided those	interventions. Further, RN #4					
	reported she had no	ot identified any issues with					
	the resident not reci	elving his/her Restorative					
	interventions as car	e planned.					
	Interview with the O	occupational Therapist (OT),					

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

STATEMEN	T OF DEFICIENCIES	WILL DOOR HE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE				OMB NO. 0938-0391
AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		185028	B. WING	i		C
NAME OF	PROVIDER OR SUPPLIER		-	STD	EET ADDRESS, CITY, STATE, ZIP CODE	09/02/2021
10111101	***************************************					
JUHNSU	ON MATHERS NURSIN	IG HOME			CONCRETE ROAD	
43443.400	51 to 10 4 a 50 4 a 50 4			CAI	RLISLE, KY 40311	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST 8E PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	I D BE COURTERION
F 656	avoided. Further, s CCP should have b his/her contractures and Resident #77's consistently implem Restorative interver	ge 196 d a decline in functionality was he revealed Resident #13's een developed to include to bilateral lower extremities, CCP should have been ented related to his/her stions to ensure safe quality eds of the individual resident.	F	656		
	Interview with the D 08/13/2021 at 2:31 (at the facility as the she expected the R followed related to c functional limitations she also expected tintervention to be im Additionally, she sta functional limitation developed to include interventions, servic current functional st in function of ROM, important for the CO implemented to ensinecessary care to re-	irector of Nursing (DON), on PM, revealed she had worked DON for one (1) year, and Al Manual Guidelines to be levelopment of the CCP for in ROM. Per the interview, he CCP for Restorative care aplemented consistently. Ited, if a resident had a in ROM, the CCP should be a the limitations and es, or treatment to maintain alus or to prevent a decrease Further, she stated it was CP to be developed and ure the IDT provided				
88	3:30 PM, revealed h since July 27, 2021. the CCP to be devel and the facility's polities who had fit to have a CCP deve interventions, servic current functional stin function of ROM.	dministrator, on 08/16/2021 at the had worked at the facility. Per interview, he expected oped per the RAI guidelines cy. Additionally, he expected unctional limitations in ROM, loped to include es, or treatment to maintain atus or to prevent a decrease. Continued interview revealed P to be implemented.				

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_			& MEDICAID SERVICES				0	MB NO	. 0938-0391
		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE		ONSTRUCTION		(X3) DA1	TE SURVEY MPLETED
_			185028	B. WING				no	C /02/2021
	NAME OF F	PROVIDER OR SUPPLIER			STRI	EET ADDRESS, CITY, STATE, ZIP CO	ODE		10212021
	10111100					CONCRETE ROAD	566		
	JUHNSO	N MATHERS NURSIN	IG HOME			RLISLE, KY 40311			
_	(X4) ID	SUMMADVOTA	TELEVIT OF DESIGNATIONS		07,				
_	PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD	BE	(X5) COMPLETION DATE
	F 656	Continued From pa	ge 198	F	556				
			ne/she had told staff he/she	' '	,50				
		did not need an air	mattress when they brought it						
		in the room. Reside	ent #36 shared that the						
		winged mattress he	/she was currently using was						
		comfortable, and he	s/she had never had an issue			18			
		with his/her bed bei	ng uncomfortable.						
		Interview with RN #	7/MDS Coordinator, on						
		U8/17/2021 at 9:20	AM, revealed that typically,						
		resident mattresses	were fall Interventions. She						
		intervention with a	were to have a new nattress, the previous						
		mattrees intomostis	nauress, the previous on would be resolved. She						
		revealed in the case	e of Resident #36, the						
		maltress had been	replaced for not even a day,						
		orior to returning the	e resident to his/her						
		winged/deep dish re	nattress. She stated the						
		decision to change	mattresses had been entirely						
		the decision of the	previous Administrator, and						
		she was uncertain v	why the previous Administrator						
		had made the chan	ge.						
		Interview with the S	DC/QI, on 08/17/2021 at						
		10:25 AM, revealed	the previous Administrator						
		nad ordered the air	mattress for Resident #36 for						
		comfort, as she tho	ught it would benefit Resident						
		the following manning	stated, when she came to work						
		are rollowing motuli	ng, Resident #36 had slid out						
		and place the deep	staff remove the air mattress dish/winged mattress back on						
		Resident #38's had	. The SDC stated she was						
		Unaware whether o	r not Resident #36 was						
		assessed by therap	y for needing an air mattress.						
			_						
		Continued Interview	with the DON, on 08/18/2021						
		at 10:40 AM, reveal	ed residents should be						
		assessed pror to ci	hanging mattresses, and care						
		higus stronto ne abi	dated whenever there was a						

change.

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NO. 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		185026	8. WING	·		C 00/02/2024
	PROVIDER OR SUPPLIER ON MATHERS NURSIN	IG HOME		23	TREET ADDRESS, CITY, STATE, ZIP CODE 323 CONCRETE ROAD CARLISLE, KY 40311	09/02/2021
PREFIX TAG	(EACH DEFICIENCY	Must be preceded by full sc identifying information)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	FORE COMPLETION
F 657	Continued From pa	ge 200 •	F6	357	new orders or change care plan updates will by the MDS nurses, I or MDS consultant fix for two weeks, then weeks, then monthly to ensure care plans updated/revised/deve	es requiring Il be reviewed JM, SDC, DON ve times a week veekly for four for two months, were eloped as
	by: Based on observation and review of the Comment (RAI) Matthe facility failed to a Care Plan (CCP) with the facility failed to a comment (RAI) with the facility failed to a comment (RAI) with the facility failed to a comment (RAI) with the facility failed to a comment (RAI) with the facility failed to a comment (RAI) with the facility failed to a comment (RAI) with the comment (RAI) with the comment (RAI) with the comment (RAI) with the comment (RAI) with the comment (RAI) with the comment (RAI) with the comment (RAI) with the comment (RAI) with the comment (RAI) with the comment (RAI) with the comment (RAI) with the comment (RAI) with the comment (RAI) with the comment (RAI) with the comment (RAI) with the comment (RAI) with the comment (RAI) with the facility of the comment (RAI) with the facility failed to a comment (RAI) with the facility failed to a comment (RAI) with the facility failed to a comment (RAI) with the facility failed to a comment (RAI) with the facility failed to a comment (RAI) with the facility failed to a comment (RAI) with the facility failed to a comment (RAI) with the facility failed to a comment (RAI) with the facility failed to a comment (RAI) with the comment (RAI) with the comment (RAI) with the comment (RAI) with the comment (RAI) with the comment (RAI) with the comment (RAI) with the comment (RAI) with the comment (RAI) with the comment (RAI) with the comment (RAI) with the comment (RAI) with the comment (RAI) with the comment (RAI) with the comment (RAI) with the comment (RAI) with the comment (RAI) with the comment (RAI) with the comment (RAI) with the comment (RAI) with the comment (RAI) with the comment (RAI) with the comment (RAI) with the comment (RAI) with the comment (RAI) with the comment (RAI) with the comment (RAI) with the comment (RAI) with the comment (RAI) with the comment (RAI) with the comment (RAI) with the comment (RAI) with the comment (RAI) with the comment (RAI) with the comment (RAI) with the comment (RAI) with the comment (RAI) with the comment (RAI) with	ion, interview, record review, enters for Medicare and CMS), "Resident Assessment anual 3.0," it was determined ansure the Comprehensive as reviewed and revised by an om composed of individuals of the resident and his/her forty-four (44) sampled #13, #22, #80, and #245).			needed. Any concerr be corrected at the til and reported to the D will be taken to the m Assurance Performal Improvement (QAPI) meeting for further re recommendation. Compliance Date: 1	me of discovery ON. Concerns conthly Quality nce committee view and
	the Fall Incident Represented a high low the same nature; he Care Plan (CCP) was resident's fall intervented.	dia fall, on 07/22/2021, and port noted the resident bed to prevent further falls of twever, the Comprehensive as not revised to reflect the ention of the high low bed to until 08/11/2021 (twenty (20)				
	prevent further falls However, the CCP v	Fail Incident Report noted				

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES					M APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MUI A. BUILL		CONSTRUCTION	(X3) DA	D. UB30-U381 NTE SURVEY PMPLETED
		185028	B. WING			l ne	C 9/02/2021
NAME OF	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		NULIZUZI
ОЗИНОС	N MATHERS NURSIN	G HOME		233	23 CONCRETE ROAD ARLISLE, KY 40311		
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F 657	resident's written plane revealed the CCP widentified resident is also by a resident's strengths, and need based on a thoroug clinical decision made current standards of a strong basis for ocare and quality of I residents. A well decision as strong basis for ocare and quality of I residents. A well decision as assessment and CC status at prescribed or if a significant chithe RAI, and then, the modified as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as appropriate as ap	consistent with each an of care. Continued review was driven not only by sues and/or conditions, but unique characteristics, is. Furthermore, a CCP h assessment and effective king, was compatible with f clinical practice that provided ptimal approaches to quality of ife needs of individual eveloped and executed CP re-evaluated the resident's intervals (quarterly, annually, ange in status occurred) using the individualized CCP was nate and necessary. ent #13's medical record admitted the resident, on agnoses including Dementia, bisorder, Arthritis, and	F	657			
	(08/11/2021).	(128/2021); and high low bed					

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

AND PLAN OF CORRECTION CARLISLE, KY 40311 CARCH DEFICIENCY MUST BE PRECEDED BY FIRE CARLISLE, KY 40311 CARCH DEFICIENCY MUST BE PRECEDED BY FIRE CARLISLE CONSTRUCTION	STATEMEN	IT OF DEFICIENCIES	MEDICAID SERVICES			0	MB NO. 0938-0391
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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		on the floor. Addition provided perineal cases by two (2) staff back was placed on the beform the bed. However, Resident include a winged may (6) days after the fast 5:15 AM. C) Review of Reside Form, dated 07/24/2 had a fall occurrence Evolution chair to the sitting on the floor, beach was resting ag Evolution chair was Additionally, the residence for the evolution of the evolution of the evolution of the evolution that resident was assisted by two (2) schair, and dycem was prevent the resident #13's CCP dycem to the chair a 07/24/2021 at 5:40 Finterview with LPN #PM, revealed she had eleven (11) years. Pevent, it was the numimplement an intervidecrease the risk of	conally, the resident was are by staff and was assisted to bed; a winged mattress and to prevent further fails #13's CCP was not revised to attress, until 07/29/2021, six II occurrence, on 07/23/2021 ant #13's Fall incident Report 2021, signed by LPN #3, 021 at 5:40 PM, the resident e in his/her room from the e floor. The resident was he lights were off, and his/her ainst the dresser; the to the resident's right side, dent was unable to give a rent related to his/her rither, the report stated the ken was the resident was staff, back to his/her Evolution as placed on the seat to from sliding out of the chair. In documented evidence was revised to include fier the fall occurrence, on PM. 3, on 08/15/2021 at 3:15 and worked at the facility for the Interview, after a fall se's responsibility to another fall of the same	F			

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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 dally 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 tollet 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,	F 657	before providing carequired the assista mobility, and was a revealed she was a safety awareness a bed and his/her Evistated it was the reensure residents we environment to kee meet their needs. In the aware the resident chair seat to prevent the chair. 2. Review of Resident revealed the facility 04/17/2019, with did Anxiety Disorder, A Syndrome, Pseudo Eladder, and Hyper Review of Resident MDS Assessment, the facility assesse and long term memimpaired cognitive of continued review of resident required estaff with bed mobil assistance of one (assistance of two (dressing, and toilet resident did not am revealed the reside and one (1) fall with Assessment.	are, was aware the resident ance of two (2) staff for fall risk. Additional interview aware Resident #13 had poor and had a history of falling from clution chair. SRNA #19 sponsibility of the staff to are provided a safe up the resident safe and to Further, she stated she was ent required dycem to the not him/her from sliding out of lent #22's medical record admitted the resident, on agnoses including Dementia, strial Fibrillation, Sick Sinus shulbar Affect, Overactive rension. It #22's Significant Change dated 02/22/2021, revealed do the resident as having short tory problems; and severely skills for dally decision making. If the Assessment revealed the extensive assistance of two (2) lity and transfers; extensive 1) staff with eating; and total 2) staff for personal hygiene, use. Per the Assessment, the abulate. Further review and had two (2) non-injury falls in injury since the prior	F	357				

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PREFIX REGULATORY OR LISC IDENTIFYING INFORMATION) F 657 Continued From page 208 have been revised to include the use of dycem on the wheelchair seat. Per the interview, she did not recall why she falled 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 Melifius, 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 impalred cognition. Continued review of the assessment revealed the resident required extensive assistance of two (2) staff for lotiel use. Per the Assessment, the resident did not ambulate, had impaired balance aduring 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	(XA) ID	SUMMARY STA	TEMENT OF DESIGNATION		C.				
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 fail 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 Melitius, 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 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 of one of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof	PREFIX	(EACH DEFICIENCY	MUST RE PRECEDED BY COLO	PREF		(EACH COR	RECTIVE ACTION SHOU RENCED TO THE APPR	HORE	(XS) COMPLETION DATE
Serious injury from falls. Further review revealed		have been revised the wheelchair seat not recall why she file evaluation or revise after the fall on 03/0 3. Review of Resid revealed the facility 11/28/2019, with dia Diabetes Mellitus, C Disorder, Morbid Ot Disorder, Morbid Ot Disorder, Morbid Ot Disorder, Morbid Ot Disorder, Morbid Ot Chronic Obstructive Chondrocalcinosis of Review of Resident Assessment, dated facility assessed the Interview for Mental (10) of fifteen (15), it cognition. Continue revealed the resider assistance of two (2 transfers, and dress one (1) staff with pe assistance of two (2 Assessment, the resident assistance. Further had not fallen since Review of Resident 06/24/2021, reveale falls, and had multip depression, medical cardiovascular, and The goal was the resident revealed was the resident of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the	o include the use of dycem on. Per the interview, she did alled to complete the the CCP to include dycem, 14/2021. ent #80's medical record admitted the resident, on agnoses including Type II beteoarthritis, General Anxiety pesity, Major Depressive sion, Congestive Heart Failure, Pulmonary Disease, and of the Right Knee and Hip. #80's Quarterly MDS 04/21/2021, revealed the resident as having a Brief Status (BIMS) score of ten andicating moderately impaired d review of the assessment at required extensive) staff with bed mobility, ing; extensive assistance of resonal hygiene; and total) staff for toilet use. Per the sident did not ambulate, had uring transitions between only stabilize with staff review revealed the resident the prior Assessment. #80's CCP, revised on d the resident had a history of le risk factors such as ion (antidepressant, a diuretic), and an actual fall. sident would be free of	F	657				

PRINTED: 10/11/2021

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				O	FORM MR NO	APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI		LE CONSTRUCTION		(X3) DAT	E SURVEY PLETED
		185028	B. WING	3				C 02/2024
	PROVIDER OR SUPPLIER IN MATHERS NURSIN	G HOME		2	STREET ADDRESS, CITY, STATE, ZIP 2323 CONCRETE ROAD CARLISLE, KY 40311	CODE	0.8/	02/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	IN SHOULD	BE	(X5) COMPLETION DATE
F 857	one (1) year), on 08 revealed Resident #80's CC/to include Interventi more timely. In add CCP's should be re residents received a individualized care. 4. Review of Resident revealed the facility 01/18/2021, with displayed the facility 01/18/2021, with displayed the facility assessed the facility assessed the four (4) of fifteen (1 impairment. Continuesident was a one mobility and self-tra a walker and wheel the resident was no seated to standing around, and surface	ON (worked as the DON for 1/31/2021 at 2:31 PM, 1/413's, Resident #22's and 1/2's should have been revised ons status post fall events lition, the DON stated the vised as necessary to ensure appropriate services and 1/4245's medical record admitted the resident, on agnoses including Parkinson's pression, Dementia, and 1/4245's Quarterly MDS 1/226/2021, revealed the 1/245's quarterly make 1/245's quarterly make 1/245's quarterly make 1/245's quarterly make 1/245's quarterly make 1/245's quarterly make 1/245's quarterly make 1/245's quarterly make 1/245's quarterly make 1/245's quarterly make 1/245's quarterly make 1/245's quarterly make 1/245's quarterly make 1/245's quarterly make 1/245's quarterly make 1/245's quarterly make 1/245's quarterly make 1/245's quarterly make 1/245's quarterly make 1/245's quarterly make 1/245's quarterly make 1/245's quarterly make 1/245's quarterly make 1/245's quarterly make 1/245's quarterly make 1/245's quarterly make 1/245's quarterly make 1/245's quarterly make 1/245's quarterly make 1/245's quarterly make 1/245's quarterly make 1/245's quarterly make 1/245's quarterly make 1/245's quarterly make 1/245's quarterly make 1/245's quarterly make 1/245's quarterly make 1/245's quarterly make 1/245's quarterly make 1/245's quarterly make 1/245's quarterly make 1/245's quarterly make 1/245's quarterly make 1/245's quarterly make 1/245's quarterly make 1/245's quarterly make 1/245's quarterly make 1/245's quarterly make 1/245's quarterly make 1/245's quarterly make 1/245's quarterly make 1/245's quarterly make 1/245's quarterly make 1/245's quarterly make 1/245's quarterly make 1/245's quarterly make 1/245's quarterly make 1/245's quarterly make 1/245's quarterly make 1/245's quarterly make 1/245's quarterly make 1/245's quarterly make 1/245's quarterly make 1/245's quarterly make 1/245's quarterly make 1/245's quarterly make 1/245's quarterly make 1/245's quarterly make 1/245's quarterly make 1/245's quarterly make 1/245's quarterly make 1/245's quarterly make 1/245's quarterly make	F	857				
	01/18/2021, revealed not address the falls and 03/13/2021. Conterventions dated timely revision of the	#245's CCP, dated and the Focus area of falls did son 02/19/2021, 02/23/2021, ontinued review of the 01/18/2021 revealed no e CCP with interventions for 1 on 02/19/2021, 02/23/2021,						á s

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

STATEMENT OF	F DEFICIENCIES	(X1) DROVIDER/ELIPPLIED/OLIV				U	MB NO. 0938-039	1
AND PLAN OF C	ORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD		PLE CONSTRU	UCTION	(X3) DATE SURVEY COMPLETED	
		185028	B. WING				C	
NAME OF PRO	OVIDER OR SUPPLIER				STREET ADD	PRESS, CITY, STATE, ZIP CODE	09/02/2021	
- ГОНИВОМ	WATUEDS MILIDON	in time.				RETE ROAD		
dominour.	MATHERS NURSIN	IG HOME				KY 40311		
(X4) ID	SUMMARY STA	NTEMENT OF DEFICIENCIES						
PRÉFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EA	PROVIDER'S PLAN OF CORRECTION CH CORRECTIVE ACTION SHOULD SS-REFERENCED TO THE APPROPI DEFICIENCY)	NAC COMPLETION	ľ
F 657 C	ontinued From pa	ino 212		-	_			_
			F 6	357	,			
***	as reathnisinis in i	update the CCP as needed.						
at be th re Ac pli Mi re ro ID	I 2:31 PM, revealed revised accurate the interview, nurse, the copy of the CCP, thated to fall events additionally, she stated accesses, during the eeting, held on Mc ovlew the CCP's affixisions were made oppopriate interventage.							
3:: R/ en sta ac an inc F 658 Se	30 PM, revealed the Manual and factors and factors and the CCP was also at the CCP was also at the CCP and ensure the CCP dividual needs.	dministrator, on 08/16/2021 at the facility was to utilize the facility was to utilize the dility policies as resources to selected as necessary. He ant for the CCP to be revised a resident's current status and death and a resident's each resident's facility.	F 6:	158	s.	F 658		
§ 4	83.21(b)(3) Comp	prehensive Care Plans			1.	Resident #242 no long	ier resides in	
Th as mu	ne services provide outlined by the coust-	ed or arranged by the facility, omprehensive care plan, all standards of quality.				the facility. On 8/19/21 and 8/20/2 and QI nurse complete all current residents ar resident charts for the to identify any resident coded in the center an Cardio-pulmonary resu	21, the DON ed a review of and discharged past 30 days t who had ad required	

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

PRINTED: 10/11/2021 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILO		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
_		185028	B. WING			C 09/02/2021
NAME OF	PROVIDER OR SUPPLIER			STR	EET AODRESS, CITY, STATE, ZIP CODE	UBIOZIZOZI
JOHNSO	N MATHERS NURSIN	G HOME			3 CONCRETE ROAD RLISLE, KY 40311	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ALD BE COMPLETION
F 658	The facility was not The facility provided Jeopardy Removal facility alleging rem Jeopardy, on 08/31 Agency validated responsively, as alleged on 09/02/2021. The non-compliance was "D" while the facility Plan of Correction: Assurance (QA) moved with systemic change in the findings included Review of the facility "Cardiopulmonary is Procedure Manual, revealed the object resident until adequivas re-established resident was not brown the policy all do chest compressions/breathing at a rate compressions/breathing, repeat the breath every (2) mit CPR process was signs of life, another	Meet Professional Standards. ified of the IJ on 08/20/2021. If an acceptable Immediate Plan on 09/01/2021, with the oval of the Immediate //2021. The State Survey imoval of the Immediate id on 08/31/2021, prior to exit a facility's remaining is at a Scope and Severity of a revelops and implements a and the facility's Quality onitors to ensure compliance ges. It is policy titled, Resuscitation, Nursing Version Date: April 2013, we was to ventilate the leathing to call 911 and begin so instructed staff on how to lone and administer rescue of thirty to two (30/2) this. Further review revealed the for two (2) minutes, then eathing; if the resident was not be process, checking for nutes. The policy stated the ocontinue until there were in rescuer took over, EMS er, or a physician gave an	F	658	responsibility during situation. The purpose and education is to enurses understand the responsibilities during Results of the CPR of concerns with education forwarded to the Quit Performance Improved committee for one madetermine further and of monitoring. Compliance Date: 1	se of the drills ensure licensed heir ig a Code Blue. drills and ation will be ality Assurance rement (QAPI) nonth to d/or frequency

Review of the American Heart Association 2020

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

STATEMENT	T OF DEFICIENCIES	CAT BECAUSE STORES		_		OMB N	<u>0. 0938-0391</u>
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILE		PLE CONSTRUCTION G	(X3) D.	ATE SURVEY
		185028	B, WING	3			C
NAME OF	PROVIDER OR SUPPLIER		L		STORT INDOCES	0	9/02/2021
10,,,,,					STREET ADORESS, CITY, STATE, ZIP CODE		
LIOHNZE	ON MATHERS NURSIN	IG HOME			2323 CONCRETE ROAD		
/////	CIRCIANA			L	CARLISLE, KY 40311		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES * MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION	PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LDBE	(X5) COMPLETION DATE
F 658	Continued From pa	245					
. 000	(determined From pa	ge 210	F 6	658	3		
	(determined how m	uch oxygen was circulating					
	for laborary body),	Oxygen was applied via mask					
	for labored preathin	g. Further review of the					
	progress note revea	aled staff were unable to					
	initiated Postbons	esident #242, and CPR was					
	Were notified and E	ote, EMS and the physician Resident #242 was transported					
	to a local hospital b	resident #242 was transported					
	or a read thooping b	y 21110.					
	Review of the EMS	run sheet, dated 01/26/2021,					
	revealed they were	dispatched at 6:08 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 apnelic (without	breath), was given CPR, and					
	pulse/oreath was re	gained. Documentation					
	indicated Resident	ad electrocardiogram (EKG)					
	vaniricular contracti	242 was throwing premature ons (extra heart beats which					
	could be dencerous	with underlying heart					
	conditions, with which	th Resident #242 had been					
	diagnosed).	AT TOSIGOTIC FE 42 Had Deell					
	- ,						
	Review of the Hospi	tal Emergency Department					
	(EU) History and Ph	vsical (H&P) revealed					
	Resident #242 arrive	ed in the ED on 01/26/2021					
	status post respirato	ry arrest and CPR at the					
	facility. Resident #2	42 met Sepsis criteria and					
	was admitted for tre	atment. Additional review of					
	the ED records indic	ated EMS staff had					
	performed a 12-lead	EKG during transport, which					
	showed Resident #2	44 nad sustained a					122
	(STEMI) the most a	on Myocardial Infarction					ļ
	C. LIMIN WIS MOST S	evere type of heart attack.					
	Review of the Hospi	tal Death Discharge					
	Summary revealed (Resident #242 received					i
	broad-spectrum intra	avenous (IV) antibiotics, fluid					
	boluses and appropr	iate sepsis protocols were					

9011161	13 FUR MEDICARE	& MEDICAID SERVICES				OMB N	O. 0938-0391
STATEMENT AND PLAN O	OF DEFICIENCIES IF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILC		CONSTRUCTION	(X3) D	ATE SURVEY DMPLETED
		185028	B. WING				C 9/02/2021
NAME OF P	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		310202.02.1
IONNEO	N MATHERS NURSIA	10 1101-5			3 CONCRETE ROAD		
JOHNSO	M MAILIERS MOKSIN	IG HOME			RLISLE, KY 40311		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	X	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	JULD BE	(XS) COMPLETION DATE
F 858	code in the Progres Incident report. Shi training, from the Sicase of a code. Ho nurse did not tell this he just smirked. It what had occurred because she could did not know how to Physician #1 and to later that evening, a happened. She staff Additionally, LPN # experience she had	acted her to document the as Notes and not to do an e stated staff got annual DC/QI nurse on what to do in owever, she stated the SDC/QI e former Administrator to stop. PN #15 stated she reported in the code to the DON not believe the Administrator to do CPR. She stated he APRN both called her and she told them what had ated nobody investigated the if to write a statement. 15 stated it was the worst dever been in and was so events of 01/26/2021 that she	F	558			
	at 1:50 PM, revealed #242 before beginn when he/she regain previous Administrated to the Surveyor how the phands over the SDI CPR for approximate arrived on the scento remember if she Corporate Clinical I Additionally, the SDI American Heart As were the facility educate the SDI nurse at the SDI nurse at the SDI nurse at the SDI nurse at the SDI nurse at the SDI nurse at the SDI nurse at the SDI nurse at the SDI nurse at the SDI nurse at the SDI nurse at the SDI nurse at the SDI nurse at the SDI nurse at the SDI nurse at the SDI nurse at the SDI nurse at the SDI nurse at the SDI nurse at the SDI nurse at the SDI nurse at the SDI nurse at the SDI nurse at the SDI nurse at the SDI nurse at the SDI nurse at the SDI nurse at the SDI nurse at the SDI nurse at the SDI nurse at the SDI nurse at the SDI nurse at the SDI nurse at the SDI nurse at the SDI nurse at the SDI nurse at the SDI nurse at the SDI nurse at the SDI nurse at the SDI nurse at the SDI nurse at the SDI nurse at the SDI nurse at the SDI nurse at the SDI nurse at the SDI nurse at the SDI nurse at the SDI nurse at the SDI nurse at the SDI nurse at the SDI nurse at the SDI nurse at the SDI nurse at the SDI nurse at the SDI nurse at the SDI nurse at the SDI nurse at the SDI nurse at the SDI nurse at the SDI nurse at the SDI nurse at the SDI nurse at the SDI nurse at the SDI nurse at the SDI nurse at the SDI nurse at the SDI nurse at the SDI nurse at the SDI nurse at the SDI nurse at the SDI nurse at the SDI nurse at the SDI nurse at the SDI nurse at the SDI nurse at the SDI nurse at the SDI nurse at the SDI nurse at the SDI nurse at the SDI nurse at the SDI nurse at the SDI nurse at the SDI nurse at the SDI nurse at the SDI nurse at the SDI nurse at the SDI nurse at the SDI nurse at the SDI nurse at the SDI nurse at the SDI nurse at the SDI nurse at the SDI nurse at the SDI nurse at the SDI nurse at the SDI nurse at the SDI nurse at the SDI nurse at the SDI nurse at the SDI nurse at the SDI nurse at the SDI nurse at the SDI nurse at the SDI nurse at the SDI	OC/QI nurse stated the sociation (AHA) quidelines					

PRINTED: 10/11/2021

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES					O. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(XZ) MU A. BUILO		ONSTRUCTION	(X3) E	CATE SURVEY
		185028	B. WING			Ι,	C 09/02/2021
NAME OF F	PROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE		JSIUZIZUZI
JOHNSO	N MATHERS NURSIN	IG HOME		2323	CONCRETE ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULO BE	(X5) COMPLETION DATE
F 658	done immediately. shocked when the ridays later. He state had overstepped he continued chest cor was not handled in Physician #1 report someone with a pull drastically. Interview with the DPM, revealed she his code. She stated she his code. She stated she his code. She stated she his code in the former Aresident needed a put of stop CPR. Additionally was received after the incident the algorithm for CPR a pulse, chest compindicated. Interview with the Rich on 08/20/2021 at 33 knowledge of the in #242 and the fact the pulse was obtained CPR should be disconderns when he stated his expect would have reporter.	He stated he was not too resident passed away two (2) and the previous Administrator or bounds in ordering impressions, and resuscitation an appropriate way. ed continuing CPR, on se, could harm them ON, on 08/19/2021, at 2:00 and not been present for the he met with the former exit day and told her it was CPR if there was a pulse. She diministrator again stated a pulse of at least sixty (60) bpm ionally, the DON stated she om the APRN who stated to least a pulse. She stated an from the APRN, about a week at included a current AHA and revealed if a resident had pressions were no longer degional Vice President (RVP), 03 PM, revealed he had no coldent regarding Resident had continued if there was a pulse. Ot aware Physician #1 had was notified of this situation, citation was the Administrator of the incident to him; others	F	558			
	have reported throu	d it to him as well. They could igh the compliance line or illy. He had no thoughts on					

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES					0. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		DINSTRUCTION	(X3) DA	TE SURVEY
		185028	B. WING			0.	C 9/02/2021
NAME OF F	ROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
JOHNSO	N MATHERS NURSIN	IG HOME			CONCRETE ROAD LISLE, KY 40311		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LDBE	(XS) COMPLETION DATE
F 658	Support Algorithm f CPR policy, and Cc instructed nurses the without a pulse, blood or with insufficient of the called immediate the checked for the always make sure of chart, 4) if a reside must be started immadon to Not Resuscita the initiated, 6) if a regit as soon as possible and 8) the nursing Basic Life Support. Providers. 4. On 8/19/2021, the Nurse Supervisor in licensed nurses for their role in CPR. Tone-hundred perce included: 1) how didicode or DNR?	or Healthcare providers, the ode Blue. The in-service hat: 1) if a resident was found of pressure (BP), respirations respirations, a Code Blue must ely, 2) the chart must always resident's code status, 3) you had the correct resident's nt was a full code, then CPR mediately, 5) if a resident was ate (DNR), then CPR must not resident was a full-code to call doctor (MD) must be notified to of the resident's condition, staff must follow the Adult Algorithm for Healthcare the DON, SDC/QI nurse, and initiated a Questionnaire with all validation of understanding the passing score was ent (100%). The questions o you know if a resident was a full code to CPR? 3) what was the code		558			
	to overhead page is breathing and/or no MD be notified if a breathing and/or no was found not breather the nurse's recontinue CPR whe	f a resident was found not pulse? 4) when should the resident was found not pulse? 5) when a resident athing and/or no pulse, what esponsibilities? and 6) do you n heart rate and breathing had					
	answer the question two attempts would with residents until	ny nurse who was unable to ons on the questionnaire after d be removed from working they ware able to validate s unable to validate knowledge					

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

						CIVID IVO. 0930-039 I
STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		(X3) DATE SURVEY COMPLETED	
_		185028	B. WING			C 09/02/2021
NAME OF F	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE	UBIVEIZUZI
ОЗИНОС	N MATHERS NURSIN	IG HOME		232	J CONCRETE ROAD RLISLE, KY 40311	
452.45.48	6114444			UN		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 658	Continued From pa		F	558		
	The staff were able questions correctly, familiar with facility accordance with sta	nd suggestions to the staff. to demonstrate and answer establishing staff were policies related to CPR, in andards of practice.				
25	the Unit Manager fa second shift staff. DON offered feedb staff. The staff was answer questions of familiar with facility	ne DON, SDC/QI nurse, and acilitated a CPR Drill for During and after the drill, the ack and suggestions to the sable to demonstrate and correctly, establishing staff was policies related to CPR, in andards of practice.				
	interdisciplinary tea the IDT included th Improvement Nursi Coordinator (SDC/Nurse, Unit Manag Services Director, a meeting, the RN Coresidents' medical code status was re twenty-five (25%) p	the DON facilitated the morning im (IDT) meeting. Members of the Administrator, DON, Quality e/Staff Development QI), Minimum Data Set (MDS) er, Activity Director, Social and Dietary Manager. At the proporate nurse reviewed charts, during which resident viewed. Approximately sercent of resident records code status was noted to be				
		he DON reviewed and updated rection with the Medical one.				
	Drill for the weeker assisted by three (a During and after the offered feedback a	the DON facilitated a CPR and staff. The DON was 3) RN's from a sister facility. e drill, the DON and RN's and suggestions to the staff. to demonstrate and answer				

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES					C	MB NO	. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILC		E CONSTRUCTION	N		(X3) DA1	TE SURVEY
		185028	B. WING					l ne	C /02/2021
NAME OF F	PROVIDER OR SUPPLIER			SI	FREET ADDRESS,	CITY, STAT	E. ZIP CODE	1 00	(VE) E OE I
JOHNSO	N MATHERS NURSIN	IG HOME		23	323 CONCRETE ARLISLE, KY	ROAD			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CO	DRRECTIVE	OF CORRECTION SHOUL TO THE APPROPENCY)	DBE	(X5) COMPLETION DATE
F 658	residents had code were no residents le vere no residents le 2. Review of CPR nurse audited one-licensed nurses for Interviews with LPN LPN #8, on 09/02/2 4:16 PM, and 4:26 were all currently C 3. Review of signe sheet, dated 08/19/in-serviced the SDC should not be contilined review renurse educated all Basic Life Support Providers, CPR Polinterviews with LPN LPN #8, on 09/02/2 4:16 PM, and 4:26 did receive CPR ed did receive CPR ed did receive CPR ed dills and quizzes a weekends. 4. Review of CPR (100%) percent of I quizzes and passe used to ensure no the education. 5. Review of CPR	ed charts to identify if any d in the last thirty days. There dentified. cards revealed the SDC/QI hundred (100%) percent of current CPR education. I #11, RN #3, LPN #10, and 1021 at 3:03 PM, 3:14 PM, PM respectively, revealed they PR certified. Id in-service documentation (2021, revealed the DON C/QI nurse regarding that CPR nued if there was a pulse, avealed the DON and SDC/QI licensed nursing staff on Adult Algorithm for Healthcare licy, and Code Blue. I #11, RN #3, LPN #10, and 1021 at 3:03 PM, 3:14 PM, PM respectively, revealed they fucation and had Code Blue cross every shift and on quizzes revealed one-hundred licensed nursing staff took the d. An employee roster was one was missed in receiving	F	558					
	the facility held drill 08/29/2021, and or	s on 08/20/2021, 08/24/2021, 08/31/2021. Continued							

review revealed they were held across all shifts

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

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AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(XZ) MUL A. BUILD		CONSTRU	CTION	(X3) DATE SURVEY COMPLETED
		185028	B. WING				C
NAME OF I	PROVIDER OR SUPPLIER		<u>'</u>	STI	REFTADDE	RESS, CITY, STATE, ZIP CODE	09/02/2021
IOUNGO			- 1			RETE ROAD	
JOHNSO	N MATHERS NURSIN	IG HOME				KY 40311	
(X4) ID	SHAMADY STA	TEMENT OF DEFICIENCIES					
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EA	ROVIDER'S PLAN OF CORRECTIO CH CORRECTIVE ACTION SHOULD S-REFERENCED TO THE APPROP DEFICIENCY)	DE COMPLETION
F 678	assigned to be at it September 2021. Sfacility management familiar with facility accordance with statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement o	PM, revealed she was ne facility until the end of She stated she would assist at in ensuring staff were policies related to CPR, in andards of practice. the DON, on 09/02/2021 at she had sent the CPR Drills 0/2021, 08/24/2021, 108/31/2021 to the QAPI scussed at the next meeting. Resuscitation (CPR)	FE		•	F 678	
	§483.24(a)(3) Persisupport, including (such emergency medica related physician or advance directives. This REQUIREMED by: Based on interview American Heart Ast Resuscitation (CPF facility's policy, it with to have an effective familiar with facility one (1) of thirty-two Status, Resident #2	onnel provide basic life CPR, to a resident requiring are prior to the arrival of it personnel and subject to orders and the resident's of its not met as evidenced or, record review, review of the sociation's Cardiopulmonary (a) guidelines, and review of the as determined the facility failed a system to ensure staff were policies related to CPR for (32) residents with Full Code (442).			2.	Resident #242 no long the facility. On 8/19/21 and 8/20/2 and QI nurse complete all current residents a resident charts for the to identify any resident coded in the center at Cardio-pulmonary residentified. On 8/18/21 completed a 100% audicensed nurses to valicensed nurses to valicensed a copy of the certification was on fill	21, the DON ed a review of nd discharged past 30 days at who had nd required suscitation dents were , the QI nurse edit of all lidate CPR reent and to CPR e at the facility.
	suffered a cardiopu Practical Nurse (LP	Imonary arrest and Licensed N) #15 called a Code Blue for n. The Staff Development			3.	On 8/19/21, the DON initiated education for nurses. The education	and QI nurse all licensed

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

<u> </u>	AD I OIL HILDICANE	TIMEDICAID SERVICES			C	<u>MB NO. 0938-0391</u>
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPFLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILD		ONSTRUCTION	(X3) DATE SURVEY COMPLETED
		185028	B. WING			C 09/02/2021
	PROVIDER OR SUPPLIER N MATHERS NURSIN	IC HOME		,	ET ADDRESS, CITY. STATE, ZIP CODE CONCRETE ROAD	1 4010111011
JOHNSO				CAR	LISLE, KY 40311	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROV DEFICIENCY)	D BE COMPLETION
F 678	Continued From pa	ge 230	F	578	one month to determi	ne further
	with systemic chan				and/or frequency of m	onitoring.
	The findings include	e:			Compliance Date: 11	/24/2021
	2020 CPR guideline breathing and had a emergency responsesident would not a	rican Heart Association (AHA) as revealed if the victim was a pulse, to monitor until ders were on the scene. A need a heartrate of sixty (60) (bpm) to discontinue CPR.				
	"Cardiopulmonary I Procedure Manual, revealed the object resident until adequivas re-established call 911 if the reside begin CPR. The percentinue for two (2) breathing; if the resident to continue until the rescuer took over, a Physician gave a Review of Residen	ty's CPR policy, titled Resuscitation, Nursing "Version Date: April 2013, ive was to ventilate the pate circulation to the brain Procedure steps included to ent was not breathing and to pilcy instructed that CPR would minutes, then stop, check for sident was not breathing, checking for breath every (2) y stated the CPR process was are were signs of life, another EMS arrived and took over, or n order to discontinue CPR. t #242's medical record admitted the resident, on				
	07/26/2017, with di Presence of Cardia Prostatic Hyperplas Pulmonary Disease Disease, Ischemic	agnoses that included agnoses that included ac Pacemaker, Benign sia, Chronic Obstructive e, Atherosclerotic Heart Cardiomyopathy, and ary Angioplasty Implant and				
	Review of the facili communication sho	ty's resuscitative level set revealed Resident #242				

CENTER	S FOR MEDICARE	& MEDICAID SERVICES				MB NO, 0938-	0391
	OF DEFICIENCIES IF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILC		E CONSTRUCTION	(X3) DATE SURVE COMPLETED	Υ
	·	185028	6. WING			C 09/02/202	11
NAME OF	PROVIDER OR SUPPLIER		-	S	TREET ADDRESS, CITY, STATE, ZIP CODE		•
IOHNEO	A MATHERE MI INCA	10.110.117			323 CONCRETE ROAD		
	N MATHERS NURSIN				ARLISLE, KY 40311		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF OEFICIENCY)	ORF COMPL	ETTON
F 678	Continued From pa	ge 232	F	678			
		CPR training through the	,				
	American Heart As						
	PM, revealed the A (AHA) guideline wa resource. Additional had Code training of	iDC/QI, on 08/19/2021 at 1:50 merican Heart Association is the facility education ally, she stated nursing staff on hire and annually. She ation occurred every two (2) AHA Instructor.					
	education was not it stated by the SDC/	y's CPR policy stated from the AHA guidelines, as QI nurse, but the education procedure Manual (Version					
	the SDC/QI nurse a	staff CPR cards validated that and the former Administrator rform CPR on 01/26/2021.					
	at 1:28 PM, revealed Resident #242 code supper. She stated #242 was having the she sat Resident # gasping and vomitic Code Blue because pulse, and the SDC started compression mask. LPN #15 standard the resident had continuity the resident had continuity the resident #242 grupulse, so she told showever, she stated resident #242 grupulse, so she stated resident #242 grupulse, so she stated resident #242 grupulse, so she stated resident #242 grupulse, so she stated resident #242 grupulse, so she stated resident #242 grupulse, so she stated resident #242 grupulse, so she stated resident #242 grupulse, so she stated resident #242 grupulse, so she stated resident #242 grupulse, so she stated resident #242 grupulse, so she stated resident #242 grupulse, so she stated resident #242 grupulse, so she stated resident #242 grupulse, so she stated resident #242 grupulse, so she stated resident #242 grupulse, so she stated resident #242 grupulse, so she stated resident #242 grupulse, so she stated resident #242 grupulse, so she stated resident #242 grupulse, so she stated resident #242 grupulse, so she stated resident #242 grupulse, so she stated resident #242 grupulse, so she stated resident #242 grupulse, so she stated resident #242 grupulse, so she stated resident #242 grupulse, so she stated resident #242 grupulse, so she stated resident #242 grupulse, so she stated resident #242 grupulse, so she stated resident #242 grupulse, so she stated resident #242 grupulse, so she stated resident #242 grupulse, so she stated resident #242 grupulse, so she stated resident #242 grupulse, so she stated resident #242 grupulse, so she stated resident #242 grupulse, so she stated resident #242 grupulse, so she stated resident #242 grupulse, so she stated resident #242 grupulse, so she stated resident #242 grupulse, so she stated resident #242 grupulse, so she stated resident #242 grupulse, so she stated resident #242 grupulse, so she stated resident #242 grupulse, so she stated resident #242 grupulse, so she stated resident #242 grupuls	w with LPN #15, on 08/19/2021 and she remembered the night ed, around 6:30 PM, right after a SRNA notified her Resident ouble breathing. She stated 242 up, and he/she was ng. She stated she called a set he resident did not have a C/QI nurse came in the room ans while staff were looking for ated, when the former in the room and discovered aded, she administered breaths els. Then, LPN #15 stated ateff to stop compressions. But the former Administrator told in compressions because they					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDERSUPPLERVICIAN 185028 NAME OF PROVIDER OR SUPPLIER 185028 STREET ADDRESS, CITY, STATE, ZIP CODE	CENTE	RS FOR MEDICARE	& MEDICAID SERVICES					B NO. 0938-0391
NAME OF PROVIDER OR SUPPLIER JOHNSON MATHERS NURSING HOME (IX4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 678 Continued From page 234 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			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		(3) DATE SURVEY
NAME OF PROVIDER OR SUPPLIER JOHNSON MATHERS NURSING HOME (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 678 Continued From page 234 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 rough 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			185028	B. WING				_
JOHNSON MATHERS NURSING HOME (XA) D PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) FOR STAGE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) FOR STAGE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) FOR STAGE FOR STAGE FOR SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) FOR STAGE 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 #8, 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	NAME OF	PROVIDER OR SUPPLIER				TETT ADDRESS OFFI PERSON		09/02/2021
IXA) ID PREFIX (EACH DEFICIENCY MANTE BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 678 Continued From page 234 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 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 cartified 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 cresh carts were	JOHNSC	ON MATHERS NURSIN	IG HOME		232	23 CONCRETE ROAD		
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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	F 678	Interview with the EPM, revealed she is code. She stated is Administrator the minimum to continue (stated the former Aresident needed a sto stop CPR. Additionally additionally additionally and the staff received Code CPR certified every CPR certified every CPR certified every CPR certified every CPR certified every CPR certified every CPR certified every CPR certified every CPR certified every CPR certified every CPR certified every CPR certified every CPR certified every CPR certified every CPR certified every CPR certified every CPR certified every CPR certified every CPR certified every CPR certified every CPR certified every CPR certified every CPR certified every CPR certified every certified every certified every certified every certified every certified every certified every certified every certified every certified every certified every certified every certified every certified every certified every certified every certified every certified every certified every certified every certified every certified every certified every certified every certified every certified every certified every certified every certified every certified every certified every certified every certified every certified every certified every certified every certified every certified every certified every certified every certified every certified every certified every certified every certified every certified every certified every certified every certified every certified every certified every certified every certified every certified every certified every certified every certified every certified every certified every certified every certified every certified every certified every certified every certified every certified every certified every certified every certified every certified every certified every certified every certified every certified every certified every certified every certified every certified every certified every certified every certified every certified every certified every certified every certified every certi	DON, on 08/19/2021, at 2:00 had not been present for the she met with the former text day and told her it was CPR if there was a pulse. She administrator again stated a pulse of at least sixty (80) bpm tionally, the DON stated she om the APRN who stated to was a pulse. The DON stated a training annually and were of two (2) years. 1/20/2021 at 9:27 AM, of the revealed the Automated or (AED) and pads on their er, there was no log of 1/46, LPN #7, and Registered 08/20/2021 at 9:35 AM, not aware where the AED was new where crash carts were the Interim Administrator of an AED in the facility. 200N, on 08/20/2021 at 9:40 bas should be audited to as working; however, she did nog. The DON stated the hAED in April 2021. However, AED education and sign-in a facility received AED training the SDC/QI nurse. The DON policy should have been the AED.	F	i78			

PRINTED: 10/11/2021 FORM APPROVED OMB NO. 0938-0391

CENTER	S FOR MEDICARE	& MEDICAID SERVICES				OM	IB NO. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		CONSTRUCTION		(X3) DATE SURVEY COMPLETED
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NAME OF F	ROVIDER OR SUPPLIER	100020	D. 11111				09/02/2021
	N MATHERS NURSIN	IG HOME		2323	EET ADDRESS, CITY, STATE, ZIP COD I CONCRETE ROAD RLISLE, KY 40311		
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F 678	No other residents	ge 236 It who had coded in the center. It had coded in the center within days, and no issues where	F	378			
	an audit of one-hun nurses' CPR certific licensed nurses on and possessed a coord. There were re the audit. The facilities assistants, Kentuck therapy staff to be on not perform CPR.	ne SDC/QI nurse completed orded (100%) percent of cations to ensure all current all shifts were certified in CPR copy of a CPR certification to concerns identified during lity did not require nursing ty Medication Aides (KMA), or CPR certified because they did Non-certified staff acted as quipment and greet EMS.					
	SDC/QI nurse, which not continue after a previous Administrated facility. The DON, Supervisor initiated The in-service was Support Algorithm I CPR policy, and Colinstructed nurses til without a pulse, bloor with Insufficient in be called immediat be checked for the always make sure chart, 4) if a resident must be started immat be started immat be Initiated, 6) if a regidal policy of the medical policy.	the DON in-serviced the chincluded that CPR should a pulse was detected. The ator was no longer at the SDC/QI nurse, and Nurse an in-service with all nurses, about the Adult Basic Life for Healthcare providers, the ade Blue. The in-service nat: 1) if a resident was found and pressure (BP), respirations respirations, a Code Blue must resident's code status, 3) you had the correct resident's not was a full code, then CPR mediately, 5) if a resident was ate (DNR), then CPR must not resident was a full-code to call doctor (MD) must be notified as of the resident's condition,					

and 8) the nursing staff must follow the Adult

STATEMENT OF DEFICIENCES (AT) PROVIDERS UPPLIER (AT) DENTERICATION NUMBER: 185028 NAME OF PROVIDER OR SUPPLIER 185028 STREET ADDRESS, CITY, STATE, JP CODE 2333 CONCRETE ROAD CARLISLE, KY 40311 XMA D		& MEDICAID SERVICES				MB NO.	0938-0391
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JOHNSON MATHERS NURSING HOME STREET ADDRESS, CITY, STATE, ZIP CODE 2232 CONCRETE ROAD (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 678 Continued From page 238 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 responsibilities of proposed in the company of the conducted duril EMS arrived, physician discontinued code, or until the resident's pulse and respirations, summoning for assistance, checking code status, paging Code Blue, initiating CPR, ensuring adequate staff responded, 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 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 were		185028	B. WING	:		1	- I
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F 678	Continued From pa in accordance with	ge 240 standards of practice.	F6	78				
	results of the CPR I Performance impro monthly for one (1) would meet monthly the CPR Orill result issues that might no into place and to de and/or frequency of Committee consiste Infection Prevention Worker, Medical Re Manager, and Hous additional staff men	d continue forwarding the Drills to the Quality Assurance vement (QAPI) Committee month. The QAPI Committee of for one (1) month and review is to determine trends and/or ead further interventions put etermine the need for further monitoring. The QAPI and of the Administrator, DON, nist, Medical Director, Social scords Director, Dietary sekeeping Supervisor, plus inbers as deemed necessary.						
	The State Survey A implementation of to Jeopardy Removal	ne facility's immediate			3-			
	through 08/20/2021 SDC/QI nurse audit percent of discharge	nentation dated 08/19/2021 revealed the DON and ed one-hundred (100%) ed charts to identify if any d in the last thirty days. There dentified.						
	nurse audited one-t	cards revealed the SDC/QI nundred (100%) percent of current CPR education.						
	LPN #6, on 09/02/2	#11, RN #3, LPN #10, and 021 at 3:03 PM, 3:14 PM, PM respectively, revealed they PR certified.						
	3. Review of signed sheet, dated 08/19/	d in-service documentation 2021, revealed the DON						

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

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AND PLAN	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUL A. BUILD		LE CONSTRUCTION	(203)	DATE SURVEY COMPLETED
		185028	B. WING				C
NAME O	F PROVIDER OR SUPPLIER		<u> </u>	_	STREET ADDRESS DOV AT AT THE		09/02/2021
i					STREET ADDRESS, CITY, STATE, ZIP CODE		
JOHNS	ION MATHERS NURSIN	(G HOME			2323 CONCRETE ROAD		
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F 07.							
F 678	B Continued From pa	ige 242	Fθ	378			
	CPR drill for second	d shift staff.					
	8. Review of the ID	OT meeting agenda, dated					
	08/25/2021, reveale	ed the Corporate RN reviewed					
	approximately twen	ity-five (25%) percent of					
	residents' charts to	ensure code status was					
	documented and up	p-to-date.					
	9 Review of facility	y documentation, dated					
	08/26/2021 reveals	ed the DON updated the					
	Medical Director via	stelenhone call					
	THE STATE OF COLOR FIE	tolephotie call.					
	10. Review of CPR 08/29/2021, reveals weekend staff.	Drill documentation, dated ed the DON held the drill for					
	revealed the Corpo (25%) percent of re electronic face shee	mentation, dated 08/29/2021, rate RN audited twenty-five sidents' charts to ensure the ets, physical charts, and care contained updated code					
	09/02/2021 at 1:18 assigned to be at th September 2021. S facility managemen familiar with facility	the Corporate RN, on PM, revealed she was ne facility until the end of She stated she would assist at in ensuring staff were policies related to CPR, in andards of practice.					e e
F 688 SS≃G	1:18 PM, revealed sanalysis from 08/20 08/29/2021, and on Committee to be dis	the DON, on 09/02/2021 at she had sent the CPR Drills 1/2021, 08/24/2021, 08/31/2021 to the QAPI scussed at the next meeting. (ecrease in ROM/Mobility 1)-(3)	F 6	88			

PRINTED: 10/11/2021

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILO		INSTRUCTION	(X3) DATE SURVEY COMPLETED
		18502B	8. WING			C 09/02/2021
NAME OF	PROVIDER OR SUPPLIER			STREE	T ADDRESS, CITY, STATE, ZIP CODE	1 08/02/2021
JOHNSO	N MATHERS NURSIN	IG HOME		2323 (CONCRETE ROAD LISLE, KY 40311	
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F 688	Significant Change 12/14/2020; and Qu dated 08/10/2021, i Status, revealed the Ilmitations in ROM (extremities. However, observati 08/09/2021, reveale his/her bilateral low of the medical reco- evidence the facility Restorative Care re- services, or treatme functional status or functional status or functional Status, r functional limitation upper and lower ex Section I: Diagnosis diagnosis of Continued review o Treatment, Procedu the resident receive Restorative Nursing assistance. However, observati 08/09/2021; 08/10/2 08/12/2021 reveale contracted with no l of the medical reco- evidence the facility Restorative Care re-	ge 244 MDS Assessment, dated Jarterly MDS Assessment, in Section G: Functional eresident had no functional for upper or lower bilateral. On of Resident #13, on ed he/she had contractures to be extremitles. Further, review or developed or implemented a regimen with interventions, and to maintain current to prevent a decrease in most recent Annual MDS 07/14/2021, Section G: evealed the resident had so in ROM on one (1) side tremity. Additional review is, revealed the resident had a cture; unspecified hand. If Section O: Special area and Programs, revealed as even (7) days of a Programs, for brace or splint ons of Resident #77, on 2021; 08/11/2021; and do his/her right hand was brace or splint. Further review or drevealed documented or inconsistently implemented a regimen with interventions, ent to maintain current	F	388	reviewed by the Interestident required so additional therapy seferrals for screen as needed. On 09/09/27/21, the Direct and/or MDS nurses serviced department activities, social work AP, maintenance, homedical records) ar regarding "Mobility ambulation, including ambulation, including ambulation, including the Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Residen	nine If the reening for ervices. ing were made 16/21 through or of Nursing proactively interesting the ads (nursing k, dietary, AR, ousekeeping, d nurses transfer and g walking.", MDS nurse will esponse Analysis Change MDS submission ks, then monthly by resident with a be reviewed by e if a referral to This process will collect will be nthly Quality ance i) committee recommendation.

functional status or to prevent a decrease in

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F 688	review revealed the outline restorative of and objectives, white resident-centered, ability required an attention and treat should notify the Ridecline occurred in mobility to ensure a manner. 1. Review of Resident revealed the facility 07/28/2017, with did Major Depressive Dischizoaffective Dischi	care and services. Continued a resident's Care Plan would goals with expected outcomes, ch were individualized and Further, a decline in functional assessment by the licensed a therapy referral for timent. The RNP SRNA NP nurse immediately when a functional abilities (i.e.) appropriate action in a timely admitted the resident, on agnoses including Dementia, Disorder, Arthritis, and order. It #13's Admission MDS 108/04/2017, Section C: revealed the resident was a Brief Interview for Mental e of three (3) of fifteen (15), ognitive impairment. If Section G: Functional Status, and had no functional limitations or lower bilateral extremities. Int, the resident was ambulatory mobility device. Further, the extensive assistance of one (1) of Daily Living (ADL) such as fer, dressing, toileting, personal actional therapy minutes,	F	388			
	Progress and Disci	harge Summary, dated					

STATEMENT OF DEFICIENCES (IX) PROVIDERSUPPLIERCIA IDENTIFICATION INMOSER. 185028 NAME OF PROVIDER OR SUPPLIER JOHNSON MATHERS RURSING HOME STREET ADDRESS, CITY, STATE, 2IP CODE 2232 CONCRETE ROAD CARLISE, IXY 40311 (XI) D SUMMARY STATEMENT OF DEFICIENCES PREPRING RECOURTED BY FULL REGOLATORY OR LSC DENTIFITING INCORMATION) FOR D PROVIDER OR SUPPLIER JOHNSON MATHERS RURSING HOME STREET ADDRESS, CITY, STATE, 2IP CODE 2232 CONCRETE ROAD CARLISE, IXY 40311 FOR D PROVIDERS PLAN OF CORRECTION BY COMPACTION OF CORRECTION RECOURTED BY FULL REGOLATORY OR LSC DENTIFITING INCORMATION) FOR D PROVIDERS PLAN OF CORRECTION BY COMPACTION OF CORRECTION RECOURTED BY FULL REGOLATORY OR LSC DENTIFITING INCORMATION) FOR D PROVIDERS PLAN OF CORRECTION BY COMPACTION OF COMPACTION OF COMPACTION OF COMPACTION OF COMPACTION OF COMPACTION OF COMPACTION OF COMPACTION OF COMPACTION OF COMPACTION OF COMPACTION OF COMPACTION OF COMPACTION OF COMPACTION OF COMPACTION OF COMPACTION OF COMPACTION OF COMPACTION OF COMPACTION OF COMPACTION OF COMPACTION OF COMPACTION OF COMPACTION OF COMPACTION OF COMPACTION OF COMPACTION OF COMPACTION OF COMPACTION OF COMPACTION OF COMPACTION OF COMPACTION OF COMPACTION OF COMPACTION OF COMPACTION OF COMPACTION OF COMPACTION OF COMPACTION OF COMPACTION OF COMPACTION OF COMPACTION OF COMPACTION OF COMPACTION OF COMPACTION OF COMPACTION OF COMPACTION OF COMPACTION OF COMPACTION OF COMPACTION OF COMPACTION OF COMPACTION OF COMPACTION OF COMPACTION OF COMPACTION OF COMPACTION OF COMPACTION OF COMPACTION OF COMPACTION OF COMPACTION OF COMPACTION OF COMPACTION OF COMPACTION OF COMPACTION OF COMPACTION OF COMPACTION OF COMPACTION OF COMPACTION OF COMPACTION OF COMPACTION OF COMPACTION OF COMPACTION OF COMPACTION OF COMPACTION OF COMPACTION OF COMPACTION OF COMPACTION OF COMPACTION OF COMPACTION OF COMPACTION OF COMPACTION OF COMPACTION OF COMPACTION OF COMPACTION OF COMPACTION OF COMPACTION OF COMPACTION OF COMPACTION OF COMPACTION OF COMPACTION OF COMPACTION OF COMPACTION OF COMPACTION OF COMPACTION OF COMP			& MEDICAID SERVICES				MB NO. 093	8-0391
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ENGINEER FOR 6017 JOHANAS BALLAN MILL TL.		unable to transfer of Continued review revidence of an assist ROM of the bilateral knees. Further, the demonstrate optimal appropriate seating proper positioning upromote optimal poincrease out of bed status. Review of Resident Discharge Summar the resident progreschalr (addressed missues) up to one (1 bed with supervision resident was dischardal as a device to positioning. Howevevidence of an assist ROM of the bilateral knees. Observation of Res 4:11 PM, revealed to thin throw over his/lextremities; bilatera at the knees and the right leg. Additional observation, revealed the resurcovered from the bilateral lower extre Further, at rest, the greater than the right leg.	or ambulate without assistance. Everaled no documented assement of the resident's at lower extremities; hips and a goal for the resident was to all positioning in the most system while maintaining up to two (2) hours a day to sitioning for ADL's and time to improve functional time to improve functional with a first of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of t	F	588			

PRINTED: 10/11/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION 185028	CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				O		APPROVED . 0938-0391
NAME OF PROVIDER OR SUPPLIER JOHNSON MATHERS NURSING HOME (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH OPERICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 688 Continued From page 250 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 apan. Further, when RN #6 statenghed to move the resident's left leg crossed of the right to grab the nurse's hands. When the resident was at rest, the resident's left leg rolled to the right to grab the nurse's hands. When the resident was at rest, the resident #13's legs were severely contracted. Per the interview, the resident had a decline in December of 2020 and had not been ambutatory 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 chalr at the bedside.			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	·				(X3) DAT	E SURVEY
JOHNSON MATHERS NURSING HOME (X4) ID REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 688 Continued From page 250 resident's legs touched each other, and the left leg crossed the right leg. The nurse stated the billateral 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's left leg off the right leg. The nurse's hands. When the resident was at rest, the resident's left leg off the right leg. 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, revaled 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 #8 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.			185028	B. WING	+				
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WITH THE PREFIX PROVIDERS PLAND F CORRECTION SHOULD BE CAD'S REFERENCED TO THE APPROPRIATE DEFICIENCY) F 688 Continued From page 250 resident's legs touched each other, and the left leg crossed the right leg. The nurse stated the billateral quadriceps were tight, and there was resistance 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'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 residents with limitations in ROM. Further, RN #6 stated the SRNA's provided ROM to residents with limitations in ROM. Further, RN #6 stated the was important to provide care to resident \$43.00 pm. 108/12/2021 at 3:41 PM, revealed the resident was not able to control normal alignment of his/her legs. 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.	NAME OF	PROVIDER OR SUPPLIER			STR	LEET ADDRESS, CITY, STAT	E. ZIP CODE	U9/	02/2021
F 688 Continued From page 250 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 legs apart. Further, when RN #6 attempted to move the resident's left leg off the right leg, 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 #8 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 residents to meet their needs and ensure quality care.	JOHNSO	N MATHERS NURSIN	IG HOME		l .				
resident's legs touched each other, and the left leg crossed the right leg. The nurse stated the billateral 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 stitting up in his/her Evolution chair at the bedside.	PREFIX	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE CROSS-REFERENCED	ACTION SHOULD TO THE APPROP	BE	COMPLETION
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 tweive (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	F 688	resident's legs toucleg crossed the righbilateral quadriceps resistance when try knees and when try legs apart. Further move the resident's resident moaned at nurse's hands. What the resident's left le right leg, and the renormal alignment of the revealed Resident's contracted. Per the decline in December ambulatory since the SRNA's provide limitations in ROM. Important to provide their needs and ensured the resident's right however, the resident's right however, the resident air, at rest. The knee was resting a linterview with State (SRNA) #19 (workeyears), on 08/12/20 was often assigned #13. Per the interview to his/	thed each other, and the left at leg. The nurse stated the awere tight, and there was ring to move the resident's ring to move the resident's ring to move the resident's ring to move the resident's ring to move the resident's ring to move the resident leg, the right leg, the right leg the resident was at rest, ring rolled to the right over the resident was not able to control of his/her legs. 16, on 08/12/2021 at 3:06 PM, #13's legs were severely resident had a ref 2020 and had not been right. Additionally, RN #6 stated at ROM to residents with rurther, RN #8 stated it was recare to residents to meet sure quality care. 15, on of Resident #13, on PM, revealed the resident Evolution chair at the bedside. I foot was resting on the floor, ant's left leg was bent at the resident's foot was suspended in resident's left leg bent at the bove the resident's right knee. 16, Registered Nurse Aide resident's left leg bent at the bove the resident's right knee. 17, Registered Nurse Aide resident at the resident of the resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resident resi	F	588				

PRINTED: 10/11/2021

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILC		DNSTRUCTION	(X3) DAT	TE SURVEY MPLETEO
		185028	B. WING			09	C 1/02/2021
NAME OF P	PROVIDER OR SUPPLIER			STAE	ET ADDRESS, CITY, STATE, ZIP CODE		100000
OSNHOL	N MATHERS NURSIN	IG HOME		l	CONCRETE ROAD LISLE, KY 40311		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE	(XS) COMPLETION DATE
F 688	was not on the there had not been seen and not been seen and not been seen and not been seen and not been seen and not been seen and not seen assessed on admission. She state assessed on admission and a decline in a therapy would not retherapy department identify and communification and the election of the election and the election and the election and the election and the election and the election and the election and the election and the election and the election and the election and the election and the election and the election and the election and the election and the election and the election and the election and the election and the election and the election and the election and the election and the election and the election and the election and the election and the election and the election and the election and the election and the election and the election and the election and the election and the election and the election and the election and the election and the election and the election and the election and the election and the election and the election and the election and the election and the election and the election and the election and the election and the election and the election and the election and the election and the election and the election and the election and the election and the election and the election and the election and the election and the election and the election and the election and the election and the election and the election and the election and the election and the election and the election and the election and the election and the election and the election and the election and the election and the election and the election and the election and the election and the election and the election and the election and the election and the election and the election and the election and the election and the election and the election and the election and the election and the election and the election and the election and the election and the election and the election and the elec	any caseload currently and in therapy for a very long time, he was not aware if Resident in ROM to his/her bitateral he resident was ambulatory on ated all residents' ROM was sion, but unless nursing staff a resident's functional status, eassess routinely. The trelied on nursing staff to unleate declines/changes in the residents to therapy via a tronic Health Record (EHR); not of functional status, uld be completed. Further, and assistance to maintain tures to prevent skin integrity int alignment, manage pain, intain further developing of set (MDS) Coordinator (at the years), on 08/13/2021 at 2:51 g the Assessment Reference ould make observations of ould be documented in a lote. Additionally, she stated, and in a resident's functional nould be made to the therapy are appropriate and timely on ensure the needs of the		588			
	#13 had a significar 2020; was palliative	Further, she stated Resident nt change in December of a care and had a decline in the stated the resident was no					

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OMAR A	IO. 0938-0391		
STATEMENT	OF DEFICIENCIES IF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL		ECONSTRUCTION	(X3) D	(X3) DATE SURVEY COMPLETED		
		185028	B. WING			1,	C 09/02/2021		
	PROVIDER OR SUPPLIER N MATHERS NURSIN	IG HOME		23	TREET ADDRESS, CITY, STATE, ZIP CODE 323 CONCRETE ROAD ARLISLE, KY 40311		33/42/2021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	DK	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPL DEFICIENCY)	ULD BE	(X5) COMPLETION DATE		
	during stretching; a degrees in ROM in Additionally, the res RNP for orthotic maprovided caregiver decreasing increasing increasing increasing increasing increasing increasing increasing and ensuring comp decrease the reside breakdown and furth hand contracture. Review of Resident 03/18/2020, reveals assistance and had maintain function of closing of the left haresident would not if upper extremity (left included encourage passive ROM, date interventions included onning the left pair splint three (3) to fo to and after removing week for twelve (12 Further intervention not participate in the document the reason However, there was facility consistently in treatment to maintate prevent a decreasing Review of Resident	ased pain to the left hand and improvement of ten (10) the left hand joints. Ident was discharged to the imagement. Further, OT training focused on ed contracture to the left hand letion of the RNP plan, to ent's risk for potential skin ther development of the left #77's CCP, initiated on ed the resident required potential to restore or imobility by opening and end. The goal was the hand). Interventions the resident to participate in do5/20/2020. Additional ed hand hygiene prior to mar orthotic; donning of the ur (4) hours; check skin prior ng the splint six (6) days a weeks, dated 03/18/2020. Included, if the resident did a splint/brace program, on, dated 03/18/2020.	FE	688					
	revealed no docume	ented evidence the resident							

		& MEDICAID SERVICES					Q. 0938-0391	
AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		CONSTRUCTION	(X3) D/	(X3) DATE SURVEY COMPLETED	
		185028	B. WING			1	С	
NAME OF	PROVIDER OR SUPPLIER		D. Trices		REET ADDRESS, CITY, STATE, ZIP CODE	_ 0:	9/02/2021	
JOHNSC	ON MATHERS NURSIN	IS HOME			23 CONCRETE ROAD			
	TO THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF				ARLISLE, KY 40311			
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F 688	Continued From pa provided.	ge 256	F	888				
	Assessment, dated Cognitive Patterns, assessed to have a Status (BIMS) score indicating severe conditional review of revealed the resident ROM on one (1) side bilateral extremities, required extensive a Activities of Daily Limbbility, transfer, are assistance of one (1) personal hygiene; all staff for eating. The occupational therapy splint and brace assistender (15) mir calendar days.	#77's Annual MDS 07/14/2021, Section C: revealed the resident was Brief Interview for Mental e of seven (7) of fifteen (15), agnitive impairment. Section G: Functional Status, at had functional limitations in e, for upper and lower . Further, the resident assistance of two (2) staff with wing (ADL) such as bed ad toileting; extensive b) staff for dressing and and total assistance of one (1) b) resident did receive y, ending on 03/09/2020 and distance seven (7) days for at autes in the last seven (7)						
	08/09/2021 at 4:28 I left hand was edem: folded down onto the	on of Resident #77, on PM, revealed the resident's atous and his/her fingers were a palm at rest. The resident of device on his/her left hand.						
	08/10/2021 at 12:20 left hand was closed	on of Resident #77, on PM, revealed the resident's I in a fist. The resident was lice on his/her left hand.						
	08/11/2021 at 9:50 A left hand was closed fingers folded onto the	on of Resident #77, on M, revealed the resident's I in a fist at rest with his/her he palm. The resident was ice on his/her left hand.						

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 10/11/2021 CENTERS FOR MEDICARE & MEDICAID SERVICES **FORM APPROVED** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING_ COMPLETED 185028 B. WING 09/02/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2323 CONCRETE ROAD **JOHNSON MATHERS NURSING HOME** CARLISLE, KY 40311 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION tn (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION DATE PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) 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 aldes 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

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

STATEMENT	T OF DEFICIENCIES	- WILDIONID SCRVICES					<u> </u>
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING			(X3) DATE SURVEY COMPLETED				
		185028	B. WING	·			C
NAME OF	PROVIDER OR SUPPLIER				STREET ADDI	RESS, CITY, STATE, ZIP CODE	09/02/2021
JOHNSO	ON MATHERS NURSIN	IG HOME		:	2323 CONCR	RETE ROAD	
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F 688	treatments to reside functioning level an without functional li	ge 260 cant to provide services and ents to keep their highest d to ensure those residents, mitations, remained at exith limitations did not	F 6	688	3		
F 689 SS=G	Free of Accident Ha CFR(s): 483.25(d)(azards/Supervision/Devices 1)(2)	F	589)	F 689	
	as free of accident §483.25(d)(2)Each supervision and assaccidents.	sure that - resident environment remains hazards as is possible; and resident receives adequate sistance devices to prevent				During the week of 9, 9/17/21, Residents # #240 and #245 were the quality improvem to determine if the ap of supervision was in any assistance device present. All residents have the affected. During the verthrough 9/17/21, the nurse supervisor and completed an assess facility residents to er appropriate level of s and/or needed assist	13, #22, #80, assessed by ent (QI) nurse epropriate level place and/or es were epotential to be week of 9/13/21 DON, UM, i MDS nurses ement of all insure the eupervision iive devices
	by: Based on observat the facility's policies failed to ensure eac free from accident t had control; and fail assistive devices to	ion, interview, and review of ion, interview, and review of it was determined the facility he resident's environment was azards over which the facility ed to provide supervision and each resident to prevent for five (5) of forty-four (44)				were present. Any re have the incorrect lev supervision had their updated. Any resider assistive device had provided and care pla	vel of care plan nt missing an the item

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			C	MB NO. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILC		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		185028	B, WING	,		C 09/02/2021
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 202/20/100
JOHNSO	N MATHERS NURSIN	IG HOME		23	23 CONCRETE ROAD ARLISLE, KY 40311	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 689	revealed Resident is 02/23/2021, 03/13/3 of the fall investigat were not updated or with interventions to the findings include Review of the facility Protocol," dated 02 would be assessed re-admission, quant change. Continued with falls who were would be assessed residents at risk for initiated related to fine Per the policy, falls determine the root investigation was called falls should be revisited by the Comprovement (QAP 1. Review of a Per Job Description and updated on 11/23/2 beyond a one-persiassist and must be staff member." The and the DON on 12 Review of Resident revealed the reside facility, on 03/26/20	itial Fall Incident Reports #245 had falls on 02/19/2021, 2021, and 03/19/202. Review ions revealed fall interventions in the CCP in a timely manner of help prevent future falls. Exists policy titled, "Falls /04/2021, revealed residents for fall risk on admission, ierly and with a significant it review revealed residents not identified as a fall risk for fall risk. Additionally, falls would have a care plan alls with multiple interventions, would be investigated to cause and validate that an ompleted. Further, trends with eard (IDT); and findings should ituality Assurance Performance (IDT) meeting. sonal Care Assistant (PCA) of Training Form for PCA #2, 1020, revealed "for anything on transfer, the PCA may only directed by a certified/licensed as form was signed by PCA #2 1/21/2020.		589		
		ified, Unspecified Atrial rbid (Severe) Obesity due to				

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

	to I OIT INCOIDMINE	G MEDICAID SERVICES				NIR MC	. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		ONSTRUCTION		TE SURVEY MPLETED
		165026	B. WING			09	C /02/2021
	ROVIDER OR SUPPLIER N MATHERS NURSIN	IG HOME		2323	ET ADDRESS, CITY, STATE, ZIP CODE CONCRETE ROAD LISLE, KY 40311		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT! (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D 9E	(XS) COMPLETION DATE
F 689	Continued From pa the rail, resulting in notified the nurse to possible.	ige 264 a fall. PCA #2 revealed she come help as soon as	F	889			
	revealed she was or room on 01/27/202 floor on his/her bac statement revealed hold on." LPN #17 completed a head to and noted skin tear	as Statement from LPN #17 called into Resident #240's 1, and noted resident on the like between the beds. LPN #17 I Resident #240 sald "I couldn't statement revealed she to toe assessment of resident, to right lower arm, skin tear to prasion to left elbow, and skin eft foot.					
	revealed she was of with SRNA #12 and LPN #2 to help bed the floor. SRNA #1	ss Statement from SRNA #11 doing rounds on 01/27/2021 of SRNA #12 yelled for her and cause Resident #240 was in 11 stated PCA #2 was changing on Resident #240 slipped out of					
	revealed she was l	ss Statement from SRNA#12 in the halfway when someone on arrival at room Resident or.					
	on 07/27/2021 at 1 not allowed to char	Social Services Director (SSD) 0:29 AM revealed PCA's were nge residents. She revealed and had a sheet that covered re allowed to do.					
	07/27/2021 at 1:15 begun utilizing PC/went on to reveal F	lity Consultant #1 on i PM revealed the facility had A during the pandemic. She PCA's were allowed to assist ig residents, but were not					

		& MEDICAID SERVICES	,			<u>DMB NC</u>), 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		LE CONSTRUCTION		TE SURVEY MPLETED
		185028	B. WING			08	C 0/02/2021
NAME OF	PROVIDER OR SUPPLIER			5	TREET ADDRESS, CITY, STATE, Z'P CODE		100,400
					2323 CONCRETE ROAD		
JOHNSO	IN MATHERS NURSIN	IG HOME					
				L.	CARLISLE, KY 40311	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LDBE	(X5) COMPLETION DATE
E 690	Continued From	- 000					
L 003	Continued From pa		F	589			
	01/27/2021, she an	d SRNA #12 had informed					
	PCA#2 not to do a	nything on her own, not to					
	provide any resider	nt care without one of them					
		e and SRNA #12 were down					
		xt thing they knew PCA #2					
	was yelling that Res	sident #240 was In the floor.					
	Internal accounts to 1966						
	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	e assisting the SRNA's, she					
	assisted the Courte	esy Aides. She revealed she one-on-one (1:1) when asked					
	to do so by overing	staff. She revealed she never					
		r transferring of residents on					
	her own.	r dansierring of residents on					
	Attempts to reach !	PN #17 during the course of					
	the survey were un	successful.					
		OON, on 08/04/2021 at 8:28					
	AM, revealed PCA'	s could not provide resident					
		She revealed PCA's could					
		evealed after Resident #240					
	fell out of bed, while	e a PCA was changing					
		ere reeducated on what PCA's					
	could and could no	ł do.					
	Intenders det de e						
		DC, on 08/04/2021 at 2:58					
	Pivi, revealed PCA	#2 should not have been trying					
	offered to consider	t #240, as PCA's were not					
	Illegated to provide	resident care without a					
		ber present, and PCA #2 had					
	Posidont #040	nd knew that. She revealed					
	helshe sould be to the	a one (1) person assist, as					
	rievana conta tierb t	turn and reposition.					
	Interview with RN #	7, the MDS Coordinator, on					
	08/04/2021 at 3:29	PM, revealed prior to					
	01/27/2021, Reside	ent #240's care plan might not					

CENTER	S FOR MEDICARE	& MEDICAID SERVICES				MB NO.	0938-0391
STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILO		CONSTRUCTION	(XJ) DATE SURVEY COMPLETED	
		185028	B. WING			1	C 02/2021
NAME OF F	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE	1 027	0412021
IOHNSO	N MATHERS NURSIN	IO HOME		ľ	3 CONCRETE ROAD		
				CA	RLISLE, KY 40311		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	assistance of two (2) Assessment, the reimpaired balance of surfaces, and could assistance. Further had not fallen since the resident 10/02/2020, revealed falls with injury and as impaired cognition 10/02/2020. The gree of serious injurrevealed intervention the resident to weather to distract to snack (10/02/2020) within easy reach (10/02/2020) within reach and arwinged mattress (0) (08/11/2021).	arsonal hygiene; and total 2) staff for toilet use. Per the sident did not ambulate, had uring transitions between it only stabilize with staff or review revealed the resident of the prior Assessment. If #13's CCP, revised on the resident had a history of had multiple risk factors, such on and an actual fall on the prior Assessment would be an are the resident would be a from falls. Further review the prior falls. Further review the resident with candy and/or it plasses (07/14/2020); the resident with candy and/or it have commonly used articles 07/14/2020); keep call light iswer timely (07/14/2020); 7/29/2021); and high low bed	F	389			
	dated 05/10/2021, the resident to have Evaluation, a total s	t #13's Fall Risk Evaluation, revealed the facility assessed a a score of ten (10). Per the score of ten (10) or higher ent was at risk for falls and red.					
	Form, dated 07/22/ Practical Nurse (LF 07/22/2021 at 5:22 occurrence in his/h the floor. The resident hetwo (2 resident had no inju	ent #13's Fall Incident Report 2021, signed by Licensed PN) #9, revealed on PM, the resident had a fall er room, falling from the bed to lent was sitting on the floor) beds. Per the report, the uries or pain. Continued e resident was unable to give a					

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

		TO INCOMPAND OF LANGER				CIND	140.0330-0331
STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		ONSTRUCTION	(XX	3) DATE SURVEY COMPLETED
		185028	B. WING				C 09/02/2021
NAME OF F	ROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE		VUIVALAUA I
JOHNSO	N MATHERS NURSIN	IG HOME		2323	CONCRETE ROAD		
				CAR	RLISLE, KY 40311		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	
F 689	revealed, on 07/23, had a fall occurrent the bed to the floor the floor between the blanket and sheet, was soiled with a buttocks were red; had been provided revealed the reside description of the einjury. Continued refurther Immediate at Review of Resident dated 07/23/2021, the resident to havindicating the resident to havindicating the resident to the latest to return the category. The State Survey / 08/15/2021 at 3:25 #16 related to the LPN #16 was not a left to return the category. Summary, dated of the fall event), sign Nurse, revealed or noted sitting his/heblanket and sheet actions taken durir head to toe assess revealed no injury, provided the reside was assisted by twinged mattress winged mattress winged mattress winged mattress winged mattress.	2021, signed by LPN #16, /2021 at 5:15 AM, the resident ce in his/her room, falling from the two (2) beds with the bed. Per the report, the resident lowel movement and his/her however, incontinence care at 3:00 AM. Continued review ent was unable to give a svent, and the resident had no review revealed there was no action taken. It #13's Fall Risk Evaluation, revealed the facility assessed e a score of fifteen (15), lent was at risk for falls and ired. Agency (SSA) Surveyor, on is PM, attempted to contact LPN Fall Incident on 07/23/2021.	F	889			
	prevent further fall	s from the bed. Further the					

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CENTERS FOR MEDICARE	OMB NO, 0938-0391						
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTR	RUCTION			SURVEY PLETED
	185028	B. WING			_	1	02/2021
NAME OF PROVIDER OR SUPPLIER			STREET AD	DRESS, CITY, STAT	TE, ZIP COOE		
JOHNSON MATHERS NURSI	IG HOME			CRETE ROAD E, KY 40311			ļ
PREFOR (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	X (E	PROVIDER'S PLAN EACH CORRECTIVE DSS-REFERENCED		BE	(X3) COMPLETION DATE
Nurse, revealed, o noted sitting on the his/her back restin Additionally, the additionally, the additionally, the additionally, the additionally, the additionally, the additionally, the additionally, dycem the resident was a the Evolution chair related to safety at Dementia. Contin resident believed I Independently but unable to do so. Tout of the Evolutionalone, which constitute chair. However, there was CCP was revised after the fall occur PM. Interview with LPh revealed, after a fresponsibility to in Immediately to dethe same nature, revised to Include ensure continuity should have had his/her Evolution fall event. Per the the CCP to include Observations of Ferritages.	age 272 sed by the Quality Indicator in 07/24/2021, the resident was a floor on his/her buttocks with g against the dresser. Ittlons taken during the sted a head to toe assessment revealed no injury. Per the was placed in the chair, and ssisted by two (2) staff back to for Further, the root cause was wareness secondary to used review revealed the ne/she could still ambulate was unsteady, weak, and the resident attempted to get in chair and go to the bathroom equently caused the fall out of as no documented evidence the to include dycem to the chair rence, on 07/24/2021 at 5:40 I #3, on 08/15/2021 at 3:15 PM, all event, it was the nurse's inplement an intervention crease the risk of another fall of Additionally, the CCP should be the immediate intervention to of care. Further, Resident #13 dycem consistently placed on chair seat after the 07/24/2021 at interview, she forgot to revise e dycem after the fall. Resident #13, on 08/09/2021 at 021 at 9:35 AM; and 08/12/2021		589				

at 3:06 PM, revealed there was no dycem in the

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILC		CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		185028	B. WING			00	C 0/02/2021
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		1022021
JOHNSO	N MATHERS NURSIN	G HOME		233	23 CONCRETE ROAD ARLISLE, KY 40311		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LDBE	(X5) COMPLETION DATE
F 689	safe and to meet the she was not aware to the chair seat to out of the chair. 3. Review of Resider revealed the facility 04/17/2019, with dispending the properties of Resident Physician's Orders, evidence of fall interpretative Bladder Review of Resident Physician's Orders, evidence of fall interpretative assessment, dated facility assessed Resident on the properties of the Significant of the Significant of the Significant of the Significant of the Significant of the Significant of the Significant of the Significant of the Significant of the Significant of the Significant of the Significant of the Significant of the Significant of the Significant of the Significant of the Significant of the Significant of the Significant of the Significant of the Significant of the Significant of the Significant of the Significant of the Significant of the Significant of the Significant of the Significant of the Significant of the Significant of the Significant of the Significant of the Significant of the Significant of the Significant of the Significant of the Significant of the Significant of the Significant of the Significant of the Significant of the Significant of the Significant of the Significant of the Significant of the Significant of the Significant of the Significant of the Significant of the Significant of the Significant of the Significant of the Significant of the Significant of the Significant of the Significant of the Significant of the Significant of the Significant of the Significant of the Significant of the Significant of the Significant of the Significant of the Significant of the Significant of the Significant of the Significant of the Significant of the Significant of the Significant of the Significant of the Significant of the Significant of the Significant of the Significant of the Significant of the Significant of the Significant of the Significant of the Significant of the Significant of the Significant of the Significant of the Significant of the Significant of the Significant of the Significant of	rironment to keep the resident eir needs. Further, she stated the resident required dycem prevent him/her from sliding ent #22's medical record admitted the resident, on agnoses that included Disorder, Atrial Fibrillation, ne, Pseudobulbar Affect, and Hypertension. #22's Monthly March 2021 revealed no documented		5689			
	perception of aware	eness/surroundings, and lications. The resident had a					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X1) CAT	. 0938-0391
	E SURVEY
486329	C /02/2021
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	14212021
JOHNSON MATHERS NURSING HOME 2323 CONCRETE ROAD CARLISLE, KY 40311	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETION DATE
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	

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STATEMENT AND PLAN 0	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUI A. BUILD		CONSTRUCTION		(X3) DATE SURVEY COMPLETED
		185020	B, WING	i			C
NAME OF F	ROVIDER OR SUPPLIER			-	REET ADDRESS, CITY, STATE, ZIP COD		09/02/2021
						E	
JOHNSO	N MATHERS NURSIN	IG HOME			23 CONCRETE ROAD ARLISLE, KY 40311		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD	BE COMPLETION
F 689	o6/24/2021 revealer falls and had multip Depression, medical cardiovascular, and The goal was the reserious injury from interventions which wheelchair, wheelchair, wheelchair, wheelchair, wheelchair, wheelchair, wheelchair, wheelchair aglass and at bed time (07/02/2021); enconon-skid footwear (articles within easy the resident a glass and at bed time (07/02/2021); the resident to have the Evaluation, a to indicated the reside follow up was required follow up was required and afall occurrent resident was lying with regular socks resident suffered signed the reside get some water, low water, took a step immediate action to provided first aid at a wheelchair.	at #80's CCP, revised on and the resident had a history of alle risk factors such as atton (antidepressant, if a diuretic), and an actual fall, esident would be free of falls. Further review revealed a Included anti roll back on the hair properly fit for resident urage resident to wear (06/08/2021); commonly used reach (08/26/2020); and give a of ice chips between meals 7/15/2021). It #80's Fall Risk Evaluation, revealed the facility assessed a score of fourteen (14). Per stall score of ten (10) or higher ent was at risk for falls and ired. It #80's Fall Incident Report (2021, signed by the QI Nurse, 1/2021 at 2:00 PM, the resident ce in his/her room. The cent his/her right side in the floor on. Per the report, the kin tears to bilateral elbows the end fell. Further, the laken was the resident was and assisted by two (2) staff into	F	589			
	review of Residen	t #80's Fall Risk Evaluation,					

dated 07/01/2021, two (2) days after the fall on

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILO		E CONSTRUCTION		E SURVEY IPLETED
		185028	8. WING	ı			C
NAME OF B	ROVIDER OR SUPPLIER			_		09/	02/2021
(pane or)	TO TIDEN ON JOIN PLEN				TREET ADDRESS, CITY, STATE, ZIP CODE		
JOHNSO	N MATHERS NURSIN	IG HOME		ŀ	323 CONCRETE ROAD		
					CARLISLE, KY 40311		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(XŠ) COMPLETION DATE
F 689	Continued From pa	tne 280	C 4	689			
,	,	_	F (308			
	facility practices we	e the Fall Protocol policy and ere maintained to ensure					
	residents were nro	vided safe care and to reduce					
	their risk for injury.	vided sale cale alld to reduce					
	mon new tot injery.						i
	Interview with the D	OON, on 08/31/2021 at 2:31					
	PM, revealed Resid	dent #13's CCP should have					
	been revised more	timely with interventions for					
		/23/2021, and 07/24/2021 fall					
		Investigation Summary(les)					
		id have been more timely.					
		esident #22's Fall Risk					
	Evaluation and CC	P revisions should have been					
		03/04/2021 fall event. The					
		ent #80's Fail Investigation Prevision should have been					
		08/29/2021 fall event,					
	-						!
		dent #245's medical record					
		admitted the resident, on					
	Disease Major Do	agnoses including Parkinson's pression, Dementia, and					
	District Mallitus 7	pression, Demenda, and Type 2. Review of the Quarterly					
	Minimum Data Set	(MDS) Assessment, dated					
	02/28/2021, reveal	ed the facility assessed the					
	resident as having	a Brief Interview for Mental					
		our (4) out of fifteen					
		ere cognitive impairment.					
		evealed in Section G the					
		(1) person assist for bed					
		ansfers. The resident used					
		walker and wheelchair. Further					
	review of section G	revealed the resident was not					
	steady for moving	from seated to standing					
	position, walking, t						
		transfers between bed and					
		er, the resident was able to					
l .	SCHOOLER WILLOUG SC	aff. Review of section J					

revealed the resident had not expressed pain

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILO		NSTRUCTION		ATE SURVEY DMPLETED
		185028	B. WING			0:	C 9/02/2021
	ROVIDER OR SUPPLIER N MATHERS NURSIN	IG HOME		2323 (T ADDRESS, CITY, STATE, ZIP CODE CONCRETE ROAD LISLE, KY 40311		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 689	Continued From pa	age 282	F	189			-
	02/23/2021, reveals sign to remind the obathroom. The International the care plan, until was completed. Review of Residen 03/13/2021, reveals sure no pillows were that dycem was in care plan, until 03/3 completed. Review of Residen 03/19/2021, reveal	t #245's Fall investigation, on ed the intervention to place a residents it was a shared ervention was not updated on 03/11/2021, after the report t #245's Fall Investigation, on ed the intervention to make re in the wheelchair seat and place was not updated on the 25/2021, after the report was t #245's Fall investigation, on ed an intervention to obtain ysician for blood work to					
	determine if there is falls, after the repo 03/24/2021. Howe	was an underlying cause of the rt was completed on ever, review of the Physician's are was no blood work ordered.					10
	dated 03/24/2021, fallen and notified himself/herself bac fall investigation st assessed, but it wa of leg pain that an	ident #245's Fall investigation, revealed the resident had staff that he/she had gotten ik up. Continued review of the nowed the resident was as not until he/she complained x-ray was obtained, and he/she nergency Department (ED) for					
	dated 03/26/2021, not a good historia had a fall. The fact been a fall the day	nt #245's ED medical record, revealed Resident #245 was in and could not state if he/she illity reported there might have before. Continued review of led Resident #245 was					

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES					IO. 0838-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUL		ONSTRUCTION	(X3) D	ATE SURVEY OMPLETED
		185028	B. WING				C
	PROVIDER OR SUPPLIER IN MATHERS NURSIN	IG HOME		2323	ET ADDRESS, CITY, STATE, ZIP COD CONCRETE ROAD RLISLE, KY 40311)E) 9/02/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	HOULD BE	(XS) COMPLETION DATE
F 689	Nurse, Activities, TI (MDS) Nurse) revise ensured the docum that the CCP was nappropriate interverevent, she stated the include an intervent reducing the risk of Qi Nurse stated shup the Fall Investigation Summittree (3) days of the investigation Summittree (3) days of the investigation and active when she was out of a backup staff member job duties and to follow-up was not continued in the dally Clinic reviewed fall events during the meeting, CCP was accurate based on the fall dediscussions. Further should be new Interfall event. However, since planned with a timely. However, since ponsible to revise Interview with the Difference was care planned with a timely. However, since ponsible to revise Interview with the Difference was care planned with a timely. However, since ponsible to revise Interview with the Difference was care planned with a timely. However, since ponsible to revise Interview with the Difference was care planned with a timely. However, since ponsible to revise Interview with the Difference was care planned with a timely. However, since ponsible to revise Interview with the Difference was care planned with a timely. However, since ponsible to revise Interview with the Difference was care planned with a timely.	Is (DON, Unit Managers, QI herapy, Minimum Data Set weed Fall incident reports and centation was thorough and centation was thorough and centation. Further, after each fall be CCP should be revised to clion to assist the resident with further falls and injury. The centen was responsible to type atton Summary with the sam (IDT) discussion. She practice was for the Fall heary to be completed within the fall event, to ensure a timely citions. The QI Nurse stated of the facility she did not have the who was responsible for that was the reason the fall	F	389			

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		185028	B. WING			C 09/02/2021
NAME OF I	PROVIDER OR SUPPLIER			STI	REET ADDRESS, CITY, STATE, ZIP CODE	U9/02/2021
ЈОНИЗО	N MATHERS NURSIN	IG HOME			23 CONCRETE ROAD ARLISLE, KY 40311	;
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	1D PREFI TAG	X	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DE COMPLETION
F 689	reduce the risk for it were completely tin updated timely. Fu	ensure there were attentions implemented limely to falls, that Fall Risk Evaluations nely, and that the CCP was other interview revealed the view in Morning Clinical	F6	389		
F 755 SS=K	Pharmacy Srvcs/Pr CFR(s): 483.45(a)(ocedures/Pharmacist/Records b)(1)-(3)	F7	755	F 755	
	drugs and biologica them under an agre §483.70(g). The fa personnel to admin	Services ovide routine and emergency als to its residents, or obtain ement described in cility may permit unlicensed ister drugs if State law ader the general supervision of			 On 07/19/21, staff nurses pain assessments on all tresidents including Resid#9, #17, #32, #34, #47, ##65, #69, #71, #79, #82 a concerns were identified. Any resident receiving a feet of the concerns. 	facility ents #1, #8, 48, #56, #60, and #84. No controlled
	pharmaceutical ser that assure the acc dispensing, and ad	ures. A facility must provide vices (including procedures urate acquiring, receiving, ministering of all drugs and the needs of each resident.			substance medication had to be affected. On 07/19/2 performed pain assessmentacility residents. No confidentified.	21, staff nurses ents on all
	§483.45(b) Service must employ or obto pharmacist who-	Consultation. The facility ain the services of a licensed			 On 07/19/21, the staff de- coordinator (SDC) initiate all licensed nurses and K 	d education for entucky
:	§483.45(b)(1) Provaspects of the prov the facility.	ides consultation on all Ision of pharmacy services in			Medication Aides (KMA) counts, narcotic count sh slips and logging narcotic	eets, packing s into the
	§483.45(b)(2) Estareceipt and disposi sufficient detail to e	blishes a system of records of lion of all controlled drugs in enable an accurate			narcotic books, On 07/12 Director of Nursing (DON education to include doc) expanded the

reconciliation; and

as needed (PRN) medications, labeling

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

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		OF INCESSOR INCOME.			CIND MO. VOCO-DOS	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (DENTIFICATION NUMBER:			(X2) MULT A. BUILDII	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185028	B. WING		C 09/02/2021	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
JOHNSON MATHERS NURSING HOME				2323 CONCRETE ROAD CARLISLE, KY 40311		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE COMPLETION	
			-			

F 755 Continued From page 288

- 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)

F 755

signatures were present on the packing slip when controlled substances were received. These audits will be completed 3 times per week for 4 weeks.

On 07/20/21, the DON, SDC, MDS nurses, Social Services Director (SSD) and Activities Director (AD) or support RN nurse began interviewing three (3) random residents with a BIMs of nine (9) or higher, weekly, to ensure they have no concerns with when or how their controlled substances are administered. On 07/21/21, the DON, UM, SDC, QI nurse, Weekend Supervisor, MDS nurses, Corporate RN or support RN, will audit storage and documentation of narcotics to ensure narcotics are stored appropriately and documentation is correct. These audits will occur five (5) times per week. Any concerns identified with any of these audits will be brought to the Administrator and/or DON for review at the morning Interdisciplinary Team (IDT) meeting. The IDT will review all audits on Friday and forward information obtained to the Quality Improvement Performance Improvement (QAPI) committee for review at their monthly meeting. All

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

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 093							<u>. 0938-0391</u>
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
185028		185028	B. WING			C 09/02/2021	
NAME OF F	ROVIDER OR SUPPLIER			STREE	T ADDRESS, CITY, STATE, ZIP CODE		
				2323 0	ONCRETE ROAD		
JOHNSO	N MATHERS NURSIN	IG HOME			ISLE, KY 40311		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)	D BE	(XS) COMPLETION DATE
F 755	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 290 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 filling 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			755	DEFICIENCY)		
		and Other Chronic Pain. The Resident #9, in an Admission					

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CENTE	RS FOR MEDICARE	E & MEDICAID SERVICES					UDJE-UJOED
STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILO		CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
		185028	B. WING	i			C
NAME OF	PROVIDER OR SUPPLIER		-	ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 08	9/02/2021
10111100					23 CONCRETE ROAD		
	N MATHERS NURSIN	IG HOME			ARLISLE, KY 40311		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 755	Continued From pa	age 292	F 7	755			
	sign for a second dose, and there was no		, ,	-			
	indication on the ba	ack of the MAR these doses					
	were given, for wha	at purpose, or whether or not					
	the doses were effe	ective. Continued review					
	revealed Resident	#9 would normally receive a					
	and 9:00 AM each	.5/325 mg between 8:00 AM					
	Interview with LPN	#12, on 08/13/2021 at 8:21					
	AM, revealed Resid	dent #9 took his/her					
	medication, would :	ask for it, knew what it looked					
	IKE, and knew wha	at pills he/she took. She laff members , including RN #1					
	and LPN #2, told he	er they had reported Resident					
	#9 not receiving his	s/her medications in June 2021					
	to the Administrator	r, although she was not aware					
	of the Administrator	r 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 tha	at he/she was not receiving					
	his/her medications	3. She stated Resident #9					i
	wanted his/her pair	pill and Klonopin, but she					
	was unable to give	It because they had been					
	sleded the DOM of	us shift. She revealed she that time, via text message of					
	Resident #9's allen	ation. LPN #9 stated Resident					
	#9 was not in any p	pain that morning, but his/her					
	routine was to rece	ive his/her PRN pain					
	medication in the m	norning.					
	Review of the Facil	lity Concern/Grievance Form,					
	dated 07/08/2021, I	initiated by Resident #9.					
	revealed the reside	ent 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 ta	king care of him/her. The					

previous Administrator was listed as the

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CENTERS FOR MEDICARE & MEDICAID SERVICES							M APPROVED	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) D	(XJ) DATE SURVEY COMPLETED	
		185028	B. WING	·_		,	C 9/02/2021	
NAME OF F	PROVIDER OR SUPPLIER			;	STREET ADDRESS, CITY, STATE, ZIP CODE		310212021	
JOHNSO	N MATHERS NURSIN	IG HOME		1	2323 CONCRETE ROAD			
				-	CARLISLE, KY 40311			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRI DEFICIENCY)	LD BE	(XS) COMPLETION DATE	
	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 294 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 Controlled Substance Count Record, initiated on 06/08/2021. Review of Resident #69's Controlled Substance Count Record, initiated on 06/08/2021. 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. Inlerview 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 been. RN #2 stated when Resident #69 had not bad his/her pain medications, he/she		Fi	755			4	
	was clear minded a	s/her pain medications, he/she and very alert. She stated if he/she had received his/her						

medications.