

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

PRINTED: 06/25/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185249	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 06/11/2025
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE AT JACKSON MANOR REHAB & WELL	STREET ADDRESS, CITY, STATE, ZIP CODE 96 HIGHWAY 3444 ANNVILLE, KY 40402
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	<p>INITIAL COMMENTS</p> <p>Based upon implementation of the acceptable plan of correction, an off-site revisit survey was conducted on 06/11/2025. It was determined the facility was in substantial compliance as of 05/24/2025 as alleged in the acceptable plan of correction</p>	{F 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 06/24/2025
---	-------	--------------------------------

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

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

PRINTED: 06/25/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185249	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/02/2025
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE AT JACKSON MANOR REHAB & WELL	STREET ADDRESS, CITY, STATE, ZIP CODE 96 HIGHWAY 3444 ANNVILLE, KY 40402
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 000	INITIAL COMMENTS A Recertification Survey was initiated on 04/28/2025, and concluded on 05/02/2025, with deficiencies cited at the highest Scope and Severity of a "D." The facility was found not to be in compliance with 42 CFR 483.5 - 483.75 - Subpart B - Requirements for Long Term Care Facilities. Total census 46.	F 000		
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.	F 640		5/24/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 05/21/2025
--	-------	-----------------------------

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

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

PRINTED: 06/25/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185249	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/02/2025
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE AT JACKSON MANOR REHAB & WELL			STREET ADDRESS, CITY, STATE, ZIP CODE 96 HIGHWAY 3444 ANNVILLE, KY 40402	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 640	<p>Continued From page 1</p> <p>§483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following:</p> <ul style="list-style-type: none"> (i) Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. <p>§483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, interview, facility document, policy review, and review of the "Long-Term Care Facility Resident Assessment Instrument [RAI] 3.0 User's Manual," the facility failed to ensure Minimum Data Set (MDS) assessments were transmitted to the Centers for Medicare & Medicaid Services (CMS) system within 14 days after the assessments were completed for three (Resident (R)12, R34, and R47) of three sampled residents reviewed for resident assessments.</p> <p>The findings included:</p>	F 640	<p>F0640 Encoding/Transmitting Resident Assessments (Long Term Care Facilities)</p> <p>1. Resident #12 the annual Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 2/27/25 and signed as complete by the MDS Coordinator on 3/10/25 was transmitted (submitted and accepted in iQIES) electronically on 4/30/25 by the MDS Coordinator.</p> <p>Resident #34 the quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of</p>	

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

PRINTED: 06/25/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185249	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/02/2025
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE AT JACKSON MANOR REHAB & WELL			STREET ADDRESS, CITY, STATE, ZIP CODE 96 HIGHWAY 3444 ANNVILLE, KY 40402		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 640	<p>Continued From page 2</p> <p>A facility policy titled, "Resident Assessment," revised on 09/15/2023, revealed, "15. The Assessment Coordinator will be responsible for ensuring that all required resident assessments are completed and submitted in accordance with current federal and state guidelines outlined in the RAI manual."</p> <p>Review of the "Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.19.1," effective 10/2024, indicated, under the "Comprehensive Assessments" section, "The MDS must be transmitted (submitted and accepted into iQIES) electronically no later than 14 calendar days after the care plan completion date (V0200C2 + 14 calendar days)." In addition, review of the "Non-Comprehensive Assessments and Entry and Discharge Reporting" section revealed that, "The MDS must be transmitted (submitted and accepted into iQIES) electronically no later than 14 calendar days after the MDS completion date (Z0500B + 14 calendar days)."</p> <p>1. A "Resident Face Sheet" indicated the facility admitted R12 on 10/28/2015 and most recently readmitted the resident on 08/29/2023.</p> <p>Review of an annual MDS, with an Assessment Reference Date (ARD) of 02/27/2025 revealed R12's assessment was signed as complete by the MDS Coordinator on 03/10/2025. A "Final Validation Report," dated 04/30/2025 at 9:22 AM, revealed the annual MDS assessment was not submitted until 04/30/2025. The Final Validation Report indicated, "Record Submitted Late: The submission date is more than 14 days after V0200C2 on this new (A0050 equals 1) comprehensive assessment (A0310A equals 01,</p>	F 640	<p>3/25/25 and signed as complete by the MDS Coordinator on 4/9/25 was transmitted (submitted and accepted in iQIES) electronically on 5/1/25 by the MDS Coordinator.</p> <p>Resident #47 the discharge Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 1/21/25 and signed as complete by the MDS Coordinator on 1/27/25 was transmitted (submitted and accepted in iQIES) electronically on 4/30/25 by the MDS Coordinator.</p> <p>2. All residents had the potential to be affected. a) On 5/19/2025 the Clinical Reimbursement Specialist audited validation reports for all MDS assessments completed in the last 6 months to ensure they were transmitted (submitted and accepted in iQIES) electronically. No late transmission MDS were identified.</p> <p>3. On 5/19/2025, the Clinical Reimbursement Specialist re-educated the MDS Coordinator on the facility's Resident Assessment Policy, and the transmission of MDS assessments using the Comprehensive Assessments and Non-Comprehensive Assessments and Entry and Discharge Reporting sections of the Long Term Care Facility Resident Assessment Instrument (RAI) 3.0 Users Manual Version 1.19.1. A post-test was given to the MDS Coordinator on</p>		

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

PRINTED: 06/25/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185249	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/02/2025
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE AT JACKSON MANOR REHAB & WELL			STREET ADDRESS, CITY, STATE, ZIP CODE 96 HIGHWAY 3444 ANNVILLE, KY 40402	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 640	<p>Continued From page 3 03.04, or 05)."</p> <p>During an interview on 05/02/2025 at 10:49 AM, the MDS Coordinator reviewed R12's MDS assessment and confirmed the assessment was not transmitted timely, and he was not sure why.</p> <p>2. A "Resident Face Sheet" indicated the facility admitted R34 on 09/17/2024 and most recently readmitted the resident on 12/18/2024.</p> <p>A quarterly MDS, with an ARD of 03/25/2025, revealed R34's assessment was signed as complete by the MDS Coordinator on 04/09/2025. A "Final Validation Report," dated 05/01/2025 at 11:44 AM, revealed the quarterly MDS assessment was not submitted until 05/01/2025. The Final Validation Report indicated, "Record Submitted Late: The submission date is more than 14 days after Z0500B on this new (A0050 equals 1) assessment."</p> <p>During an interview on 05/02/2025 at 10:44 AM, the MDS Coordinator reviewed R34's MDS assessment and stated the assessment was not transmitted timely as it should have been transmitted by day 14 after completion. He stated he was not sure why the MDS was not transmitted timely other than that he was new and still learning.</p> <p>3. A "Resident Face Sheet" indicated the facility admitted R47 on 12/11/2024.</p> <p>A discharge MDS, with an ARD of 01/21/2025, revealed R47's assessment was signed as complete by the MDS Coordinator on 01/27/2025.</p>	F 640	<p>5/19/2025 after the education was provided. A score of 100 percent was required. If a 100 percent score was not achieved, the MDS Coordinator was reeducated and then provided another post-test. This process continued until a 100 percent score was obtained. MDS Coordinator scored 100%.</p> <p>All new MDS Coordinators will be required to have all education and post-test during orientation by the Clinical Reimbursement Specialist prior to their working. A score of 100 percent is required and anyone not receiving a 100 percent score will be re-educated and provided with another post-test. This process will continue until a 100 percent score is obtained by all staff.</p> <p>Starting 5/22/2025, the Clinical Reimbursement Specialist will review 5 MDS assessments to ensure they were completed and submitted in accordance with current state and federal guidelines outlined in the RAI manual to include transmission within 14 days. These audits will be conducted weekly for 4 weeks, then reduced to monthly for 2 months. Results of the audits will be presented to the QAPI Committee for review and recommendation. Once the committee determines the problem no longer exists the audits will be conducted on a random basis.</p> <p>4. An Ad Hoc Quality Assurance and Performance (QAPI) meeting was held on</p>	

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

PRINTED: 06/25/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185249	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/02/2025
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE AT JACKSON MANOR REHAB & WELL	STREET ADDRESS, CITY, STATE, ZIP CODE 96 HIGHWAY 3444 ANNVILLE, KY 40402
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 640	<p>Continued From page 4</p> <p>A "Final Validation Report," dated 04/30/2025 at 9:31 AM, revealed the discharge assessment was not submitted until 04/30/2025. The Final Validation Report indicated, "Record Submitted Late: The submission date is more than 14 days after Z0500B on this new (A0050 equals 1) assessment."</p> <p>During an interview on 05/02/2025 at 10:55 AM, the MDS Coordinator reviewed R47's MDS assessment and confirmed the assessment was transmitted late.</p> <p>During an interview on 05/02/2025 at 5:16 PM, the Administrator revealed he expected all MDS assessments to be completed and transmitted timely according to the most recent RAI manual.</p>	F 640	<p>5/23/2025 with the Medical Director, the Facility Administrator, the Director of Nursing, the Clinical Reimbursement Specialist, and the Signature Care Consultant (SCC) regarding plan of correction formulated and implemented at that time on 5/23/2025. The Facility Administrator presented the plan and information and the results of the initial audits at the QAPI meeting on 5/23/2025. The Medical Director attended on 5/23/2025 and was notified of implementation of plan of correction. The Medical Director reviewed the entirety of the plan and made no further suggestions. The Medical Director stated the plan was appropriate. Starting on 5/23/2025 the Facility Administrator will hold a Quality Assurance meeting weekly for 4 weeks, then it will decrease to monthly for recommendations and further follow up regarding the above stated plan. The QAPI Committee will determine at what frequency any ongoing audits will need to continue. The Facility Administrator is responsible for the implementation of this plan. The Facility Administrator or Social Services Director will present the results of the audits to the QAPI committee not less than monthly. The QAPI committee will consist of, but is not limited to, the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Medical Records, MDS Coordinator, and Social Services Director (SSD). The QAPI committee will assess and direct frequency of audits, re-education needs, and resolution of the issue.</p>	
-------	---	-------	---	--

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

PRINTED: 06/25/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185249	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/02/2025
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE AT JACKSON MANOR REHAB & WELL	STREET ADDRESS, CITY, STATE, ZIP CODE 96 HIGHWAY 3444 ANNVILLE, KY 40402
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641 SS=D	<p>Accuracy of Assessments CFR(s): 483.20(g)</p> <p>§483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, the facility failed to ensure the accuracy of Minimum Data Set (MDS) assessments for three (Resident (R) 107, R21, and R53) of 15 sampled residents. MDS data was not coded accurately, in accordance with instructions from the Resident Assessment Instrument (RAI) User Manual, related to fall history, antipsychotic use, and/or discharge status.</p> <p>Findings included:</p> <p>A facility policy titled, "Resident Assessment," revised on 09/15/2023, revealed, "1. The Resident Assessment Instrument User Manual version 3.0 will be utilized for all items coded on Minimum Data Set (MDS) assessments.", Care Area Assessments (CAA) development, Care planning, MDS scheduling, submission, modifications, and Medicare regulations." The policy continued, "6. Assessment data will/may be collected from sources including the resident's medical record, interview with the resident and/or resident representative, observations, assessment tools including PASRR Level II determination and the Preadmission Screening & Resident Review (PASRR) evaluation, facility electronic medical records, and from other healthcare professionals with knowledge of the resident to ensure the assessment accurately reflects the resident's status."</p>	F 641	<p>F0641</p> <p>1. Resident #107 on 4/30/2025, the admission Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 4/24/25 was corrected to accurately reflect the residents fall and transmitted (submitted and accepted in iQIES) electronically by the MDS Coordinator.</p> <p>Resident #21 on 4/30/2025, the quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 12/13/24 was corrected to accurately reflect the residents use of antipsychotic medication and transmitted (submitted and accepted in iQIES) electronically by the MDS Coordinator.</p> <p>Resident #53 on 5/19/2025, the discharge Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 2/28/25 was corrected to accurately reflect the residents discharge status and transmitted (submitted and accepted in iQIES) electronically by the MDS Coordinator.</p> <p>2. All residents had the potential to be affected. a) Starting on 5/19/2025 and completed</p>	5/24/25

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

PRINTED: 06/25/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185249	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/02/2025
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE AT JACKSON MANOR REHAB & WELL			STREET ADDRESS, CITY, STATE, ZIP CODE 96 HIGHWAY 3444 ANNVILLE, KY 40402		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 641	Continued From page 6 1. A "Resident Face Sheet" indicated the facility admitted R107 on 04/17/2025. Review of an admission MDS, with an Assessment Reference Date (ARD) of 04/24/2025, identified that R107 had not had any falls since admission/entry, reentry, or their prior assessment. However, review of an "Event Report" revealed R107 sustained a fall on 04/23/2025 at 4:02 PM, while attempting to get up unassisted. During an interview on 04/30/2025 at 9:42 AM with the MDS Coordinator and the Clinical Reimbursement Consultant (CRC), the MDS Coordinator stated R107's MDS should have indicated the resident had a fall with minor injury. The CRC confirmed the resident's fall was not captured in the MDS and should have been recorded as a fall with minor injury. During an interview on 05/02/2025 at 5:13 PM, the Administrator stated R107's fall on 04/23/2025 should have been captured in the resident's MDS assessment. 2. A "Resident Face Sheet" indicated the facility admitted R21 on 09/02/2020, and most recently readmitted the resident on 08/11/2021. According to the "Resident Face Sheet," the resident had a medical history that included diagnoses of paranoid personality disorder; major depressive disorder, and schizophrenia. a. Review of R21's 12/2024 "Medication Administration History" revealed documentation that the resident received Seroquel 25 milligrams (mg) in the morning on 12/07/2024, 12/08/2024, 12/10/2024, 12/11/2024, and 12/12/2024 and	F 641	on 5/22/2025, the Clinical Reimbursement Specialist audited all MDS assessments completed in the last 6 months for residents with falls to ensure that the assessments accurately reflected the falls. b) Starting on 5/19/2025 and completed on 5/22/2025, the Clinical Reimbursement Specialist audited all MDS assessments completed in the last 6 months for residents taking antipsychotic medication to ensure that the assessments accurately reflected the use of antipsychotics. c) Starting on 5/19/2025 and completed on 5/22/2025, the Clinical Reimbursement Specialist audited all discharge MDS assessments completed in the last 6 months to ensure that the assessments accurately reflected the discharge status. 3. On 5/19/2025, the Clinical Reimbursement Specialist re-educated the MDS Coordinator on the facility's Resident Assessment Policy and accuracy of assessments in accordance with the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 Users Manual Version 1.19.1. A post-test was given to the MDS Coordinator on 5/19/2025 after the education was provided. A score of 100 percent was required. If a 100 percent score was not achieved, the MDS Coordinator was reeducated and then provided another post-test. This process continued until a 100 percent score was obtained. All new MDS Coordinators will be required to have all education and post-test during orientation by the Clinical Reimbursement		

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

PRINTED: 06/25/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185249	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/02/2025
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE AT JACKSON MANOR REHAB & WELL	STREET ADDRESS, CITY, STATE, ZIP CODE 96 HIGHWAY 3444 ANNVILLE, KY 40402
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 641	<p>Continued From page 7</p> <p>received Seroquel 100 mg at bedtime on 12/07/2024, 12/08/2024, 12/09/2024 and 12/13/2024.</p> <p>Review of R21's quarterly MDS, with an ARD of 12/13/2024, revealed the resident took an antipsychotic medication during the last seven days or since admission/entry or reentry if less than seven days. However, under section "N0450. Antipsychotic Medication Review," the MDS was marked, "0. No- Antipsychotics were not received," which indicated the resident did not receive antipsychotic medications since admission/entry or reentry or the prior OBRA assessment, whichever was more recent.</p> <p>b. Review of R21's 03/2025 "Medication Administration History: 03/01/2025 - 03/31/2025" revealed documentation that the resident received Seroquel 25 mg in the morning on 03/08/2025, 03/09/2025, 03/10/2025, 03/11/2025, 03/12/2025, 03/13/2025 and 03/14/2025 and received Seroquel 100 mg at bedtime on 03/08/2025, 03/09/2025, 03/10/2025, 03/11/2025, 03/12/2025, 03/13/2025, and 03/14/2025.</p> <p>Review of R21's quarterly MDS, with an ARD of 03/14/2025, revealed the resident took an antipsychotic medication during the last seven days or since admission/entry or reentry if less than seven days. However, under section "N0450. Antipsychotic Medication Review," the MDS was marked "0. No- Antipsychotics were not received," which indicated the resident did not receive antipsychotic medications since admission/entry or reentry or the prior OBRA assessment, whichever was more recent.</p> <p>During an interview on 04/30/2025 at 9:52 AM</p>	F 641	<p>Specialist prior to their working. A score of 100 percent is required and anyone not receiving a 100 percent score will be re-educated and provided with another post-test. This process will continue until a 100 percent score is obtained by all staff.</p> <p>Starting 5/22/2025, the Clinical Reimbursement Specialist will review 5 MDS assessments for residents with falls to ensure the assessments accurately reflect the falls in accordance with current state and federal guidelines outlined in the RAI manual. These audits will be conducted weekly for 4 weeks, then reduced to monthly x 2 months. Results of the audits will be presented to the QAPI Committee for review and recommendation. Once the committee determines the problem no longer exists the audits will be conducted on a random basis.</p> <p>Starting 5/22/2025, the Clinical Reimbursement Specialist will review 5 MDS assessments for residents who receive antipsychotic medication to ensure the assessments accurately reflect the use of antipsychotic medication in accordance with current state and federal guidelines outlined in the RAI manual. These audits will be conducted weekly for 4 weeks, then reduced to monthly x 2 months. Results of the audits will be presented to the QAPI Committee for review and recommendation. Once the committee determines the problem no longer exists the audits will be conducted</p>	
-------	---	-------	--	--

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

PRINTED: 06/25/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185249	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/02/2025
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE AT JACKSON MANOR REHAB & WELL			STREET ADDRESS, CITY, STATE, ZIP CODE 96 HIGHWAY 3444 ANNVILLE, KY 40402	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	<p>Continued From page 8</p> <p>with the MDS Coordinator and the CRC, the MDS Coordinator stated R21's MDS related to the Antipsychotic Medication Review should have indicated the resident routinely received antipsychotic medications. He stated it was an oversight when he was reviewing the resident record. The CRC confirmed the MDS assessments were coded incorrectly.</p> <p>During an interview on 05/02/2025 at 5:15 PM, the Administrator stated he expected the MDS Coordinator to review the resident's entire medical record and complete MDS assessments accurately.</p> <p>3. A "Resident Face Sheet" indicated the facility admitted R53 on 02/07/2025. According to the "Resident Face Sheet," the resident had a medical history that included a diagnosis of unspecified displaced fracture of the first cervical vertebra.</p> <p>Review of a physician's order, dated 02/21/2025, revealed an order for R53 to discharge home with home health services. Per the "Resident Face Sheet," the resident discharged home with home health services on 02/28/2025. Review of a "Resident Progress Notes," dated 02/28/2025 at 12:16 PM, also revealed R53 discharged home with home health services.</p> <p>Review of the discharge MDS, with an ARD of 02/28/2025, revealed it documented R53's discharge status as "04. Short-Term General Hospital," rather than a discharge to home.</p> <p>During an interview on 05/02/2025 at 10:47 AM, the MDS Coordinator stated R53's discharge location documented in the MDS was inaccurate,</p>	F 641	<p>on a random basis.</p> <p>Starting 5/22/2025, the Clinical Reimbursement Specialist will review 5 discharge MDS assessments to ensure they accurately reflect the discharge status of the resident in accordance with current state and federal guidelines outlined in the RAI manual. These audits will be conducted weekly for 4 weeks, then reduced to monthly for 2 months. Results of the audits will be presented to the QAPI Committee for review and recommendation. Once the committee determines the problem no longer exists the audits will be conducted on a random basis.</p> <p>4. An Ad Hoc Quality Assurance and Performance (QAPI) meeting was held on 5/23/2025 with the Medical Director, the Facility Administrator, the Director of Nursing, the Clinical Reimbursement Specialist, and the Signature Care Consultant (SCC) regarding plan of correction formulated and implemented at that time on 5/23/2025. The Facility Administrator presented the plan and information and the results of the initial audits at the QAPI meeting on 5/23/2025. The Medical Director attended on 5/23/2025 and was notified of implementation of plan of correction. The Medical Director reviewed the entirety of the plan and made no further suggestions. The Medical Director stated the plan was appropriate.</p> <p>Starting on 5/23/2025 the Facility</p>	

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

PRINTED: 06/25/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185249	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/02/2025
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE AT JACKSON MANOR REHAB & WELL			STREET ADDRESS, CITY, STATE, ZIP CODE 96 HIGHWAY 3444 ANNVILLE, KY 40402		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 641	<p>Continued From page 9</p> <p>confirming that the resident discharged home with home health services and did not discharge to the hospital. He stated it was a mistake and the MDS should have been coded as "12," for "home under care of organized home health service organization," not "04," for a short-term hospital.</p> <p>During an interview on 05/02/2025 at 1:29 PM, the Director of Nursing (DON) stated R53's MDS assessment was inaccurate. He stated the MDS should have been coded to identify the resident discharged home with home health services, not to a short-term hospital. He stated his expectation was for MDS assessments to be completed accurately.</p> <p>During an interview on 05/02/2025 at 5:15 PM, the Administrator stated he expected all MDS assessments to be completed accurately. He stated R53's MDS discharge assessment was inaccurate and should have reflected that the resident discharged home and not to a hospital.</p>	F 641	<p>Administrator will hold a Quality Assurance meeting weekly for 4 weeks, then it will decrease to monthly for recommendations and further follow up regarding the above stated plan. The QAPI Committee will determine at what frequency any ongoing audits will need to continue. The Facility Administrator is responsible for the implementation of this plan. The Facility Administrator or Social Services Director will present the results of the audits to the QAPI committee not less than monthly. The QAPI committee will consist of, but is not limited to, the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Medical Records, MDS Coordinator, and Social Services Director (SSD). The QAPI committee will assess and direct frequency of audits, re-education needs, and resolution of the issue.</p>		

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

PRINTED: 06/25/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185249	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED R 06/11/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE AT JACKSON MANOR REHAB & WELL	STREET ADDRESS, CITY, STATE, ZIP CODE 96 HIGHWAY 3444 ANNVILLE, KY 40402
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

{K 000}	<p>INITIAL COMMENTS</p> <p>Based on the acceptable Plan of Correction (POC) and the onsite revisit survey initiated and concluded on 06/11/2025, it was determined the facility had achieved substantial compliance with Life Safety Code on 05/21/2025.</p>	{K 000}		
---------	---	---------	--	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 06/24/2025
---	-------	--------------------------------

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

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

PRINTED: 06/25/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185249	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/30/2025
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE AT JACKSON MANOR REHAB & WELL	STREET ADDRESS, CITY, STATE, ZIP CODE 96 HIGHWAY 3444 ANNVILLE, KY 40402
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

E 000	Initial Comments Type of Structure: One (1) story, (1989), Type III (200), unprotected ordinary construction with five (5) smoke compartments and a complete automatic dry sprinkler system. An Emergency Preparedness Recertification Survey was conducted on 04/30/2025, in accordance with 42 Code of Federal Regulations, Subpart 483.73 (a)(3): (emergency preparedness) Requirements for Long Term Care Facilities. Signature Healthcare at Jackson Manor Rehab and Wellness Center was found to be in compliance with the Requirements for Participation in Medicare and Medicaid.	E 000		
-------	---	-------	--	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X8) DATE 05/25/2025
---	-------	--------------------------------

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

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

PRINTED: 06/25/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185249	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 04/30/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE AT JACKSON MANOR REHAB & WELL	STREET ADDRESS, CITY, STATE, ZIP CODE 96 HIGHWAY 3444 ANNVILLE, KY 40402
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

K 000	INITIAL COMMENTS Type of Structure: One (1) story, (1989), Type III (200), unprotected ordinary construction with five (5) smoke compartments and a complete automatic dry sprinkler system. A Life Safety Recertification Survey was initiated on 04/30/2025 and concluded on 4/30/2025, in accordance with 42 Code of Federal Regulations (CFR), Subpart 483:90(a) Requirements for Long Term Care Facilities. During this Recertification Survey, Signature Healthcare at Jackson Manor Rehab and Wellness Center was found not to be in compliance with the Requirements for Participation in Medicare and Medicaid.	K 000		
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9	K 321		5/21/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 05/25/2025
--	-------	-----------------------------

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185249	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 04/30/2025
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE AT JACKSON MANOR REHAB & WELL			STREET ADDRESS, CITY, STATE, ZIP CODE 96 HIGHWAY 3444 ANNVILLE, KY 40402		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 321	<p>Continued From page 1</p> <p>Area Automatic Sprinkler Separation N/A</p> <p>a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide separation of hazardous areas from other areas in the facility in accordance with National Fire Protection Association (NFPA) Standards. The deficient practice had the potential to affect one (1) hazardous office door, and staff. The facility had the capacity for 51 beds with a census of 47 on the day of the survey.</p> <p>The findings include:</p> <p>Observation, during the building inspection tour on 4/30/2025 at 1:22 PM, revealed the Dietary Manager office was over 50 square feet, being used to store combustible materials, and was equipped with an automatic or self-closing device, but was being help open with a permanently mounted doorstop on the bottom of the door.</p> <p>Interview, on 4/30/2025 at 1:23 PM with the Maintenance Director, revealed the facility was not aware the Dietary Manager Office door was being held open with the doorstop.</p>	K 321	<p>K0321 Hazardous Areas - Enclosure</p> <p>1. On 04/30/2025, the Maintenance Director did remove the permanently mounted doorstop on the bottom of the door of the Dietary Managers office.</p> <p>2. All Stakeholders, residents, and visitors could have been affected.</p> <p>3. On 4/30/2025:</p> <p>a. The Regional Plant Operations Director in-service the Maintenance Director on hazardous areas enclosures.</p> <p>b. The Maintenance Director will audit doors to hazardous areas enclosures 1 time per week for 4 weeks then 1 time per month for 3 months, or until substantial compliance is achieved, to ensure they do not have any permanently mounted doorstops on the doors.</p> <p>4. The Maintenance director is to provide copies of the audits to the Quality Assurance/Process Committee monthly or until substantial compliance</p>		

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

PRINTED: 06/25/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185249	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 04/30/2025
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE AT JACKSON MANOR REHAB & WELL			STREET ADDRESS, CITY, STATE, ZIP CODE 96 HIGHWAY 3444 ANNVILLE, KY 40402		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 321	Continued From page 2 The finding was verified by the Maintenance Director at the time of observation and the Administrator at the exit conference on 4/30/2025. Actual NFPA Standard: NFPA 101 Life Safety Code, (2012) 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.7.1 19.3.2.1.3 The doors shall be self-closing or automatic closing. 19.3.2.1.5 Hazardous areas shall include, but shall not be restricted to, the following: (1.) Boiler and fuel-fired heater rooms (2.) Central/bulk laundries larger than 100 ft2 (9.3 m2) (3.) Paint shop. (4) Repair shops (5) Rooms with soiled linen in volume exceeding 64 gal (242 L) (6) Rooms with collected trash in volume exceeding 64 gal (242 L) (7) Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard	K 321	is achieved.		
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors	K 363		5/21/25	

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

PRINTED: 06/25/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185249	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 04/30/2025
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE AT JACKSON MANOR REHAB & WELL			STREET ADDRESS, CITY, STATE, ZIP CODE 96 HIGHWAY 3444 ANNVILLE, KY 40402		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 363	Continued From page 3 Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was	K 363			
			K0363		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185249	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 04/30/2025
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE AT JACKSON MANOR REHAB & WELL			STREET ADDRESS, CITY, STATE, ZIP CODE 96 HIGHWAY 3444 ANNVILLE, KY 40402		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 363	<p>Continued From page 4</p> <p>determined the facility failed to maintain doors protecting corridors in accordance with National Fire Protection Association (NFPA) Standards. The deficient practice had the potential to affect one (1) resident room door, staff, and two (2) residents. The facility had the capacity for 51 beds with a census of 47 on the day of survey.</p> <p>The findings include:</p> <p>Observation, during the building inspection tour on 04/30/2025 at 2:00 PM, revealed the corridor door to Resident Room A1 failed to close and latch in the frame due to the resident trash can and patient wheelchair.</p> <p>Interview, on 04/30/2025 at 2:01 PM with the Maintenance Director, revealed the facility was not aware the door would not latch and close properly.</p> <p>The finding was verified by the Maintenance Director at the time of observation and the Administrator at the exit conference on 04/30/2025</p> <p>Actual NFPA Standard: NFPA 101 Life Safety Code, (2012) 19.3.6.3* Corridor Doors. 19.3.6.3.1 * Doors, including doors or panels to nurse servers and pass-through openings, protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be doors constructed to resist the passage of smoke and shall be constructed of materials such as the following: 1. 1 3/4 in. thick, solid-bonded wood core 2. Material that resists fire for a minimum of 20 minutes. 19.3.6.3.5 * Doors shall be provided with a means</p>	K 363	<p>1. On 4/30/2025, the Maintenance Director moved the trash can as well as the wheelchair so that the door would shut and latch into the frame for the corridor door to Resident Room A1.</p> <p>2. All Stakeholders, residents, and visitors could have been affected.</p> <p>3. On 4/30/2025: a. The Regional Plant Operations Director in-serviced the maintenance Director on ensuring all corridor doors are unobstructed, close, and latch into the frame. b. The Maintenance Director will audit corridor doors 1 time per week for 4 weeks then 1 time per month for 3 months, or until substantial compliance is achieved, to ensure corridor doors are unobstructed, close, and latch within their frames.</p> <p>4. The Maintenance Director is to provide copies of the audits to the Quality Assurance/Process Committee monthly or until substantial compliance is achieved.</p>		

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

PRINTED: 06/25/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185249	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 04/30/2025
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE AT JACKSON MANOR REHAB & WELL			STREET ADDRESS, CITY, STATE, ZIP CODE 96 HIGHWAY 3444 ANNVILLE, KY 40402		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 363	Continued From page 5 for keeping the door closed, and the following requirements also shall apply: 1. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. 2. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with 19.3.5.7.	K 363			
K 920 SS=E	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assemblies that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced	K 920		5/21/25	

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

PRINTED: 06/25/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185249	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 04/30/2025
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE AT JACKSON MANOR REHAB & WELL			STREET ADDRESS, CITY, STATE, ZIP CODE 96 HIGHWAY 3444 ANNVILLE, KY 40402	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 920	<p>Continued From page 6</p> <p>by: Based on observation and interview, the facility failed to maintain power strips and extension cords in accordance with National Fire Protection Association (NFPA) Standards. The deficient practice had the potential to affect four (4) rooms, staff, and two (2) residents. The facility had the capacity for 51 beds with a census of 47 on the day of the survey.</p> <p>The findings include:</p> <p>1). Observation, during the building inspection tour on 04/30/2025 at 1:27 PM, revealed an unrated power strip located in the Therapy Room with a refrigerator plugged into it overloading the rating. Interview, on 04/30/2025 at 1:28 PM with the Maintenance Director, revealed the facility was not aware of the refrigerator plugged into the power strip.</p> <p>2). Observation, during the building inspection tour on 04/30/2025 at 1:58 PM, revealed an extension cord located in the Soiled Linen Room with a refrigerator plugged into it as a substitute for permanent wiring. Interview, on 04/30/2025 at 1:59 PM with the Maintenance Director, revealed the facility was not aware of the extension cord in the room.</p> <p>3). Observation, during the building inspection tour on 04/30/2025 at 2:15 PM, revealed an unrated power strip located in the Therapy Office with a coffee maker plugged into it overloading the rating. Interview, on 04/30/2025 at 2:16 PM with the Maintenance Director, revealed the facility was not aware of the power strip in the room.</p> <p>4). Observation, during the building inspection</p>	K 920	<p>K0920 Electrical Equipment - Power Cords and Extension Cords</p> <p>1. On 4/30/2025, the Maintenance Director did remove:</p> <p>a. An unrated power strip located in the Therapy Room with a refrigerator plugged into it.</p> <p>b. An extension cord located in the Soiled Linen Room with a refrigerator plugged into it.</p> <p>c. An unrated power strip located in the Therapy Office with a coffee maker plugged into it.</p> <p>d. An unrated power strip located in the Administrator office with a refrigerator plugged into it.</p> <p>2. All Stakeholders, Residents, and visitors could have been affected.</p> <p>3. On 4/30/2025:</p> <p>a. The Regional Plant Operations Director in-serviced the Maintenance Director on power cords and extension cords.</p> <p>b. The Maintenance Director will audit all rooms 1 time per week for 4 weeks and then 1 time per month for 3 months, or until substantial compliance is achieved, for unrated power strips, power strips with appliances plugged into them, and extension cords being used as a substitute for permanent wiring.</p> <p>4. The Maintenance Director will provide copies of the audits to the facilities Quality Assurance/Process Committee monthly or until substantial compliance is achieved.</p>	

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

PRINTED: 06/25/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185249	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 04/30/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE AT JACKSON MANOR REHAB & WELL	STREET ADDRESS, CITY, STATE, ZIP CODE 96 HIGHWAY 3444 ANNVILLE, KY 40402
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

K 920	<p>Continued From page 7</p> <p>tour on 04/30/2025 at 2:17 PM, revealed an unrated power strip located in the Administrator Office with a refrigerator plugged into it, overloading the rating. Interview, on 04/30/2025 at 2:18 PM with the Maintenance Director, revealed the facility was not aware of the refrigerator plugged into the power strip.</p> <p>The findings were verified by the Maintenance Director at the time of observation and the Administrator at the exit conference on 04/30/2025.</p> <p>Actual NFPA Standard: NFPA 99 Health Care Facilities Code, (2012) 10.2.3.6 Multiple Outlet Connection. Two or more power receptacles supplied by a flexible cord shall be permitted to be used to supply power to plug-connected components of a movable equipment assembly that is rack-, table-, pedestal-, or cart mounted, provided that all of the following conditions are met: (1) The receptacles are permanently attached to the equipment assembly. (2) *The sum of the ampacity of all appliances connected to the outlets does not exceed 75 percent of the ampacity of the flexible cord supplying the outlets. (3) The ampacity of the flexible cord is in accordance with NFPA 70, National Electrical Code. (4) *The electrical and mechanical integrity of the assembly is regularly verified and documented.</p> <p>10.2.4 Adapters and Extension Cords. 10.2.4.1 Three-prong to two-prong adapters shall not be permitted. 10.2.4.2 Adapters and extension cords meeting the requirements of</p>	K 920		
-------	--	-------	--	--

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

PRINTED: 06/25/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185249	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 04/30/2025
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE AT JACKSON MANOR REHAB & WELL			STREET ADDRESS, CITY, STATE, ZIP CODE 96 HIGHWAY 3444 ANNVILLE, KY 40402		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 920	Continued From page 8 10.2.4.2.1 through 10.2.4.2.3 shall be permitted. 10.2.4.2.1 All adapters shall be listed for the purpose. 10.2.4.2.2 Attachment plugs and fittings shall be listed for the purpose. 10.2.4.2.3 The cabling shall comply with 10.2.3 10.2.3.2 Grounding Conductor. 10.2.3.2.1 Each electric appliance shall be provided with a grounding conductor in its power cord. Actual NFPA Standard: NFPA 70 National Electrical Code, (2011) 400.8 Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces Exception to (4): Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of 368.56(B) (5) Where concealed by walls, floors, or ceilings or located above suspended or dropped ceilings (6) Where installed in raceways, except as otherwise permitted in this Code (7) Where subject to physical damage	K 920			