STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 296	F 755		

stated Resident #82 told her that he/she had not actually received the narcotics because, he/she had not needed any. RN #1 stated she examined Resident #82's narcotic sheet and discovered LPN #1 had signed out for one (1) Hydrocodone 5/325 mg on 06/19/2021, two (2) Hydrocodone 5/325 mg on 06/20/2021, and one (1) Hydrocodone 5/325 mg on 06/21/2021, which Resident #82 stated he/she had not received. She stated she showed the Administrator the MAR, and the Administrator stated this was "becoming a problem" and that Resident #9 had already "called the state on us." RN #1 stated the Administrator met with Resident #82 for about twenty (20) minutes, after which Resident #82 stated the Administrator told him/her she would get to the bottom of it, but as he/she had heard that before, he/she knew they "weren't going to do crap" about it. RN #1 stated Resident #82 usually took three (3) or four (4) Hydrocodone 5/325 mg a month for breakthrough pain.

Review of Resident #82's Medication Administration Record (MAR) for June 2021 revealed, on 06/19/2021, one (1) dose of Hydrocodone 5/325 mg was administered, followed by two (2) doses on 06/20/2021, and a fourth dose on 06/21/2021, all administered by LPN #1. Prior to that, Resident #82 had received a total of five (5) doses during the preceding three (3) weeks, with only two (2) doses on consecutive days. These four (4) doses were not signed out on the back of the MAR. Review of Resident #82's 07/2021 MAR revealed five (5) doses administered of Hydrocodone 5/325 mg, four (4) of which were on consecutive days. Further review revealed Hydrocodone 5/325 mg was administered, on 07/06/2021 and 07/13/2021, with no documentation on the back of the MAR

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

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F 755	Continued From page 298	F 755		

her about Resident #82, although there had been a grievance regarding the resident believing he/she was not getting pain medications that had been signed out during the night. She stated if someone had reported anything to her, she would have reported it to the Director of Nursing (DON). She stated if a nurse had a suspicion of drug diversion, the nurse should contact the DON immediately and initiate a grievance form. The SDC/QI said she would expect staff to follow the chain of command in reporting concerns, which would be nursing staff, herself, and the DON.

Interview with the DON, on 08/04/2021 at 8:28 AM, revealed the Administrator approached her after the grievance by Resident #82 and stated Resident #82 might not have received his/her medication. She stated the Administrator told her LPN #1 needed to be watched. The DON stated, in her review of the MAR's, she was unable to identify LPN #1 was signing out more PRN medications than other night shift staff.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185026	A. BUILDING _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 300	F 755		

Dementia without Behavioral Disturbance. The facility assessed Resident #17, in a Quarterly MDS Assessment, dated 05/17/2021, as a three (3) of fifteen (15) on the BIMS, indicating severe cognitive impairment. Continued review revealed 01/18/2021 physician's order for Percocet 5/325 mg every eight (8) hours as needed.

Continued interview with LPN #7, on 08/05/2021 at 9:09 AM, revealed she had suspicions regarding LPN #1 and was counting medications with her one evening and noted Resident #17 had one (1) Percocet left in a card and a second skid of thirty (30) Percocet. She revealed Resident #17 would have received one (1) Percocet that shift, and he/she should have had a full skid remaining when she returned the following morning. However, she stated, when she came to work the following morning, the second skid only contained twenty-nine (29) Percocet, and only one (1) had been signed out by LPN #1. She stated she reported this to the SDC/QI, although she was uncertain of the date, and did not say anything to LPN #1. LPN #7 stated the DON came and was auditing her cart later, and the DON shared she was doing so because a whole skid of Percocet was missing, not due to her report of a single Percocet missing.

Additional interview with LPN #7, on 08/14/2021 at 10:29 AM, revealed at shift change, staff counted the number of skids in the narcotics drawer and counted the number of Controlled Substance Count Records to ensure the numbers matched. Then, both nurses signed off on the Shift Change Controlled Substance Count Sheet at the front of the book. She stated she had never had a missing skid or a count be off, and if she did, she would get the DON or Administrator

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 302	F 755		

reported immediately to the DON. Regarding disposal of medication skids, she LPN #6 stated, the process was for the nurse to wrap the Controlled Substance Count Record around the medication skid, hand it to the DON, and sign the skid out on the Shift Change Controlled Substance Count Check. She revealed she never had any discrepancies in her medication cart when working with either LPN #1 or LPN #2.

Interview with SRNA/KMA #9, on 08/02/2021 at 2:55 PM, revealed narcotics were delivered at night, with one (1) nurse signing them in, then giving them to the nurse in charge of each medication cart where the medications needed to go.

Review of Resident #17's Controlled Substance Count Record revealed a sheet, two (2) of three (3), delivered on 06/28/2021 with no receiving signature and date on the sheet. Despite repeated requests, the facility was unable to provide either sheet one (1) of three (3), or a Controlled Substance Count Record for Percocet 5/325 mg covering the time frame, 06/19/2021 through 07/08/2021. Sheet three (3) of three (3) was the sheet missing, as identified by pharmacy on 07/09/2021. Sheet 2 of 3 revealed LPN #1 signed the first medication out at 12:00 AM on 07/09/21, with LPN #7 replacing her on the medication cart on the morning of 07/09/2021. Review of Resident #17's MAR for July 2021 revealed eighty-two (82) doses of Percocet 5/325 mg had been administered. However, no staff signed on the back of the MAR indicating the administration or the results.

Interview with the SDC/QI, on 08/03/2021 at 9:29 AM and again on 08/13/2021 at 4:00 PM,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185026	A. BUILDING _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 304	F 755		

revealed neither LPN #1 nor LPN #2 were suspended, and she had been told by the Administrator they were not suspending anyone as they could not prove who had taken the skid. The DON revealed it was not the facility's policy to drug test someone based on allegations of taking narcotics from residents, and she would have to suspect someone was under the influence to warrant a drug test, which she never suspected of LPN #1.

Interview with the Regional Vice President (RVP), on 08/20/2021 at 3:03 PM, revealed he was part of the trigger call that occurred on 07/09/2021. He revealed the facility reported the incident and also notified police of the missing skid of thirty (30) tablets of Percocet. However, he stated administrative staff was unable to determine which specific nurse might have taken the skid, so neither nurse was suspended at that time. He revealed he had not been informed of any prior allegations for LPN #1 diverting medications, and as RVP he would have expected to be notified of those types of allegations.

3. Interview with the Facility Consultant, on 07/27/2021 at 1:15 PM, revealed, on 07/18/2021, the DON informed her that LPN #2 had found two (2) pills taped into a Roxicodone (Oxycodone, Schedule II narcotic pain reliever) skid, belonging to Resident #32, which were not Roxicodone. In addition, she stated this was followed by a second resident, Resident #84, who also had two (2) pills taped into a Roxicodone skid which were not Roxicodone. She revealed the pills used to replace the Roxicodone were determined to be Primidone, an anti-seizure medication. The Facility Consultant revealed police were present and had already detained LPN #1. She stated it

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 306	F 755		

narcotics removed from her medication cart until the end of the shift and stated this was common practice among nurses at the facility. LPN #1 was charged with two (2) counts of Wanton Endangerment in the First Degree; thirteen (13) counts of Theft by Unlawful Taking, Controlled Substance; three (3) counts of Possession of a Controlled Substance; and two (2) counts of Abuse and Neglect of an Adult Person.

A) Interview with LPN #2, on 07/30/2021 at 4:29 PM, revealed she was working the night of 07/18/2021, and was on administering medications, when she noted Resident #32's narcotic skid had tape on it, with the medications taped inside being thicker than the other medications in the skid. She revealed she contacted the DON and had SRNA/KMA #20 witness, as she searched the rest of the cart and found two (2) more medications taped in place for Resident #84's narcotics. She stated she contacted Adult Protective Services and was advised by Social Services Clinician I (SSC I) to have other staff witness her medication administration involving any narcotics, which she did by having staff, SRNA/KMA #8 and SRNA/KMA #20, witness every narcotic pulled.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 308	F 755		

Interview with LPN #12, on 08/13/2021 at 8:21 AM, revealed she was working on the night of 07/18/2021, when another nurse and SSCI came around checking medication carts. She revealed her medication cart was okay, and the only medication cart she thought had an issue was LPN #1's cart.

B) Review of Resident #65's medical record revealed the resident was admitted by the facility, on 10/25/2019. The facility assessed Resident #65, in a Quarterly MDS Assessment, dated 06/29/2021, as fifteen (15) of fifteen (15) on the BIMS, indicating no cognitive impairment. Continued review revealed a physician's order for Neurontin (Gabapentin) 200 mg three times a day, dated 06/04/2021; and Roxicodone 5 mg every 6 hours, dated 06/21/2021.

Review of Resident #65's Controlled Substance Count Record for Roxicodone 5 mg revealed a missing (not documented) tablet, on 07/18/2021, which the DON documented as giving a dose for the missing tablet/previously undocumented midnight dose. Review of Resident #65's MAR for June 2021 revealed one (1) dose of Roxicodone 5 mg missing, at 6:00 PM on 06/24/21, with no documentation on the back of the MAR indicating the reason for the missed dose.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 310	F 755		

review of the record revealed a physician's order for Neurontin 100 mg at bedtime, dated 03/23/2021; and a physician's order for Roxicodone 5 mg every 8 hours PRN, dated 05/10/2021.

Review of Resident #84's Controlled Substance Count Record for Roxicodone 5 mg, delivered on 06/10/2021, revealed frequent use of once a day, with use twice a day on multiple occasions. LPN #1 had signed out eight (8) tablets on the record, with two (2) tablets documented as replaced with Primidone, on 07/18/2021. Review of Resident #84's MAR, for July 2021, revealed a dose of Roxicodone 5 mg was administered on 07/08/2021, but was not documented on the Controlled Substance Count Record. In addition, per the record, of ten (10) documented administrations during July 2021, on the MAR, only six (6) were documented on the back of the MAR. Review of the June 2021 MAR revealed, of twenty-two (22) doses administered, only six (6) were documented on the back of the MAR. The last dose administered on the MAR was on 07/18/2021 at 8:00 PM by LPN #2. Continued review of Resident #84's Controlled Substance Count Record for Roxicodone 5 mg, delivered on 06/10/2021, revealed no signature or date by the receiving nurse. Further review of Resident #84's medical record revealed a Clinical Laboratory Report, dated 07/19/2021, revealing no Primidone detected in Resident #84's system and a negative result for opiates.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 312	F 755		

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

Review of Resident #71's Controlled Substance Count Record for Gabapentin 300 mg, delivered 07/13/2021, revealed a missing 8:00 PM dose, on 07/18/2021, noted by the DON at 11:50 PM. Continued review of Resident #71's MAR for July 2021 revealed a missing dose of Gabapentin 300 mg, on 07/26/2021 at 2:00 PM, with no documentation indicating the reason for the missed dose.

H) Review of Resident #1's medical record revealed the resident was admitted by the facility, on 12/22/2016, and was assessed in the Quarterly MDS Assessment, dated 05/03/2021, as fifteen (15) of fifteen (15) on the BIMS, indicating no cognitive impairment. Continued review revealed a 01/06/2021 physician's order for Gabapentin 300 mg at bedtime; a 05/25/2021 physician's order for Norco (Schedule II narcotic pain reliever) 5/325 mg PRN, which changed to twice a day, on 07/06/2021; and a 06/04/2021 physician's order for Lyrica (pain reliever for nerve pain) 150 mg twice per day.

Review of a July MAR for Resident #1 revealed Gabapentin 300 mg was not documented on the MAR as administered on 07/27/2021, with no documentation supporting why it was not administered. Further review of the resident's Controlled Substance Count Records revealed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 314	F 755		

She stated she did not know which medications were wasted, but knew there were a lot.

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

Review of Resident #9's Controlled Substance Count Records revealed no evidence skids were delivered, on 07/15/2021, despite multiple requests by the SSA Surveyor for all Controlled Substance Count Records for this resident for June 2021 and July 2021.

Review of a Shift Change Controlled Substance Count Check form, for Resident Rooms 136 to 149, revealed an incomplete form with LPN #2 not signing in, next to LPN #6, who signed out, on 07/18/2021 at 6:30 PM. The form indicated forty-six (46) count sheets remaining. However, review of the form revealed LPN #2 indicated the sheet count was forty-two (42).

Continued interview with LPN #2, on 07/30/2021 at 4:29 PM, revealed, when individual pills were taken from her cart, both she and the removing staff signed on the narcotics sheet, but the Administrator and DON had taken the Shift

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 316	F 755		

skids of controlled medications. She revealed of the four (4) skids missing, all were accounted for except the missing one for Resident #9, for Percocet. She stated the decision was made to suspend LPN #2 at that time.

Interview with the SDC/QI, on 08/05/2021 at 12:22 PM and again on 08/16/2021 at 2:45 PM, revealed if someone reported a discrepancy on the medication count to her, she would report it to the DON, and whoever was on the medication cart would be removed until a full cart audit could be completed. She stated the process for disposal of narcotics, when a resident was discharged or died, was the nurse on the floor would pull them from the medication cart, verify the number in the skid with the Controlled Substance Count Sheet, reduce the number of skids on the Shift Change Controlled Substance Record, and take the sheet with the medications to the DON or SDC/QI. She stated she or the DON would then take them to lock up in the South Unit medication room, under triple lock, where only the DON had the key. She stated they would not be logged as they were put in the box, and at times, there was only herself or the DON (she would get keys from the DON) in and out of the box with no witness. She then said she or the DON would take the medications from the box to one (1) of their offices, log them on a reconciliation sheet, and pop them out into the drug buster, which was contained in a biohazard container in the dirty utility room. She stated they had not always followed policy in having two (2) nurses, or a nurse and a pharmacist, when wasting medications. She stated her expectation was that wasted medications would be witnessed by a second nurse and disposed of in the sharps container. She revealed it was important to have

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 318	F 755		

a medication skid and compare it to the matching Controlled Substance Count Record for accuracy. She stated she thought any completed medication skids were taken to the DON, and any not completed skids due to a discharge or medication change, were taken to the DON to be wasted.

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

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

Interview with the DON, on 08/18/2021 at 10:48

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 320	F 755		

She stated she also recognized staff were always counting narcotic sheets, so at times when something did go missing, staff did not notice it. In addition, the DON stated she was aware, prior to this incident, that skids were being taped when damaged.

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

Interview with the Interim Administrator, on 08/20/2021 at 10:24 AM, revealed he expected the facility to have a good investigation program, a good audit program, and a good count program for narcotics that started when they came to the facility. He stated this included signing by two (2) nurses, to limit the possibility of drug diversion occurring.

Interview with the Senior Vice President, on 08/20/2021 at 1:40 PM, revealed if there was a drug diversion situation, she would expect the facility to initiate investigative protocols, determine if they could identify at what point diversion occurred, and take appropriate action with staff members. She stated, if administrative staff were able to determine a responsible party, she expected the responsible party to be suspended to protect other residents. She revealed she always referred to facility policies.

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

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

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F 755	Continued From page 322	F 755		

locking carts, MAR's, shift change count sheets, signatures, declining count sheets, wasted narcotics, back side of narcotic medication skids, skid cards numerical order, no missing skids, all narcotics accounted for, and/or pharmacy packing slips. These audits were completed five (5) times weekly. Any missing, incomplete, or incorrect documentation would be immediately reported to the DON and/or Administrator for investigation. Any concerns and trending would be reviewed and discussed weekly on Fridays. The audits would continue until the Quality Assurance Performance Improvement (QAPI) committee determined the audit frequency could be reduced.

7. On 07/12/2021, 07/13/2021, 07/20/2021, 07/21/2021, 07/22/2021, 07/24/2021 to 08/01/2021, 08/01/2021 to 08/13/2021, and 08/22/2021 to 08/29/2021, an RN Corporate consultant worked in the facility. An RN Corporate nurse continues to be at the facility five (5) days a week through September 2021, ensuring the facility adheres to proper signing of packing slips, properly counts and documents narcotics, correctly disposes of controlled medications, and maintains an effective system of reconciliation. An RN Corporate nurse continues at the facility to provide oversight of the performance improvement plan five (5) days a week through September 2021. An RN corporate nurse may complete any audit in place of the assigned auditor. An RN Corporate nurse continues to ensure the facility adheres to proper signing of packing slips, properly counts and documents narcotics, correctly disposes of controlled medications, and maintains an effective system of reconciliation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 324	F 755		

suspended the nurse and reported the information to the Office of Inspector General (OIG), Adult Protective Services (APS), and the Police.

13. On 7/20/2021, the DON, ADON (Assistant Director of Nursing), SDC/QI, MDS nurses, Weekend Supervisor, Social Services Director (SSD), Activities Director (AD), and/or support RN's began interviewing weekly three (3) random residents, with a BIMS of nine (9) or above, to ensure they had no concerns with when or how their narcotic medications were administered. Any concern regarding narcotic administration would be reported to the DON or Administrator for review at the morning interdisciplinary team (IDT) meeting. The three (3) audits would continue five (5) times a week until the QAPI committee determines a reduction can be made. The results of these audits would be reviewed in QAPI meetings.

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

14. On 7/21/2021, the DON, ADON, Unit Manager, SDC, QI, Weekend Supervisor, MDS

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 326	F 755		

present. This education also included signing the Shift Change Controlled Substance Count Check sheet at the beginning and end of the shift. This education included the signature was the nurse's affirmation the count was correct and must be signed when counting. It could not be signed early or late. Nurses and KMA's were also educated regarding deliveries of multiple cards of narcotics. The nurse receiving the narcotics and the nurse whose cart would hold the narcotics must both sign for receipt. If the same nurse was both receiving and had the medication cart, a second nurse must sign. This education was added to the new employee orientation for new nurses, new KMA's, and new agency nurses.

16. On 7/26/2021, the DON, Unit Manager, SDC/QI, nurse supervisor, MDS nurse, and Corporate RN consultants began administering a medication administration post-test to all licensed nurses and KMA's. The quiz covered both medication administration and physician notification and validated licensed nurses and KMA's continued competency in a written form. Any licensed nurse or KMA not scoring one-hundred percent (100%) on the quiz would receive additional education.

17. On 7/29/2021, the DON facilitated a Medical Director Update telephone call.

18. On 8/10/2021, the DON facilitated a QAPI Committee meeting with the Medical Director present. The committee discussed the facility's survey status, including the abuse/neglect PIP. Review of actions taken and audit results concluded in the recommendation for the facility to: 1) continue with the narcotics PIP, 2) provide on-going education and 3) continue auditing.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 328	F 755		

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

27. On 8/28/2021, the SDC/QI monitored and audited the north-front medication cart and verbally quizzed the cart nurse, to include how to sign a pharmacy packing slip and properly dispose of narcotics. The nurse was able to answer questions correctly.

28. On 8/28/2021, the SDC/QI, support RN, and Corporate RN consultant monitored medication carts, narcotic medication documentation, and the facility's progress with the plan of correction.

29. On 8/29/2021, the DON, four (4) support RN's, and a Corporate RN interviewed staff and residents, inspected medication carts, and reviewed narcotic documentation. No new staff concerns were received. No new resident concerns were received. Residents stated they were receiving their medications. No narcotic medications were identified as missing.

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

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

1. Review of a QAPI PIP, dated 07/09/2021, revealed, as a result of one (1) missing blister pack of thirty (30) Percocet tablets, identified in a pharmacy audit completed on 07/09/2021, the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 330	F 755		

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

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

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

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

Interview with Facility Consultant #1, on 08/05/2021 at 12:35 PM, revealed on 07/09/2021, she started education with nurses and KMA's about signing at shift change, accepting the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 332	F 755		

Continued review revealed ongoing audits completed by the DON, SDC/QI, MDS nurse, support RN's, and Corporate nurses. No concerns were identified in review of these audits.

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

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

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

Interview with the DON, on 09/02/2021 at 9:10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 334	F 755		

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

12. Review of documentation confirmed the DON audited medication carts, on 07/20/2021, and, after investigation of the initial four (4) missing skids, finally determined Resident #9 was missing one (1) skid, skid two (2) of two (2) for Percocet.

Review of a Long Term Care Facility/Self-Reported Incident Form, dated 07/20/2021, confirmed the facility reported an allegation of misappropriation to appropriate parties on 07/20/2021, to include OIG, and documented suspension of LPN #2.

13. Review of Resident Interview Medication Administration confirmed facility staff interviewed three (3) or more residents each week, beginning on 07/20/2021. Residents were questioned whether or not they had concerns regarding administration of their medications. If residents indicated concerns, this was explored further, to include to whom residents reported concerns, and when. No unaddressed issues were identified during documentation review.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 336	F 755		

could not sign for a nurse. She stated drugs were all to be wasted in the Drug Buster, which was a chemical container that drugs were placed in for disposing. She stated staff members were educated on the requirement for two (2) staff to sign for receipt of narcotics.

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

Interview with RN #3, on 09/02/2021 at 3:14 PM, revealed she had been educated since the drug diversion on the importance of signing out narcotics on the narcotic count sheet as well as the front (and for PRN, the back) of the MAR. She revealed for PRN pain medications, a pre and post pain assessment was documented on the back of the MAR. RN #3 was able to verbalize the procedure for medication cart transfers at shift change and reconciling narcotic counts. RN #3 revealed now, when narcotics were received, two (2) nurses were required to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 338	F 755		

concerns identified during review of the narcotics quizzes.

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

18. Review of a QAPI Committee meeting agenda, from 08/10/2021, revealed staff was continuing to work on the issue of narcotics misappropriation, with pharmacy continuing to monitor medication administration and narcotics during facility visits. Review of a sign in sheet, dated 08/10/2021, revealed the Medical Director was in attendance at the meeting.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 340	F 755		

medication counts noted, the cost for each individual dose, resident payors, and the total cost of all medications reimbursed, which was three hundred and four dollars and ninety-seven cents ($304.97).

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

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

Interview with the Administrator on 09/02/21 at 6:32 PM revealed he was present for the phone call with the Medical Director on 08/26/21 in which the jeopardy citations were discussed, as well as the audits the facility had been doing and the education the facility had provided. He revealed they went down each one of the tags, discussing issues and what was being done to address issues.

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

28. Review of Shift Change Narcotic Review sheets, completed by the SDC/QI, support RN's, and Corporate RN's, revealed medication carts and narcotic documentation were monitored on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 801 Continued From page 342

F 801 Qualified Dietary Staff
SS=D CFR(s): 483.60(a)(1)(2)

§483.60(a) Staffing
The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e)

This includes:
§483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who-
(i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose.
(ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional.
(iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the

F 801
F 801

F 801

1. The Food Service Manager (FSM) present at the time of the survey no longer works for the facility.
2. An advertisement was placed by the Administrator to hire a replacement with the required qualifications.
3. On 08/30/21, the Administrator was educated by the Corporate Nurse on the minimum requirements for a Food Service Manager. On 09/30/21 a new FSM was selected. The new FSM was enrolled in a certification course on 10/12/21 and will have Registered Dietician (RD) oversight to ensure compliance is maintained and to ensure certification classes are completed.
4. The Regional Vice President (RVP) during center visits will validate with the Administrator and by review of the Dietary Department that the FSM meets the qualifications required. This review will be documented on routine visits to the center for the next 3 months, October, November, and December 2021. Any concerns will be reviewed monthly at the Quality Assurance Performance Improvement (QAPI) Committee

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 801	Continued From page 344	F 801		

facility failed to meet current requirements for a qualified Dietary Manager. The current Dietary Manager (DM) was not certified or currently enrolled in a Certified Dietary Manager (CDM) course, as to meet the requirements to be certified within one (1) year after hire. In addition, the Consultant Registered Dietitian (RD) was not available to provide proper supervision/consultations for the Dietary Manager.

The findings include:

Review of the facility's job description titled, "Food Service Manager," dated 01/12/2007, revealed the primary purpose of the position was to plan, organize, develop, and direct the overall operation of the Dietary Department. In addition, the job description stated the Dietary Department must be operated in accordance with the current applicable federal, state, local standards, guidelines, regulations, the facility's established policies and procedures, and as could be directed by the Administrator, Regional Vice President, Consultant, and Dietitian, to assure that quality food service was provided at all times.

Review of the Health Department certificate titled, "Certified Food Service Manager," with an expiration date of 12/12/2022, revealed the certificate belonged to the Assistant Food Service Manager, which showed she was a Certified Food Service Manager. The facility did not have a copy of the Health Department certificate titled "Certified Food Service Manager" for the Dietary Manager.

Review of the Health Department report, dated 01/29/2021, revealed staff needed training for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 801	Continued From page 346	F 801		

Interim Administrator about hiring a CDM. The consultant company, she stated, had instructed her not to enter a facility with an active case of COVID. Per the interview, she stated she was available by phone for questions by the Dietary staff.

Interview with the Assistant Dietary Manager, on 08/13/2021 at 3:00 PM, revealed the RD was here last week. She stated she called the RD and often sent messages with questions to her. In addition, she stated sister facilities were available to assist the facility with food service as needed. The Assistant Dietary Manager stated the RD conducted sanitation walk-throughs and talked with dietary staff about sanitation of the department. She stated the RD provided staff copies of the sanitation inspections the RD performed.

Interview with the Dietary Manager (DM), on 08/13/2021 at 3:15 PM, revealed she had been employed at the facility for one (1) year. She stated the RD was present at the facility last week. She stated the contract company's policy for the RD was for her to only visit virtually with an active case of COVID in the building. The DM also stated she could not locate any earlier copies of the RD inspection reports prior to 06/2021. She stated she had been offered Certified Dietary Manager (CDM) classes, but had not been able to schedule the classes yet.

Interview with the Director of Nursing (DON), on 08/18/2021 at 10:48 AM, revealed the RD had not visited the facility lately due to a resident with an active case of COVID, and the contract company did not allow her to enter the building. The DON stated the RD used electronic means for

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 812	Continued From page 348 standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policies, it was determined the facility failed to store, prepare, and distribute food under sanitary conditions and in accordance with professional standards for food safety. Observations, during the initial tour on 08/09/2021 and the tour on 08/10/2021, revealed dried grease on a wall, frozen hamburger on the top shelf of the walk-in refrigerator, and condensation falling from the air conditioner vent. Continued tour of the nourishment refrigerators on the North, South, Memory Care Units, and the Dining Room revealed the temperatures for freezers not recorded. The findings include: Review of the facility's policy titled, "Cleaning of Equipment and Utensils," not dated, revealed nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. Review of the facility's form "Assigned Cleaning Jobs," not dated, revealed only two (2) initialed tasks completed by staff. Per the form, on 07/03/2021, under cooks, revealed only one (1) signature for deep fryer. In addition, the form showed, on 07/27/2021, there was only one (1) initial for Walk-In Cooler, straighten and sweep. Per the form, the wall behind the fryer area, between the production equipment, was not listed.	F 812	3. The Assistant Food Service Manager (AFSM) was educated on the importance of establishing a routine cleaning schedule and validating it is being followed by the Administrator on 09/14/21. On 09/14/21 the Assistant FSM began education of the dietary staff on the cleaning schedule and correct storage of food. On 09/30/21, education regarding recording daily temperatures of nourishment refrigerators was completed by the Director of Nursing (DON) for the Unit Managers. Temperature log sheets were placed in binders for each unit and will be kept by the Unit Managers. Nursing staff were educated on proper storage of ice scoops. 4. Beginning 11/1/21, audits will be conducted weekly for 4 weeks, by the Administrator, DON, Support RN, or the Corporate RN, then monthly for 2 months, to validate kitchen cleanliness, appropriate food storage, storage of ice scoops and logging of daily nourishment temperatures. Identified concerns will be addressed by the Administrator at that time. Audit	

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 812	Continued From page 350	F 812		

Observation, on 08/10/2021 at 9:00 AM, during the continued tour of the kitchen, revealed inside the main entrance door, ceiling tiles with water stains and peeling tile. The appearance of grease remained on the wall between production areas.

Observations of the four (4) unit nourishment refrigerators, on 08/10/2021 between 8:40 AM and 9:07 AM revealed in the North Unit, Memory Care Unit, and Dining Room, there were no thermometers in the freezer and no freezer temperature documentation. In addition, observation in the South Unit revealed no documentation of freezer temperature, but a thermometer was present. Further observation of the North Unit refrigerator revealed a blue, flowered cloth snack bag that was not labeled with an identification, room location, or date. The blue, flowered cloth snack bag contained perishable snack foods. Additionally, a clear plastic cup was found left in the ice chest.

Observation of the kitchen, on 08/10/2021 at 11:15 AM, during the lunch resident tray line, revealed the appearance of dried grease remained on the wall behind the production equipment. In addition, the air duct near the food service line was observed with condensation and dripping, between the resident tray line and the refrigerator, to the floor.

Interview with the Consultant Registered Dietitian (RD), on 08/11/2021 at 12:19 PM, revealed she visited once weekly, usually on a Friday. She stated she conducted sanitation audits and provided the top five (5) things to work on after her visits. She stated she tried to stay in touch

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 352	F 812		

responsible to clean their area after every use, including the wall behind the fryer because grease could attract insects and grow bacteria. The drips over the resident tray line, she stated, could create the potential for cross contamination. She further revealed she called the Consultant RD, and the RD messaged them often. She stated the Consultant RD talked with dietary staff about sanitation of the department and possibly provided copies to the administrator of the content of the talks. The Assistant Dietary Manager stated the RD could only visit virtually due to the Consultant RD company policy with COVID in the facility.

Interview with the Dietary Manager (DM), on 08/13/2021 at 3:15 PM, revealed the hamburger was left on the wrong refrigerator shelf, and it was moved from the top shelf to the bottom shelf to prevent cross contamination of other foods. She stated the cleaning list was posted for the month with assigned areas and extra areas to clean, and the posted cleaning schedule was signed by staff about half of the time. Per the interview, the DM stated the wall in the production area had grease and needed to be cleaned to prevent cross contamination of food. The DM further revealed maintenance could not address the water dripping over the resident tray line, and she was not aware of the peeling ceiling tiles above the door, which could cause cross contamination of food. She further stated the Consultant RD visited last week; however, due her company policy, her visit was virtual because of the case of COVID in the facility. Additionally, she stated it was important to record nourishment freezer temperatures to check the operation of the freezer.

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	185028	A. BUILDING _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 354 AM, revealed she expected the kitchen to be clean, sanitized, and staff to follow the cleaning schedule. She stated she expected the kitchen wall in the production area to be cleaned of grease to prevent possible fire, bugs, growth of bacteria, and cross contamination of food. All staff, she said, needed to record nourishment refrigerator freezer temperatures to prevent food spoilage if the freezer was not working properly. The DON stated a plastic cup should not be used to scoop out of the ice chest and presented a potential for physical cross contamination. Per the interview, the DON stated the Consultant RD had been scheduled to visit weekly; however, during any facility reported case(s) of COVID, the RD could only perform virtual visits. Interview with the Interim Administrator, on 08/18/2021 at 3:55 PM, revealed he expected staff to follow the cleaning schedule for cleanliness and sanitation of the kitchen. In addition, he stated the Maintenance Director should address any concerns related to repairs. Per the interview, he stated nourishment refrigerators on the units should record the freezer temperatures to keep food at a safe temperature. Further, the Administrator said he expected the Consultant RD to be available to train the staff and promote quality of food for the residents. Additionally, he stated the RD provided him reports with her dietary recommendations.	F 812		
F 835 SS=K	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and	F 835	F 835 1. Previous Administrator was suspended on 07/21/21 and is no longer employed by the facility. The	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 835	Continued From page 356 anti-convulsive medication, which she stated she had switched with Resident #32's and Resident #84's controlled medications. Further, on 01/26/2021 at 6:30 PM, LPN #15 assessed Resident #242 to be non-responsive with no pulse and called a Code Blue. The Staff Development Coordinator/Quality Improvement (SDC/QI) nurse responded to the resident's room and initiated chest compressions. The previous Administrator responded to the code and provided breaths to the resident without a mask. After two (2) minutes of cardiopulmonary resuscitation (CPR), LPN #15 alerted the SDC/QI and previous Administrator that Resident #242 had a pulse and to stop chest compressions. However, the previous Administrator directed that CPR could not stop until the resident had a pulse of sixty (60) beats per minute (bpm) or a physician's order to stop CPR. Additionally, the previous Administrator placed her hands over the SDC/QI nurse's hands and forced chest compressions for approximately one (1) more minute. Emergency Medical Services (EMS) arrived on-site and transported the resident to the local hospital. The facility failed to have an effective system to ensure staff were familiar with the facility's policies related to Cardiopulmonary Resuscitation (CPR) in accordance with standards of practice for sampled Resident #242. The facility's failure to be administered in an effective manner enabled misappropriation of medications to occur and failure to ensure that the Administrator followed facility policies, has caused, or is likely to cause, serious injury, harm, impairment, or death. Immediate Jeopardy (IJ)	F 835	misappropriation, investigations, ensuring pharmacy practices are in place, professional standards, the Administrator's role of oversight as it relates to all issues identified in the plan of correction, policies and procedures in place for the Administrator and how the Administrator will ensure polices are followed. 4. A RN corporate nurse will continue to provide oversight of the performance improvement plan five days a week, including nights and weekends, through September 2021. The RN corporate nurse will speak with the Administrator and/or RVP 5 times per week through September 2021 to ensure questions and/or concerns are addressed. A corporate Vice President will continue to provide oversight of the facility via daily telephone calls and weekly on-site visits through September 2021. Any identified concerns regarding the administration of the facility will be addressed at the time of discovery and reviewed at the monthly Quality Assurance Performance	

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

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F 835	Continued From page 358	F 835		

maintained at all times. Further review revealed, under duties, the Administrator was responsible for reviewing and monitoring the competence of the work force and assuring the facility was maintained in a safe manner for resident comfort and convenience.

Review of the facility's policy titled, "Administrative Policies," dated 01/2009, revealed, in the section on Philosophy, that each person had physical, mental, emotional, and spiritual needs and rights that must be respected and advocated for and must not be violated.

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

Review of the facility's CPR policy, titled "Cardiopulmonary Resuscitation, Nursing Procedure Manual," Version Date: April 2013, revealed the objective was to ventilate the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 835	Continued From page 360	F 835		

08/04/2021 at 8:28 AM, and again, on 08/18/2021 at 10:48 AM, revealed the former Administrator made many decisions without involving other staff and did not delegate authority or keep other staff involved. She revealed she was not part of the trigger call (a call between management staff and corporate regarding facility concerns and reportable incidents), on 07/09/2021, when the decision was made by the Administrator and corporate not to suspend LPN #1 or LPN #2, despite evidence one (1) of them had diverted medications.

Interview with the Interim Administrator, on 08/20/2021 at 10:24 AM, revealed the Administrator was the Chief Operating Officer of the facility and was responsible for each action and decision in the building. He stated the Administrator was responsible to investigate any concerns thoroughly.

Interview with the Regional Vice President (RVP), on 08/20/2021 at 3:03 PM, revealed the Administrator was responsible to report to him allegations of medication misappropriation and any identified concerns. He stated he was not aware of previous concerns identified by residents and staff regarding LPN #1, when he participated in a trigger call on 07/09/2021. He further stated the former Administrator did not make him aware of the concerns about CPR and Resident #242. The RVP stated the facility had processes and systems in place to catch or identify concerns, and it was the Administrator's responsibility to bring anything to his attention.

Interview with the Senior Vice President, on 08/20/2021 at 1:40 PM, revealed it was her absolute expectation that the Administrator keep

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 835	Continued From page 362	F 835		

accounted for, and/or pharmacy packing slips. These audits were completed five (5) times weekly. Any missing, incomplete, or incorrect documentation would be immediately reported to the DON and/or Administrator for investigation. Any concerns and trending would be reviewed and discussed weekly on Fridays. The audits would continue until the Quality Assurance Performance Improvement (QAPI) committee determined the audit frequency could be reduced. The QAPI Committee consisted of the Administrator, DON, Infection Preventionist, Medical Director, Social Worker, Medical Records Director, Dietary Manager, and Housekeeping Supervisor, plus additional staff members as deemed necessary.

3. On 07/21/2021, the RVP arrived on-site to initiate and coordinate the investigation. The investigation focused on abuse/neglect/misappropriation of resident/residents' property.

4. On 07/21/2021, the RVP interviewed and suspended the facility Administrator.

5. On 07/21/2021 through 07/23/2021, the RVP provided administrative coverage for the facility.

6. On 07/23/2021, the Interim Administrator participated in a QAPI meeting to go over the current plan of correction that was developed by the QAPI Committee.

7. On 07/27/2021, the RVP educated and reviewed, with the Interim Administrator, the responsibilities of the management and operation of the facility and reviewed job duties with the Interim Administrator.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 835	Continued From page 364	F 835		

were addressed. The RN CN consultant would provide oversite to ensure compliance.

13. On 08/23/2021 and 08/24/2021, the Vice President of Employee Experience was at the facility offering education on the Code of Conduct and providing support to the Interim Administrator.

14. On 08/23/2021 through 08/27/2021 and on 08/30/2021, a sister facility Administrator was on-site to provide guidance and support to the Interim Administrator.

15. On 08/23/2021 through 08/27/2021, a sister facility Administrator was on-site to provide education and quiz staff on the Code of Conduct. Also, the sister facility Administrator talked with staff to complete employee surveys.

16. On 08/26/2021, the RVP brought in the new Administrator. The RVP educated the new Administrator to include the Appointment Letter as Facility Administrator. The Appointment Letter outlined the Administrator's responsibilities: enforce rules and regulations; and maintain an ongoing liaison among the governing body, medical and nursing staff, and other professional and supervisory staff of the facility. The facility had a five (5) times a week interdisciplinary team (IDT) meeting, which was part of the quality assurance process, during which the RN CN attended. And, the RVP attended the IDT meeting during facility visits.

17. On 08/26/2021 through 08/29/2021, the RVP, sister facility Administrator, and RN CN educated the new Administrator on: abuse, misappropriation, investigations, ensuring

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

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F 835	Continued From page 366	F 835		

committee meetings would include the Medical Director and at least two (2) corporate staff.

23. A Corporate Vice President continued to provide oversight of the facility. Oversight was provided daily via telephone and weekly via on-site visits through September 2021.

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

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

2. Review of documentation revealed the DON audited all medication carts, on 07/13/2021, confirming staff was signing in and out of medication carts as expected, narcotic skids were being counted as expected, and the narcotic count sheets matched the number of narcotic skids in the cart.

Continued review revealed ongoing audits beginning on 07/21/2021 were completed on the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 835	Continued From page 368	F 835		

Administrator regarding management and operation of the facility on 07/27/2021.

8. Interview with the RVP, on 09/02/2021 at 7:07 PM, confirmed he was present to provide support and oversight for the Interim Administrator, from 07/27/2021 through 08/09/2021.

Interview with the Interim Administrator, on 08/05/2021 at 2:48 PM, confirmed the RVP had been available and provided guidance in facility management.

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

Interview with State Registered Nurse Aide (SRNA) #24, on 09/02/2021 at 3:30 PM, revealed she had received training on the Code of Conduct, which included abuse, neglect, misappropriation, what to report, who to report to, and when to report. She revealed if she were to report an allegation to her supervisor and did not feel like it was being addressed, she could contact the DON and Administrator, as well as call or fax the corporate compliance line.

Interview with the Occupational Therapist, contracted to work at the facility, revealed she had received the Code of Conduct in-service, which covered abuse, neglect, and misappropriation. She revealed she would report

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

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F 835	Continued From page 370	F 835		

review revealed the RVP reviewed inservices and audits again, on 08/25/2021 and 08/29/2021.

13. Review of quizzes on the Code of Conduct confirmed employees were trained and tested on 08/23/2021 and 08/24/2021. Review of the Principle LTC Code of Conduct booklet, revised 04/2019, revealed "Principle LTC is committed to its role in preventing health care fraud and abuse and complying with applicable state and federal laws related to health care fraud and abuse." The booklet provided guidance on the reporting chain of command, as well as the availability of the corporate compliance phone number.

14. Review of documentation confirmed a licensed Administrator from a sister facility was on-site 08/23/2021 through 08/27/2021 and again on 08/30/2021.

15. Review of documentation, to include Employee Surveys, revealed the sister facility Administrator met with staff and provided education on the Code of Conduct.

16. Review of the Appointment Letter as Facility Administrator, dated 08/26/2021, confirmed the RVP appointed the new Administrator on 08/26/2021. Review of an Administrator job description, dated 08/26/2021, confirmed the Administrator reviewed and agreed to his job duties and responsibilities.

Interview with the Administrator, on 09/02/2021 at 6:32 PM, revealed he was informed the previous Administrator was not following processes corporate wanted to be followed. He stated he wanted to make sure he knew what had occurred when he was came into this situation. The

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F 835	Continued From page 372	F 835		

Review of the Narcotic Cart Audits confirmed support RN's conducted audits on 08/28/2021 and 08/29/2021 of all facility medication carts, with no concerns identified.

Continued interview with the DON, on 09/02/2021 at 1:18 PM, confirmed staff did well on the CPR drill and responded appropriately.

Interview with the Clinical Director, on 09/02/2021 at 9:10 AM, revealed, on 08/28/2021 and 08/29/2021 a mock survey/audit was done, by her and sister facility support RN's, on all medication carts. The Clinical Director revealed there had been no concerns identified during their audits.

Interview with the SDC/QI, on 09/02/2021 at 4:49 PM, revealed she was uncertain what was written in the plan of correction regarding frequency of CPR drills, but she planned on ensuring CPR drills were conducted at least monthly for six (6) months, then maybe quarterly after that. She revealed she had been present during all three Code Blue drills, and it seemed like they were getting a little smoother each time.

19. Review of the Quality Assurance and Performance Improvement Guidance Manual, revised 06/26/2019, revealed the RVP functioned as the governing body, appointed the Administrator, and with the Administrator, was accountable for developing, leading, and closely monitoring the facility QAPI program for which the facility administration was responsible.

Interview with the RVP, on 09/02/2021 at 7:07 PM, revealed he had known the new Administrator for many years, describing him as a

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F 835	Continued From page 374 23. Continued interview with the Clinical Director, on 09/02/2021 at 1:18 PM, revealed the RVP did onsite visits and phone calls and had been at the facility frequently since the incident of drug diversion. She revealed whenever the RVP was not present, RVP #2, or another corporate Vice President was present at the facility. Continued interview with the RVP, on 09/02/2021 at 7:07 PM, revealed he worked with the Administrator and the facility as an overseer to ensure they had what they need. He stated, as RVP, he did a weekly clinical call (when not on-site) where he reviewed with each facility what was going on clinically in the building and got basic updates on different things. He stated the Administrator and DON for each building were usually on the call.	F 835		
F 837 SS=K	Governing Body CFR(s): 483.70(d)(1)(2) §483.70(d) Governing body. §483.70(d)(1) The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and §483.70(d)(2) The governing body appoints the administrator who is- (i) Licensed by the State, where licensing is required; (ii) Responsible for management of the facility; and (iii) Reports to and is accountable to the governing body.	F 837	F 837 1. The Regional Vice President (RVP) is the governing body that governs the facility. 2. The RVP is responsible for ensuring the new Administrator knows his role to ensure oversight of the policies and procedures is effective. The RVP will ensure the Administrator is acting as the governing body directs. 3. On 08/23/21, the Senior VP of Health Services trained the RVP on the responsibilities of the management and operations of the facility. On 08/26/21-08/28/21, the	

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F 837	Continued From page 376 42 CFR 483.70 Administration (F-835) and Governing Body (F-837). The facility's failure to provide an effective governing body responsible for establishing and implementing policies regarding the management and operation of the facility has caused or is likely to cause serious injury, harm, impairment, or death to residents. Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) were identified at 42 CFR 483.12 Freedom from Abuse, Neglect, Exploitation (F-600), with a scope and severity (S/S) of a "J" and were determined to exist on 07/18/2021; Free from Misappropriation (F-602), with a S/S of a "K" and was determined to exist on 07/09/2021; Investigate/Prevent/Correct Alleged Violation (F-610), with a S/S of a "K" and was determined to exist on 07/09/2021; and 42 CFR 483.25 Quality of Life, Cardio-Pulmonary Resuscitation (F-678), with a S/S of a "J" and was determined to exist on 01/26/2021. In addition, Immediate Jeopardy (IJ) was identified at 42 CFR 483.21 Comprehensive Resident Centered Care Plan, Services Provided Meet Professional Standards (F-658), with a S/S of a "J" and was determined to exist on 01/26/2021; 42 CFR 483.45 Pharmacy Services, Pharmacy Services/Procedures/Pharmacist Records (F-755) with a S/S of a "K" and was determined to exist on 07/09/2021; and 42 CFR 483.70 Administration, Administrator (F-835) and Governing Body (F-837) with a S/S of a "K" and was determined to exist on 01/26/2021. The facility was notified of the IJ and SQC on 08/20/2021.	F 837	and reviewed at the monthly Quality Assurance Performance Improvement (QAPI) meeting for further recommendations. Date of Compliance: 11/24/2021	

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F 837	Continued From page 378 08/20/2021 at 9:48 AM.	F 837		

The Chief Operations Officer was not available for interview on 08/20/2021 at 2:53 PM.

Interview with Registered Nurse (RN) Facility Consultant #1, on 07/27/2021 at 1:15 PM, revealed the Pharmacist did an audit, on 07/09/2021, and discovered the facility was missing a skid (package of thirty (30) tablets) of narcotics. The facility had a problem of a nurse receiving medications with only her signature. She stated she did not know that the policy clearly said two (2) signatures were required when narcotic medications arrived from the Pharmacy. However, she stated it was good nursing practice to do so.

Interview with the Director of Nursing (DON), on 08/05/2021 at 12:22 PM, and, on 08/18/2021 at 10:48 AM, revealed the first time she heard about the missing medications was when the Pharmacy Consultant it on 07/09/2021. The DON stated the facility policy did not specifically talk about narcotic delivery and did not address the best practice of two (2) nurses signing the narcotic delivery instead of one (1) nurse. She further stated, if a nurse was suspected of drug diversion, he/she should be suspended from medication administration to prevent further potential diversion.

Interview Regional Vice President (RVP) #2, on 08/12/2021 at 8:21 AM, revealed according to policy, the Regional Vice President (RVP) was a part of the governing body. Her role was to be supportive, provide guidance, reinforce procedure, and provide policy education through communication with administration.

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F 837	Continued From page 380	F 837		

the RVP to be knowledgeable about the areas under his/her supervision.

Interview with RVP #1, on 08/20/2021 at 3:03 PM, revealed he was the overseer of the facility, and he was not aware of the prior allegations concerning the two (2) nurses and drug diversion. However, he stated he expected to be notified of those types of allegations. He stated the Administrator was responsible to bring anything to his attention. In addition, he stated he expected the processes and systems the facility had in place to have caught or identified any concerns.

Additional interview with the DON, on 08/19/2021 at 2:00 PM, revealed, regarding Resident #242, she had not been present for the full code. She stated she had met with the former Administrator the next day and told her it was wrong to continue CPR if there was a pulse. She further stated the former Administrator again stated a resident needed a pulse of at least sixty (60) beats per minute to stop CPR. Additionally, the DON stated she sought guidance from the Advanced Practice Nurse Practitioner (APRN), who advised to stop CPR if there was a pulse.

Interview with the Medical Director, on 08/10/2021 at 4:11 PM, revealed the former Administrator had overstepped her bounds in ordering continued chest compressions when Resident #242 had a pulse. He stated the resuscitation was not handled in an appropriate way. In addition, the Medical Director stated that continuing CPR on someone with a pulse could harm them drastically.

Continued interview with RVP #1, on 08/20/2021 at 3:03 PM, revealed he had no knowledge of the

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F 837	Continued From page 382	F 837		

Principle LTC RN's not employed by the facility (support RN's), and corporate nurses started audits of medication carts and narcotic medication documentation. The audits included: locking carts, Medication Administrator Records (MAR), shift change count sheets, signatures, declining count sheets, wasted narcotics, back side of narcotic medication skids, skid cards numerical order, no missing skids, all narcotics accounted for, and/or pharmacy packing slips. These audits were completed five (5) times weekly. Any missing, incomplete, or incorrect documentation would be immediately reported to the DON and/or Administrator for investigation. Any concerns and trending would be reviewed and discussed weekly on Fridays. The audits would continue until the Quality Assurance Performance Improvement (QAPI) committee determined the audit frequency could be reduced. The QAPI Committee consisted of the Administrator, DON, Infection Preventionist, Medical Director, Social Worker, Medical Records Director, Dietary Manager, and Housekeeping Supervisor, plus additional staff members as deemed necessary.

3. On 07/21/2021, the RVP arrived on-site to initiate and coordinate the investigation. The investigation focused on abuse/neglect/misappropriation of resident/residents' property.

4. On 07/21/2021, the RVP interviewed and suspended the facility Administrator.

5. On 07/21/2021 through 07/23/2021, the RVP provided administrative coverage for the facility.

6. On 07/23/2021, the Interim Administrator

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F 837	Continued From page 384	F 837		

11. On 08/23/2021, the Senior Vice President of Health Services trained the RVP on responsibilities of the management and operation of the facility.

12. On 08/23/2021, the RVP reviewed all audits and in-services related to tags F-600, F-602, F-610, F-658, F-678, F-755, and F-835 for completion and to ensure all areas of concern were addressed. The RN CN consultant would provide oversite to ensure compliance.

13. On 08/23/2021 and 08/24/2021, the Vice President of Employee Experience was at the facility offering education on the Code of Conduct and providing support to the Interim Administrator.

14. On 08/23/2021 through 08/27/2021 and on 08/30/2021, a sister facility Administrator was on-site to provide guidance and support to the Interim Administrator.

15. On 08/23/2021 through 08/27/2021, a sister facility Administrator was on-site to provide education and quiz staff on the Code of Conduct. Also, the sister facility Administrator talked with staff to complete employee surveys.

16. On 08/26/2021, the RVP brought in the new Administrator. The RVP educated the new Administrator to include the Appointment Letter as Facility Administrator. The Appointment Letter outlined the Administrator's responsibilities: enforce rules and regulations; and maintain an ongoing liaison among the governing body, medical and nursing staff, and other professional and supervisory staff of the facility. The facility had a five (5) times a week interdisciplinary team

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F 837	Continued From page 386	F 837		

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

22. The facility increased the QAPI Committee meetings from quarterly to monthly for three (3) months, beginning on 08/10/2021. The QAPI committee meetings would include the Medical Director and at least two (2) corporate staff.

23. A Corporate Vice President continued to provide oversight of the facility. Oversight was provided daily via telephone and weekly via on-site visits through September 2021.

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

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

2. Review of documentation revealed the DON

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F 837	Continued From page 388	F 837		

Administrator while that position was vacant.

6. Review of the QAPI Meeting minutes, dated 07/23/2021, confirmed the Interim Administrator attended the meeting in which the facility plan to correct identified deficiencies was reviewed.

7. Review of documentation confirmed the RVP reviewed the responsibilities of the Interim Administrator regarding management and operation of the facility on 07/27/2021.

8. Interview with the RVP, on 09/02/2021 at 7:07 PM, confirmed he was present to provide support and oversight for the Interim Administrator, from 07/27/2021 through 08/09/2021.

Interview with the Interim Administrator, on 08/05/2021 at 2:48 PM, confirmed the RVP had been available and provided guidance in facility management.

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

Interview with State Registered Nurse Aide (SRNA) #24, on 09/02/2021 at 3:30 PM, revealed she had received training on the Code of Conduct, which included abuse, neglect, misappropriation, what to report, who to report to, and when to report. She revealed if she were to report an allegation to her supervisor and did not

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F 837	Continued From page 390	F 837		

sure policies were established and implemented regarding management and operation of the facility, and the responsibility of the RVP for appointing the licensed Administrator who reported to and was accountable to the RVP.

12. Review of a Governing Body Internal Audit confirmed the RVP completed review of inservices and audits on 08/23/2021. Continued review revealed the RVP reviewed inservices and audits again, on 08/25/2021 and 08/29/2021.

13. Review of quizzes on the Code of Conduct confirmed employees were trained and tested on 08/23/2021 and 08/24/2021. Review of the Principle LTC Code of Conduct booklet, revised 04/2019, revealed "Principle LTC is committed to its role in preventing health care fraud and abuse and complying with applicable state and federal laws related to health care fraud and abuse." The booklet provided guidance on the reporting chain of command, as well as the availability of the corporate compliance phone number.

14. Review of documentation confirmed a licensed Administrator from a sister facility was on-site 08/23/2021 through 08/27/2021 and again on 08/30/2021.

15. Review of documentation, to include Employee Surveys, revealed the sister facility Administrator met with staff and provided education on the Code of Conduct.

16. Review of the Appointment Letter as Facility Administrator, dated 08/26/2021, confirmed the RVP appointed the new Administrator on 08/26/2021. Review of an Administrator job description, dated 08/26/2021, confirmed the

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F 837	Continued From page 392	F 837		

reporting to the RVP. The Administrator revealed the RVP had a weekly call with all Administrators and DON's, every Tuesday.

18. Review of a Quality Initiative (QI) CPR Drill, dated 08/29/2021, confirmed support RN's executed a Code Blue Drill during day shift. Review of the drill revealed staff responded appropriately, with no retraining required.

Review of the Narcotic Cart Audits confirmed support RN's conducted audits on 08/28/2021 and 08/29/2021 of all facility medication carts, with no concerns identified.

Continued interview with the DON, on 09/02/2021 at 1:18 PM, confirmed staff did well on the CPR drill and responded appropriately.

Interview with the Clinical Director, on 09/02/2021 at 9:10 AM, revealed, on 08/28/2021 and 08/29/2021 a mock survey/audit was done, by her and sister facility support RN's, on all medication carts. The Clinical Director revealed there had been no concerns identified during their audits.

Interview with the SDC/QI, on 09/02/2021 at 4:49 PM, revealed she was uncertain what was written in the plan of correction regarding frequency of CPR drills, but she planned on ensuring CPR drills were conducted at least monthly for six (6) months, then maybe quarterly after that. She revealed she had been present during all three Code Blue drills, and it seemed like they were getting a little smoother each time.

19. Review of the Quality Assurance and Performance Improvement Guidance Manual, revised 06/26/2019, revealed the RVP functioned

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F 837	Continued From page 394 meeting was held on 08/10/2021, and there would be additional QAPI meetings in September and October. She stated the Medical Director had attended on 08/10/2021, and the dates for the September and October meetings had not yet been set, as the plan was to schedule them to ensure the Medical Director would be in attendance. 23. Continued interview with the Clinical Director, on 09/02/2021 at 1:18 PM, revealed the RVP did onsite visits and phone calls and had been at the facility frequently since the incident of drug diversion. She revealed whenever the RVP was not present, RVP #2, or another corporate Vice President was present at the facility. Continued interview with the RVP, on 09/02/2021 at 7:07 PM, revealed he worked with the Administrator and the facility as an overseer to ensure they had what they need. He stated, as RVP, he did a weekly clinical call (when not on-site) where he reviewed with each facility what was going on clinically in the building and got basic updates on different things. He stated the Administrator and DON for each building were usually on the call.	F 837		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880	F 880 1. Beginning on 9/13/21, all employees will be trained on correct hand washing. Licensed staff were trained on sanitizing the glucometers between uses by the DON and Unit Managers and provide correct return demonstration. In addition, all	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 880 Continued From page 398

contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review, review of the manufacturer's directions for use, and review of the facility's policy, it was determined the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent and control the development and transmission of communicable diseases and to implement interventions per the Centers for Medicare and Medicaid Services (CMS), the Centers for Disease Control and Prevention (CDC), and the Kentucky Department for Public Health (Health Department) state guidelines for COVID-19.

Observation of medication administration for Resident #64, on 08/11/2021, with Registered Nurse (RN) # 4 revealed improper hand hygiene

F 880 to ensure proper handwashing, and correct mask wearing. Five licensed nurses will be audited weekly for four weeks, then five licensed nurses will be audited monthly for two months, to ensure correct cleaning of glucometers. This audit will be completed for 5 weeks, then monthly for 2 months. Data collected will be taken to the monthly Quality Assurance Performance Improvement (QAPI) committee meeting for review and further recommendations.

The Quality Assurance Performance Improvement (QAPI) Committee consists of the Administrator, DON, UM, MDS nurse, Activities Director, Social Services Director, Therapy Manager, Food Service Manager, and Medical Director on a minimum of a quarterly basis.

Compliance Date: 11/24/2021

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 398	F 880		

Continued review revealed gloves should be applied prior to cleaning a glucometer. Per the policy, an Environmental Protection Agency (EPA) registered germicidal disposable cloth/wipe should be used to thoroughly wet the entire external surface of the glucometer. Then cover/wrap the entire glucometer with the wipe and place in a plastic disposable cup on the medication cart and allow full minutes' exposure time according to the manufacture's product directions for disinfection. Further, after full minutes' exposure time, remove the cloth wipe and discard. Return the glucometer to the plastic cup to allow thorough air dry time. Continued review revealed gloves should be removed at that time and hand hygiene should be performed. When the glucometer was completely dry, it then could be used for the next resident or stored in the medication cart, and the plastic cup should be discarded.

Review of the "Long Term Care Facility Guidance Principle Inc", dated 04/03/2020, revealed full PPE should be worn per CDC guidelines for the care of any resident with known or suspected COVID-19.

Review of the facility's procedures "Handwashing" and "Alcohol Hand Sanitizer" both dated 03/10/2020, revealed hands should be washed before and after contact with residents, after handling contaminated items, and whenever hands were visibly soiled. In addition, alcohol-based hand sanitizer could be used, unless hands were visibly soiled.

Review of Professional Disposables International (PDI) Incorporated, website https://pdihc.com/, dated 2021, revealed Super Sani-Cloth

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 400	F 880		

performing hand hygiene, and applied a topical Nicotine patch to the resident's right upper arm. The RN did not perform hand hygiene after doffing gloves and re-donning gloves to administer medication via the gastrostomy tube. Further observation, on 08/11/2021 at 12:15 PM, revealed RN #4 entered the resident's room, donned gloves without performing hand hygiene and administered medication via the resident's gastrostomy tube, then setup an inhalation medication in a nebulizer machine without performing hand hygiene or changing her gloves. Continued observation, on 08/11/2021 at 12:20 PM, revealed RN #4 entered the resident's room, donned gloves without performing hand hygiene, and administered a swish and spit oral medication.

2. Continued observation of Resident #64, on 08/11/2021 at 12:25 PM, by RN #4 revealed the nurse gathered the glucometer, a lancet, an alcohol pad, and the test strip bottle from the medication cart and entered the resident's room. The nurse placed the gathered items on the bedside table without preparing a clean area. Observation revealed the nurse washed her hands and donned gloves and performed a finger stick blood glucose check. Additionally, the glucometer was then placed on the bedside table until the reading was calculated; then RN #4 removed her gloves around the contaminated test strip and placed the glucometer in her scrub top pocket and discarded the soiled gloves into the trash can at the bedside. Continued observation revealed RN #4 then picked up the bottle of test strips, turned the resident's tube feeding back on, exited the room, signed the MAR, and sat the test strip bottle on top of the medication cart. Further RN #4 then entered the resident's room and

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 402	F 880		

the machine with a Sani-Cloth Bleach wipe, discarding the wipe and laid the machine to dry on top of the medication cart. The KMA doffed her gloves and did not perform hand hygiene. The KMA stated it was her understanding to wipe the glucometer's surface for fifteen (15) to twenty (20) seconds after each use and allow it to dry for two (2) minutes. Per the interview, it was important to clean the glucometer properly to ensure germs were not cross contaminated and to maintain infection control.

Record review revealed, on 08/11/2021, KMA # 9 worked on four (4) of the six (6) hallways in the facility and performed finger stick blood glucose checks with the same glucometer. There were three (3) additional residents who were ordered finger stick blood glucose checks, which KMA #9 performed: Resident #1, Resident #3, and Resident #60. Therefore, a total of five (5) residents received finger stick blood glucose checks with a glucometer that had been improperly disinfected by KMA #9.

3. Observation of the Speech Therapist, on 08/10/21 at 12:05 PM, revealed she was in a resident room assisting a resident with his/her meal tray. Additionally, the Speech Therapist was observed to touch the resident while assisting with the meal tray, without the use of gloves.

Observations and interviews, on 08/10/21 at 12:17 PM, revealed two (2) State Registered Nurse Aides (SRNA) were passing dinner trays on the South Unit and entered residents' rooms without sanitizing or washing their hands. A bottle of hand sanitizer was observed on top of the meal tray cart but was not being used by staff. Food

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

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F 880	Continued From page 404	F 880		

Further, the resident's roommate was now placed in quarantine.

Observation and interview, on 08/13/2021 at 2:03 PM, revealed Housekeeper #3 was wearing a surgical mask in the hallway outside of the Memory Care Unit; however, it had been reported a resident had tested positive for COVID-19 that morning. Housekeeper #3 stated she did not know she was supposed to wear an N95 mask. Additional interview revealed she had received training on Personal Protective Equipment (PPE) from the SDC.

Observation and interview, on 08/13/2021 at 2:12 PM, revealed PCA #3 was wearing a surgical mask in the hallway near the South Unit nurse's station; however, it had been reported a resident had tested positive for COVID-19 that morning. PCA #3 stated she had been told there was a positive case of COVID-19 at the facility but chose not to wear an N95 mask. The PCA stated she had been trained on PPE and Infection Control.

Interview with Resident #69, on 08/14/2021 at 12:16 PM, revealed the resident saw the nurses wearing their masks and washing their hands but stated several of the aides would come into his/her room with their masks under their chins. Additionally, the resident stated he/she was unsure if aides performed hand hygiene. Further, the resident stated he/she had COVID-19 last year and was in the hospital for a few days and did not want it again.

Interview with Central Supply (CS), on 08/14/2021 at 11:30 AM, revealed the facility did not have a shortage of supplies or PPE. Further, the CS had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 406	F 880		

08/18/2021 at 11:00 AM, revealed she expected the facility policies related to medication administration/hand hygiene, and glucometer cleaning and disinfecting to be maintained at all times. Additionally, she expected nursing staff to perform hand hygiene and don gloves per standards of practice. Continued interview revealed it was important to maintain infection control practices related to gloves and hand hygiene to decrease the risk of cross contamination. Further, she expect staff to clean glucometers prior to use and after each use with residents per the facility policy and manufacturer's recommendations. Per the interview, it was important to ensure infection control was maintained with medical devices to reduce the spread of communicable disease.

Continued interview with the DON, on 08/18/2021 at 11:00 AM, revealed training and education was provided to staff by the DON, SDC, facility consultants and the former Administrator. Additionally, she stated updated policies were provided to staff as updates were received and training given as needed through in-services or policies reviewed. Per the interview, all COVID-19 positive cases were discussed in daily IDT meetings and monthly QAPI meetings. Further, the DON stated she expected staff to follow Infection Control procedures and wear N95 masks when the facility had a COVID-19 positive resident, and surgical masks should be worn at other times. Also, she stated staff who entered a COVID-19 positive room were expected to wear proper PPE (gloves, gown, N95 masks) and to dispose of PPE properly, before exiting the resident's room. Per the interview, she would tell staff to put on N95 masks if she saw them not wearing one when they should be and follow

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	185028	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	08/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	2323 CONCRETE ROAD CARLISLE, KY 40311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS CFR: 42 CFR 483.70(a) BUILDING: 01 PLAN APPROVAL: 1962, RENOVATED IN 1994 SURVEY UNDER: 2012 Existing FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: One (1) story, Type III (000) Unprotected SMOKE COMPARTMENTS: Five (5) smoke compartments. COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM Installed in 1991 and upgraded in 1994. FULLY SPRINKLED, SUPERVISED (Wet SYSTEM) Installed in 1994 EMERGENCY POWER: Type II Diesel Generator installed in 1979. A Life Safety Code Survey was initiated and concluded on 8/10/2021. The facility was found not to be in compliance with title 42, Code of Federal Regulation, 483.90(a)et seq (Life Safety from Fire). The facility was licensed for one hundred four (104) beds with a census of eighty-eight (88) the day of the survey. Deficiencies were cited at the highest scope and	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 02/21/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	08/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	2323 CONCRETE ROAD CARLISLE, KY 40311

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K 271	Continued From page 2 The findings were verified by the DOM and acknowledged by the Administrator at the exit interview. Reference: NFPA 101 (2012 edition) 7.1.6.2 Changes in Elevation. Abrupt changes in elevation of walking surfaces shall not exceed 1/4 in. (6.3 mm). Changes in elevation exceeding 1/4 in. (6.3 mm), but not exceeding 1/2 in. (13 mm), shall be beveled with a slope of 1 in 2. Changes in elevation exceeding 1/2 in. (13 mm) shall be considered a change in level and shall be subject to the requirements of 7.1.7. 7.1.6.3 Level. Walking surfaces shall comply with all of the following: (1) Walking surfaces shall be nominally level. (2) The slope of a walking surface in the direction of travel shall not exceed 1 in 20, unless the ramp requirements of 7.2.5 are met. (3) The slope perpendicular to the direction of travel shall not exceed 1 in 48. Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface in accordance with CMS Survey and Certification Letter 05-38. 18.2.7, 19.2.7, S&C 05-38	K 271		
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure	K 321		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	08/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 321	Continued From page 4 The findings include: Observation, on 8/10/2021 with the Director of Maintenance (DOM) and Regional Director of Maintenance, (RDOM) revealed large amounts of combustibles, i.e., paper files were being stored in the Medical Records Office thus creating a Hazardous Area. The Medical Records Office Door did not have a door closer on it and was not self or automatic closing as required by NFPA 101 (2012) 19.3.2. The Medical Records Office Door opened to the corridor and was in excess of fifty (50) square feet in size. The findings were acknowledged by the Administrator and verified by the DOM upon exit. Actual NFPA Standard: Reference: NFPA 101 (2012 Edition) 19.3.2 Protection from Hazards. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating (with ¾ hour fire rated doors) or shall be provided with an automatic fire extinguishing system in accordance with 8.7.1. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Laundries (larger than 100 square feet)	K 321		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	08/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An Emergency Preparedness Survey was conducted on 8/10/2021. It was determined there were no concerns with 42 CFR §483.73 related to E-0024 (b) (6).	E 000		

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

02/21/2022

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