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FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185309	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>OFFICE OF INSPECTOR GENERAL</u> DIVISION OF HEALTH CARE FACILITIES AND SERVICES B. WING _____	(X3) DATE SURVEY COMPLETED 06/30/2011
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NAME OF PROVIDER OR SUPPLIER HEARTLAND VILLA CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8005 US HWY 60 WEST LEWISPORT, KY 42351
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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
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F 000 INITIAL COMMENTS

A standard Health survey was conducted 06/28/11-06/30/11 and found the facility not meeting minimum Federal regulatory requirements. Deficiencies were cited, with the highest scope and severity of an "E". A Life Safety survey was conducted on 06/28/11 with deficiencies cited, with the highest scope and severity of an "F".

F 164 SS=D 483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS

The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.

Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.

Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.

The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.

The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment

F 000

"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, **Heartland Villa Care & Rehabilitation Center** does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."

F 164

F164

Re-education was conducted with CNA #6 and CNA #7 in relation to resident privacy during personal care on 6/29/11 by Assistant Director of Nursing. Resident #3 was provided privacy for personal care on 6/30/11 and thereafter.

The Administrator conducted rounds at the facility on 7/1/11 to ensure residents were provided privacy during care. No issues were identified.

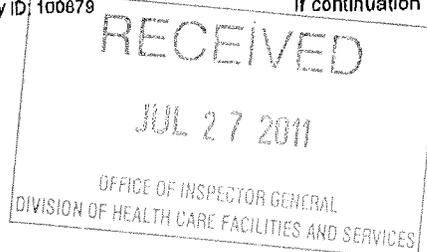
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Kathy K... [Signature]</i>	TITLE <i>Director of Nursing</i>	(X6) DATE <i>7/27/11</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution 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.

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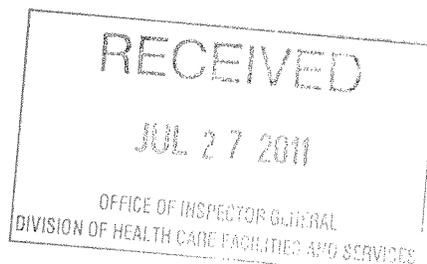
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F 164	<p>Continued From page 1 contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, interview and review of the facility's policy, it was determined the facility failed to provide privacy for one (1) of thirteen (13) sampled residents. Staff did not pull the privacy curtain when administering incontinence care for Resident #3.</p> <p>The findings include:</p> <p>A review of the facility's policy on privacy, revealed residents are to be treated in a manner that maintains privacy of their bodies during personal care.</p> <p>Record review for Resident #3 revealed the facility admitted the resident on 10/19/09, with the diagnoses of Paraplegia, Head Injury, Anxiety, and Calculus of the Kidney. The quarterly Minimum Data Set dated 05/20/11 assessed the resident as total dependence and assist of one for hygiene and bathing.</p> <p>Observation, on 06/29/11 at 2:58PM, revealed Certified Nursing Assistant (CNA) #6 and CNA #7 providing personal care for Resident #3. The CNAs had not pulled the privacy curtain around the resident's bed. Resident #3 was lying in bed with the lower portion of his/her body exposed to his/her roommate.</p> <p>An interview with CNA #6, on 06/29/11 at 3:10PM, revealed the facility's policy was to use the privacy curtain when providing personal care for a</p>	F 164	<p>Re-education regarding resident privacy during personal care was conducted by the Assistant Director of Nursing with certified nursing assistants working on 6/29/2011. Staff re-education on resident privacy during personal care was conducted on 7/21/2011 by the Assistant Director of Nursing and Clinical Case Manager.</p> <p>Visual observations will be conducted when personal care is being provided to residents three times per week for four weeks; then one time per week for eight weeks. Visual observations will be conducted by the Administrator, Director of Nursing or Assistant Director of Nursing. Any identified issues or concerns will be addressed and corrected at that time. Administrator, Director of Nursing, Assistant Director of Nursing, Clinical Case Manager, Health Information Coordinator, Social Service Director, House Keeping/Laundry Supervisor, Activities Director and Maintenance Director will assess during Ambassador Rounds weekly that privacy of residents is being maintained when appropriate.</p>



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F 164	<p>Continued From page 2 resident.</p> <p>An interview with CNA #7, on 06/29/11 at 3:10PM, revealed the privacy curtain should be pulled at all times when providing personal care for a resident. She further related she had quickly gone to the cart in the hallway to "grab something", while CNA #7 remained in the room with Resident #3.</p> <p>Interview with Licensed Practical Nurse (LPN) #4, on 06/29/11 at 4:25PM, revealed the facility's resident privacy policy was important and should be followed at all times. She stated the passing of medications, provision of medical treatment and personal care should always be carried out in the privacy of the resident's room and never in public view. LPN #4 stated, when personal care is conducted, the resident should be covered and the privacy curtain pulled.</p> <p>An interview with the Director of Nursing (DON), on 06/29/11 at 5:07PM, revealed all medications and treatments should be performed in the privacy of the resident's room. When providing personal care, the curtain should be pulled around the resident's bed for privacy. The staff are aware of the policy and are expected to follow it.</p>	F 164	<p>The Director of Nursing will report the results of the audits to the Performance Improvement Committee monthly which includes the Administrator, Director of Nursing, Medical Director (Quarterly), Assistant Director of Nursing, Maintenance Director, Activity Director, Social Services Director, Business Office Manager, Nutrition Services Director, Therapy Program Manager, Pharmacy General Manager (quarterly) and Environmental Services Director for further recommendations.</p> <p>Completion Date: 7/25/2011</p> <p>F226</p> <p>Housekeeper #1 was interviewed on 6/28/11 by Administrator and Director of Nursing. Resident #8 was informed by the Director of Nursing that the allegation was being investigated.</p> <p>The Administrator reviewed previous (1 year) allegations of alleged abuse/neglect/misappropriation investigations on 6/29/11 and no other resident was affected by this practice. A resident council was held on</p>
F 226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p>	F 226	



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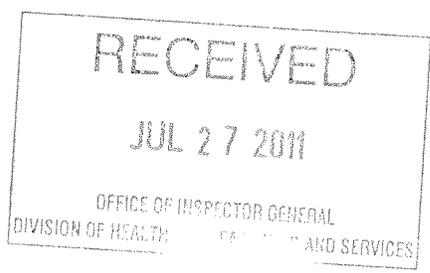
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F 226	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on record review, interview and review of the facility's policy it was determined the facility failed to complete a thorough investigation of reported neglect for one (1) of thirteen (13) sampled residents. The facility did not interview the staff member that reported an incident of alleged neglect regarding Resident #8. The findings include: Record review of the Abuse/Abuse Reporting Policy, by SunBridge Healthcare Corporation, dated 2008, revealed a description of the seven (7) mandatory parts of Abuse Policy, and outlines Section V: Investigation- which stated the center must have evidence that all alleged violations were thoroughly investigated. Review of the clinical record for Resident #8 revealed he/she was admitted on 10/01/06 with diagnoses of Congestive Heart Failure, Muscle Weakness, Hypertension, Diabetes type II, and Gastrointestinal Hemorrhage. The Minimum Data Set (MDS) assessment tool dated, 04/15/11 assessed Resident #8 with a cognitive ability of "8" on a fifteen (15) point scale. Review of the care plan dated 12/01/11, revealed Resident #8 had a care plan for Urinary Incontinence with no ability to improve function. Record review of the Event Investigation Tool, revealed the DON interviewed Certified Nursing Assistant (CNA) #5 and Resident #8 and documented both statements. The Investigation Tool included an attachment with a unsigned hand-written note that documented a	F 226	7/20/11 by the Activity Director to identify any potential allegations of abuse. Any issues will be addressed immediately. Re-education was completed by the Administrator with the Director of Nursing on 07/13/11 regarding investigating any allegation of abuse/neglect and/or misappropriation. Staff re-educated on investigations and prevention of mistreatment, neglect, and abuse of residents was completed on 07/18/11 by the Administrator and 07/21/11 by the Assistant Director of Nursing Services and Clinical Case Manager. The Director of Nursing, Assistant Director of Nursing, Clinical Case Manager, Health Information Coordinator, Social Service Director, Environmental Services Director, and Activities Director & Maintenance Director will have a binder that contains all of the necessary information to guide them through a thorough and complete investigation.



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<p>F 226 Continued From page 4</p> <p>conversation between the DON and the Housekeeping Supervisor with a description of the allegation which included a request for Housekeeper #1 to submit a written statement of the incident surrounding the allegation of neglect.</p> <p>Interview, on 06/29/11 at 10:15AM, with Housekeeper #1 revealed while she was cleaning room 105-2, Resident #8 was returned to his/her room by a CNA #5. Upon return to the room, Resident #8 was covered with a bath blanket and was sitting on a rolling shower chair and was left sitting in the hallway outside the resident's room. Housekeeper #1 stated that CNA #5 said, "Quick! Hand me that trash can!" and then placed a trash can under the shower chair Resident #8 was seated in. When Housekeeper #1 asked why CNA #5 placed the trash can under Resident #8, CNA #5 said it was in case Resident #8 had a bowel movement. CNA #5 said someone else would need to take Resident #8 to the bathroom because she did not have time to do so. Housekeeper #1 reported the incident to her supervisor and was asked to prepare a written statement of the allegation of neglect regarding Resident #8. Housekeeper #1 said she prepared the statement and provided it to the Housekeeping Supervisor. About two weeks later, Housekeeper #1 asked the Director of Nursing (DON) if she could get a copy of the statement provided regarding the incident of neglect regarding Resident #8. The DON told Housekeeper #1, she never received a report from Housekeeper #1. When Housekeeper #1 recounted the event, the DON replied, "We don't believe CNA #5 would do anything like that." Housekeeper #1 said she didn't believe the concern was investigated, and said the DON</p>	F 226	<p>Upon the conclusion of any investigation of an allegation, the Administrator will review information to ensure the necessary components of an investigation have been completed. The Administrator will report the results to the Performance Improvement Committee which includes the Medical Director, (Quarterly), Director of Nursing, Assistant Director of Nursing, Clinical Case Manager, Activity Director, Social Services Director, Business Office Manager, Nutrition Services Director, Therapy Program Manager, Pharmacy General Manager (quarterly) and Environmental Services Director as indicated for further review and recommendations.</p> <p>Completion Date: 7/25/2011</p>	



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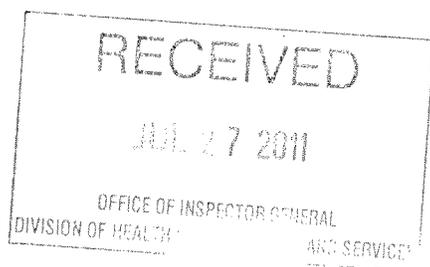
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<p>F 226 Continued From page 5</p> <p>must have assumed the allegation was a lie, since CNA #5 had been employed longer than Housekeeper #1. Housekeeper #1 said she didn't know if she observed any future Incident of abuse or neglect, it would be worth reporting because the incident regarding Resident #8 had not been investigated. Housekeeper #1 said she was not interviewed by the DON regarding the allegation, and was not asked to provide another written statement.</p> <p>Interview, on 06/29/11 at 11:30AM, with the Administrator and the Director of Nursing revealed the DON was told of the allegation regarding Resident #8 by the Housekeeping Supervisor. The DON said Housekeeper #1 should have reported the allegation of neglect directly to her rather than to the Housekeeping Supervisor. The DON initiated an investigation which included an interview with Resident #8 and CNA #5. The DON said Resident #8 and CNA #5 denied the allegation, and she could not substantiate the allegation of neglect as reported by Housekeeper #1. The DON stated she requested a written statement from Housekeeper #1, but she never received the statement. The DON stated she did not interview Housekeeper #1 because she thought she had the information needed to reach a conclusion, and added she probably should have done a formal interview with Housekeeper #1 to complete the investigation.</p> <p>Interview, on 06/29/11 at 12:15PM, with Resident #8 revealed he/she recalled an incident when he/she was returned from the shower room and was left sitting in the hall with only a cover over her body. Resident #8 said when he/she returned</p>	F 226		



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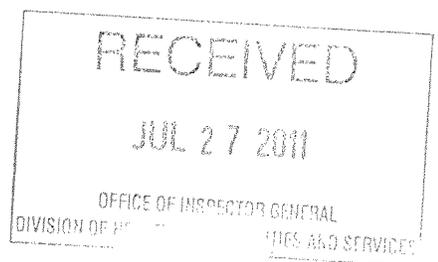
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F 226	Continued From page 6 from the shower room, and asked the CNA to take him/her to the bathroom, he/she was told the CNA did not have time. Resident #8 said the CNA put something under the chair in case the resident could not wait, and thought it was a trash can. Resident #8 said he/she had to go quickly and said, "It was terrible." Resident #8 said the wait was about ten (10) or fifteen (15) minutes; then he/she saw one of his/her "friends," (a CNA she was familiar with) and that CNA assisted the resident to the bathroom. Resident #8 said, "I was so embarrassed," but said he/she did not report the incident, and added, "I probably should have." Resident #8 said this incident should have been reported to the Administrator.	F 226	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide care for two (2) of thirteen (13) sampled residents in a dignified and respectful manner. The facility did not enhance the dignity of Resident #10 and Resident #13 regarding their request to be toileted. Resident #10 and Resident #13 were told by a staff member to take a number and stand in line to be toileted. The findings include:	F 241	F241 Certified Nursing Assistant #8 was re-educated and disciplined on 07/20/11 by the Assistant Director of Nursing in regards to enhancing resident's dignity and respect. Resident # 10 and 13 were toileted on 6/30/11 by a certified nursing assistant. A resident council was held on 7/20/11 by Activity Director to identify any potential residents not addressed in a dignified and respectful manner. Interviews were conducted with the residents on 07/15/11 by the Social Services Director who typically



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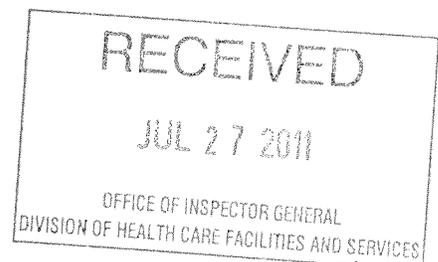
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<p>F 241 Continued From page 7</p> <p>Record review of Resident #10, admitted to the facility on 09/21/10, revealed the following diagnoses; Alzheimer's, Hypertension, Congestive Heart Failure, Chronic Obstructive Pulmonary Disease and Urinary Tract Infection. The quarterly Minimum Data Set (MDS) dated 06/17/11, revealed the resident was assessed as total dependence with assist of one person for toileting and a BIMS (Brief Interview for Mental Status) score of 00 indicating (severe cognitive impairment).</p> <p>Record review for Resident #13 revealed the resident was admitted by the facility on 04/08/11, with the following diagnoses: Cerebral Palsy, Anxiety Disorder, Post Traumatic Stress Disorder, and Obsessive Compulsive Disorder. The annual MDS assessment dated 04/28/11 assessed the resident as total dependence with assist of one person for toileting and a BIMS score of fifteen (15) (no impairment) for cognition.</p> <p>Observation, on 06/30/11 at 8:45AM, revealed the visitor of Resident #10 was wheeling him/her in front of the nursing station and informed Certified Nursing Assistant (CNA) #8 the resident needed to go to the restroom. CNA #8 told the visitor to take a number and stand in line behind Resident #13, who was seated in his/her wheelchair in front of the nursing station. The CNA stated she had to take care of the breakfast trays.</p> <p>Interview with the Visitor of Resident #10, on 06/30/11 at 9:00AM, revealed it was common to see residents line up in front of the nursing station after breakfast waiting for assistance to the restroom.</p>	F 241	<p>congregate in front of the nurse's station. Any issues will be addressed immediately.</p> <p>Education was presented at the resident council meeting on 7/20/11 to reinforce Resident Rights and educate the residents on who they can report allegations of abuse to with an emphasis on dignity by the Activity Director. Staff re-education on resident rights with an emphasis on addressing residents with dignity and in a respectful manner was completed 7/21/11 by the Assistant Director of Nursing and Clinical Case Manager.</p> <p>The Social Services Director and Activity Director will complete three (3) resident and or family interviews daily for one (1) week. Interviews will begin after staff education is completed on 7/21/11. Three (3) resident and or family interviews will be completed weekly for three (3) weeks then monthly for three months. The Social Services Director or Activities Director will report the results of the audits to the Performance Improvement Committee</p>	



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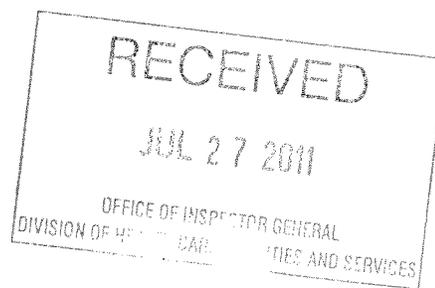
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<p>F 241 Continued From page 8</p> <p>Interview with CNA #8, on 06/30/11 at 9:10AM, revealed she did tell the visitor of Resident #10, to take a number and stand in line for assistance to the restroom. When questioned if her response was appropriate, she explained she was only joking. She stated residents requiring assistance to the restroom, formed a line after the breakfast meal.</p> <p>An interview was not conducted with Resident #10 due to his/her cognitive status. Interview with Resident #13, on 06/30/11 at 8:50AM, revealed he/she was waiting for assistance to the restroom. He/she did not hear the comment by the CNA to take a number and stand in line.</p> <p>Interview with the Director of Nursing (DON), on 06/30/11 at 9:30AM, revealed she would not expect a CNA to tell a resident to take a number and get in line for assistance to the restroom. She further stated the staff had been recently educated regarding their interactions with the residents. The DON stated the staff become too familiar with the residents and lose their professionalism.</p>	F 241	<p>which includes the Administrator, Medical Director (Quarterly), Director of Nursing, Assistant Director of Nursing, Clinical Case Manager, Maintenance Director, Activity Director, Social Services Director, Business Office Manager, Nutrition Services Director, Therapy Program Manager, Pharmacy General Manager (quarterly) and Environmental Services Director for further review and recommendations.</p> <p>Completion Date: 7/25/11</p>	
<p>F 279 483.20(d), 483.20(k)(1)-DEVELOP SS=D COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive</p>	F 279	<p>Resident #10 utilizes 1/4 side rails on the bed to assist in turning and repositioning. The care plan was updated to include this intervention on 06/30/11 by the Assistant Director of Nursing.</p> <p>A review of the comprehensive care plans was completed on 7/20/11 of residents utilizing side rails by the Administrator, Assistant Director of Nursing and the Clinical Case Manager. Issues identified were corrected immediately.</p>	



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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185399	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/30/2011
NAME OF PROVIDER OR SUPPLIER HEARTLAND VILLA CARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 8005 US HWY 60 WEST LEWISPORT, KY 42351	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE
F 279	<p>Continued From page 9 assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to revise the comprehensive care plan for one (1) of thirteen (13) sampled residents. The facility failed to have the side rails included in the comprehensive care plan for Resident #10.</p> <p>The findings include:</p> <p>Record review revealed the facility admitted Resident #10 on 09/21/10, with the following diagnoses: Alzheimer's; Hypertension; Congestive Heart Failure; Chronic Obstructive Pulmonary Disease and Urinary Tract Infection. A physician order dated 11/01/10 stated side rails to upper bed bilaterally to enable the resident's mobility in bed.</p> <p>Observation of resident #10, on 06/29/11 at 10:15AM and at 4:00PM, revealed the resident in bed with bilateral upper side rails engaged.</p>	F 279	<p>The Clinical Case Manager was re-educated to add side rails to resident care plans as indicated on 07/01/11 by the Administrator. Licensed Nurses were re-educated to update care plans with change of condition on 07/21/11 by the Assistant Director of Nursing and Clinical Case Manager.</p> <p>The Director of Nursing and Assistant Director of Nursing Services will audit three (3) care plans daily for one (1) week. Audits will begin after staff education is complete 7/21/11. Three (3) care plans will be audited weekly for three (3) weeks, then three (3) care plans will be audited monthly for three (3) months. The Director of Nursing or Assistant Director of Nursing will report the results of the audits to the Performance Improvement Committee which includes the Administrator, Medical Director (Quarterly), Director of Nursing, Assistant Director of Nursing, Clinical Case Manager, Maintenance Director, Activity</p>



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<p>F 279 Continued From page 10 Interview with the Director of Nursing (DON), on 06/30/11 at 9:45AM, revealed there was no facility policy on revising the comprehensive plan of care. She stated the Minimum Data Set Coordinator is responsible for the initial care plan. During the clinical meetings, new orders from the previous day are reviewed and the care plans are updated. The DON could not locate an initial side rail assessment nor care plan regarding the side rails for Resident #10.</p> <p>F 309 483.25 PROVIDE CARE/SERVICES FOR SS=D HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to provide the necessary care and services to maintain the highest practicable well being in accordance with the comprehensive assessment and plan of care for three (3) of thirteen (13) sampled residents. Resident #2, #7 and #10 did not have side rail assessments completed.</p> <p>The findings include: Record review for Resident #2, revealed an admission date to the facility of 04/29/11, with diagnoses of a Pressure Ulcer, Dysphagia,</p>	<p>F 279</p> <p>F 309</p>	<p>Director, Social Services Director, Business Office Manager, Nutrition Services Director, Therapy Program Manager, Pharmacy General Manager (quarterly) and Environmental Services Director for further recommendations</p> <p>Completion Date: 7/25/11</p> <p>F309</p> <p>Device Evaluations were completed for residents #2, #7 and #10 on 06/30/11 by the Director of Nursing and Assistant Director of Nursing.</p> <p>Current residents utilizing side rails were audited for device evaluations on 07/20/11 by Administrator, Assistant Director of Nursing and Clinical Case Manager. Issues identified were corrected immediately.</p>	



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F 309	Continued From page 11 Pneumonitis due to Aspiration, Vertebra Fracture, Hypertension, and Alzheimer's, revealed a physician order, dated 06/08/11, for Halo Bars bilaterally to the top of the bed to enable bed mobility and an order for Low Air Loss Mattress for pressure reduction. The record review revealed no side rail assessment was completed. Observation of Resident #2, on 06/29/11 at 9:10AM, at 9:50AM, and on 06/30/11 at 2:00PM, revealed the resident was in bed on the Low Air loss Mattress with bilateral Halo Bars engaged at the top of the bed. Record review for Resident #7 revealed the facility admitted the resident on 11/30/09, with the following diagnoses of Cardiovascular Disease, Cerebral Vascular Accident, Chronic Obstructive Pulmonary Disease, Anxiety, and Chronic Pancreatitis. A physician's order dated 06/07/11, indicated Halo Bars bilaterally to the bed to enable bed mobility. The record review revealed no completed side rail evaluation. Observation of Resident #7, on 06/28/11 at 7:30AM and 06/30/11 at 9:00AM revealed the resident in bed with bilateral Halo Bars engaged at the top of the bed. Record review for Resident #10 revealed the facility admitted the resident on 09/21/10n with the following diagnoses, Alzheimer's, Hypertension, Congestive Heart Failure, Chronic Obstructive Pulmonary Disease and Urinary Tract Infection. A physician order, dated 11/01/10, stated side rails to upper bed bilaterally to enable resident to move in bed. The record review did not have a completed side rail evaluation.	F 309	The licensed nurses were re-educated to utilize a device evaluation assessment tool prior to application, quarterly and with a significant change in condition for side rails and any assistive/restrictive devices on 07/21/11 by the Assistant Director of Nursing and Clinical Case Manger. The Director of Nursing and Assistant Director of Nursing Services will audit three (3) medical records daily for one (1) week to insure the appropriate device evaluation has been completed. Audits will begin after staff education is complete 7/21/11. Three (3) medical records will be audited weekly for three (3) weeks, and then three (3) medical records will be audited monthly for three (3) months. The Director of Nursing or Assistant Director of Nursing will report the results of the audits to the Performance Improvement Committee which includes the Administrator, Medical Director (Quarterly), Director of Nursing, Assistant Director of Nursing, Clinical Case Manager, Maintenance Director, Activity



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F 309 Continued From page 12

Observation of Resident #10, on 06/29/11 at 10:15AM and at 4:00PM, revealed the resident in bed with bilateral upper side rails engaged.

Interview with Licensed Practical Nurse (LPN) #3, on 06/30/11 at 10:30AM, revealed the Director of Nursing or the Minimum Data Set Coordinator completed the initial assessments. The unit nurse completed the follow-up assessments. However, LPN #3 was unsure when the follow-up assessment were to be completed. She stated the assessment form has a green area which alerts the nurse to complete a required assessment.

Interview with the Director of Nursing (DON), on 06/30/11 at 10:00AM revealed there was no policy on completing side rail assessments. She stated there was a sheet in the record which stated-to be completed before any device is used and updated quarterly. Side rails are included on the form. The DON could not locate side rail assessments for Resident #3, #7 or #10. She stated the side rail assessments should have been completed after receiving a physician order for side rails.

F 315 483.25(d) NO CATHETER, PREVENT UTI, SS=D RESTORE BLADDER

Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract

F 309

Director, Social Services Director, Business Office Manager, Nutrition Services Director, Therapy Program Manager, Pharmacy General Manager (quarterly) and Environmental Services Director for review and further recommendations

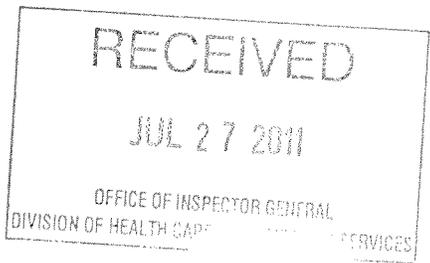
Completion Date: 7/25/11

F 315

Resident #3 received catheter care on 6/30/11 by a certified nursing assistant. Certified Nurse Aide # 3 and #8 were re-educated on 6/30/11 by the Director of Nursing on catheter care to prevent urinary tract infections.

F 315

Current residents with catheters were assessed for signs and symptoms of urinary tract infections by Licensed Nurses on 7/16/11 and 7/17/11. No residents were identified.



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NAME OF PROVIDER OR SUPPLIER HEARTLAND VILLA CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8005 US HWY 60 WEST LEWISPORT, KY 42351
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F 315 Continued From page 13
infections and to restore as much normal bladder function as possible.

This REQUIREMENT is not met as evidenced by:
Based on observation, record review, and interview, the facility failed to adequately train Certified Nursing Assistants (CNA) who provide catheter care to prevent recurrent Urinary Tract Infections (UTI) for one (1) (Resident #3) of thirteen (13) sampled residents.

The findings include:

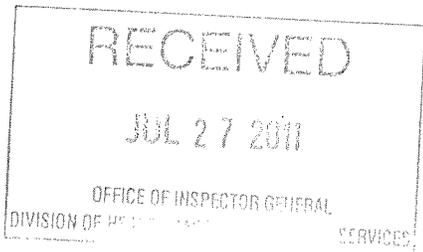
Policy review of the SunBridge Peri Care/Incontinence Care/Catheter Care, dated 03/2010, revealed peri-care products are used according to the manufacturer's directions for use. The peri-care procedure detailed instructions to use warm water in a basin with peri-wash.

Interview, on 06/30/11 at 10:25AM, with the Director of Nursing (DON) revealed the Sunbridge policy stated that soap and/or water could be used during peri-care and catheter care, and that she prefers the staff use soap to decrease the incidence of UTI. The DON stated the facility policy was "a little vague" on the procedure of catheter care. The DON was aware Resident #3 had a history of frequent UTIs, and said CNA #8 told her during the observation of catheter care for Resident #3, she became "nervous" about using soap, so she only used warm water. The DON stated, "We intend to initiate training to ensure the use of soap during catheter care."

F 315

CNA # 3 and CNA #8 were re-educated regarding catheter care to prevent urinary tract infections on 6/30/11 by Assistant Director of Nursing. Nursing staff were re-educated regarding catheter care to prevent urinary tract infections on 07/21/11 by Assistant Director of Nursing and Clinical Case Manager.

The Director of Nursing, Assistant Director of Nursing or Licensed nurses will complete catheter care visual reviews one (1) time per shift three (3) days weekly for one (1) week. Catheter care visual reviews will continue one (1) time per shift two (2) days per week for one (1) month, then one (1) monthly on each shift for three (3) months. The Director of Nursing or Assistant Director of Nursing will report the results of the audits to the Performance Improvement Committee which includes the Administrator,



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NAME OF PROVIDER OR SUPPLIER HEARTLAND VILLA CARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 8005 US HWY 60 WEST LEWISPORT, KY 42351	

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F 315 Continued From page 14

Review of the clinical record for Resident #3, revealed the date of admission was 10/19/09 with diagnoses of Paraplegia, Kidney Stones, Head Injury, and UTI. A physician progress note dated 05/15/11, detailed Resident #3 had a history of UTI, and probable increased drug resistant UTI.

Observation, on 06/29/11 at 11:00AM, of catheter care provided for Resident #3 by CNA #3 and CNA #8, revealed the peri-care and catheter care was performed with the use of warm water and clean wash cloths. The peri-care and catheter care did not include the use of any peri-care product.

Interview, on 06/29/11 at 11:10AM, with CNA #3 and CNA #8, revealed they were both trained to perform peri-care and catheter care with the use of warm water. CNA #3 said any type of soap would increase the risk of infection, because of a residue left by the soap. CNA #8 stated she was also trained to use warm water only with peri-care and catheter care.

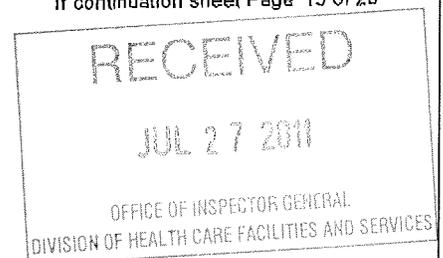
Interview, on 06/30/11 at 9:50AM, with LPN #1 revealed the DON provided staff training when Resident #3 was admitted, to ensure staff were familiar with the resident care needs. She stated Resident #3 is known to have a history of frequent UTIs. LPN #1 said CNA's were trained to use warm water and soap of any kind to provide peri-care and catheter care. LPN #1 stated the use of soap was necessary to decrease incidence of UTI.

Interview, on 06/30/11 at 10:05AM, with CNA #2 revealed during CNA certification training at a

F 315

Medical Director (Quarterly), Director of Nursing, and Assistant Director of Nursing, Clinical Case Manager, Maintenance Director, Activity Director, Social Services Director, Business Office Manager, Nutrition Services Director, Therapy Program Manager, Pharmacy General Manager (quarterly) and Environmental Services Director for further review and recommendations

Completion Date: 7/25/11



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F 315 Continued From page 15
local high school, she was trained to use only warm water during catheter care because, "soap can cause an infection, right?" CNA #2 said the facility policy directs staff to use warm water during catheter care.

F 315

Interview, on 06/30/11 at 10:20AM, with the Associate Director of Nursing (ADON) revealed she overheard staff discussing the use of warm water without peri-wash during catheter care, and intends to do some education. The ADON said peri-wash with warm water should be used during catheter care to decrease the incidence of UTIs.

F 323 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES
SS=E

F 323

F323

The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

The bathroom doors in rooms #102, #107, #109, #204 and #205 were repaired to open and close by the Maintenance Director on 7/01/11.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview, and record review, the facility failed to provide a hazard free environment by not ensuring bathroom doors opened and closed properly. Five (5) resident bathroom doors of the twenty-nine (29) doors checked did not open and close properly.

Resident bathroom and room doors in the facility were inspected by the Maintenance Director on 06/30/11 to assure they opened and closed. No other doors were identified.

The Maintenance Director was educated by the Administrator on 07/13/11 to complete preventive maintenance room inspections to

The findings include:

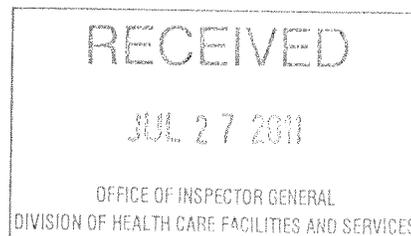
Review of the facility's policy/procedure for



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<p>F 323 Continued From page 16 identifying potential/actual environmental conditions revealed residents rooms are monitored through the use of a Resident Room Checklist which included "doors and frames close properly and are in good condition."</p> <p>Observation, on 06/28/11 at 8:15AM, revealed the bathroom doors in rooms #102, #107, and #109 would stick when opening and closing.</p> <p>Observation, on 06/28/11 at 9:09AM, revealed the bathroom door in room #204 did not fit the frame and could not be closed securely, and the bathroom door in room #205 would stick when opening and closing.</p> <p>Interview with the Director of Maintenance, on 06/30/11 at 8:40AM, revealed the doors did not fit properly, and would have to be removed and repaired. He stated it would be a problem if a resident entered the bathroom and could not get the door open. He related bathroom doors not opening and closing properly is a safety issue for the residents.</p> <p>Interviews with Housekeeper #1 and #2, on 06/30/11 at 8:49AM, revealed when the resident's room is cleaned, they check to make sure everything is working properly. If there is a concern, it is reported to the Director of Maintenance by writing it in the Maintenance Log, which is kept at the nurses station. Both housekeepers stated the bathroom doors should work properly so residents can open and close the doors easily.</p> <p>Interview with Licensed Practical Nurse (LPN) #3, on 06/30/11 at 8:56AM, revealed "sticking"</p>	F 323	<p>include doors & frames opening and closing and to provide a hazard free environment in every room on a minimum of a quarterly basis.</p> <p>The Maintenance Director will complete preventative maintenance audits, to included opening and closing of doors, in seven rooms per month for three months. The Maintenance Director will report the results of the audits to the Performance Improvement Committee which includes the Administrator, Medical Director (Quarterly), Director of Nursing, Assistant Director of Nursing, Clinical Case Manager, Maintenance Director, Activity Director, Social Services Director, Business Office Manager, Nutrition Services Director, Therapy Program Manager, Pharmacy General Manager (quarterly) and Environmental Services Director for review and further recommendations.</p> <p>Completion Date: 7/25/11</p>	



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F 323 Continued From page 17
bathroom doors are a problem, especially if a resident is attempting to enter or exit. She stated it is a safety issue that could lead to an accident. She further related all doors should operate properly in the event of a fire.

F 386 ; 483.40(b) PHYSICIAN VISITS - REVIEW SS=E CARE/NOTES/ORDERS

The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications.

This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to ensure physician orders were signed and dated for six (6) of thirteen (13) sampled residents. Resident #3, #4, #5, #6, #7, and #8 had monthly orders which were not signed and dated by the physician.

The findings include:

Record review for Resident #3 revealed the facility admitted the resident on 10/19/09, with the following diagnoses of Paraplegia, Head Injury, Anxiety and Calculus of the Kidney. The monthly orders for May were not signed by the physician.

Record review for Resident #4 revealed the facility admitted the resident on 10/01/06, with the

F 323

F 386

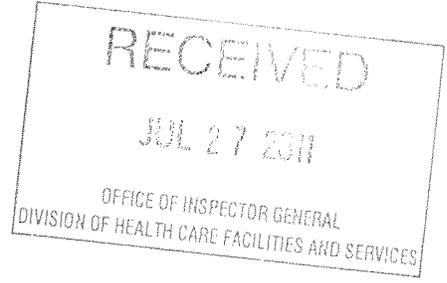
F 386

Physician orders for residents #3, #4, #5, #6, #7, #8 were signed on 07/14/11 by the physician.

An audit was completed on current resident's physician orders on 07/06/11 and 7/11/11 by the Health Information Manager. Orders that required signatures were signed by the physician 07/14/11.

The Health Information Manager was re-educated by the Administrator on 07/05/11 on timeliness of physician orders being signed.

The Health Information Manager will audit current resident charts monthly for physician signatures and dates of physician orders. The Health Information Manager will communicate to the Administrator by the 25th of each month any physician orders that require a signature and/or date.



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185399	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/30/2011
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NAME OF PROVIDER OR SUPPLIER HEARTLAND VILLA CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8006 US HWY 60 WEST LEWISPORT, KY 42351
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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
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F 386 Continued From page 18 following diagnoses of Rheumatoid Arthritis, Muscle Weakness, Psychosis, Bowel Syndrome and Hypothyroidism. The monthly orders for April were not signed and dated by the physician.

Record review for Resident #5 revealed the facility admitted the resident on 12/16/09, with the following diagnoses of Osteoarthritis, Hypertension, Contractures of the Lower Leg Joint, Depression and Anxiety. The monthly orders for April, and May were not signed and dated by the physician.

Record review for Resident #6 revealed the facility admitted the resident on 11/23/10, with the diagnoses of Renal Failure, Pneumonia, Cardiac Arrest, Hypertension, Diabetes, Cardiovascular disease, and Dementia. The monthly orders for April and May were not signed and dated by the physician.

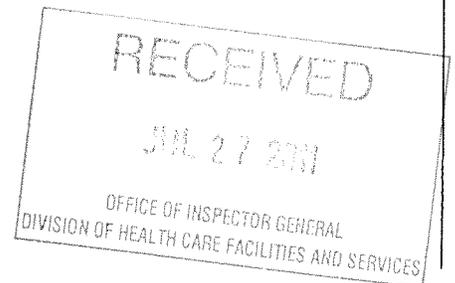
Record review for Resident #7 revealed the facility admitted the resident on 11/30/09, with the following diagnoses of Cardiovascular Disease, Cerebral Vascular Accident, Chronic Obstructive Pulmonary Disease, Anxiety, and Chronic Pancreatitis. The monthly orders for April and May were not signed and dated by the physician.

Record review for Resident #8 revealed the facility admitted the resident on 10/01/06, with the following diagnoses of Congestive Heart Failure, Femoral Fracture, Muscle weakness, Hypertension, Diabetes, and Gastrointestinal Hemorrhage. The monthly orders for May were not signed and dated by the physician.

Interview with the the Director of Nursing (DON)

F 386 The Administrator, Director of Nursing, or Assistant Director of Nursing will complete a monthly physician visit audit tool on five (5) residents for three months. The Administrator will report the results of the audits to the Performance Improvement Committee which includes the Administrator, Medical Director (Quarterly), Director of Nursing, Assistant Director of Nursing, Clinical Case Manager, Maintenance Director, Activity Director, Social Services Director, Business Office Manager, Nutrition Services Director, Therapy Program Manager, Pharmacy General Manager (quarterly) and Environmental Services Director for further review and recommendations.

Completion Date: 7/25/11



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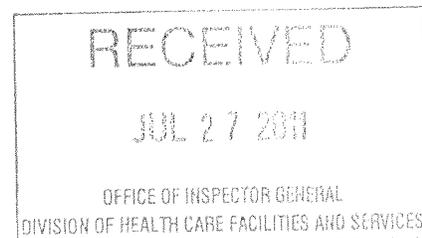
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F 386	Continued From page 19 and the Assistant Director of Nursing (ADON), on 06/30/11 at 4:40PM, revealed the physician orders should be signed and dated per regulation. The DON stated any new orders written between the monthly orders were taken to the physician's office by a staff member and retrieved by the staff member to ensure the physician signed the orders. However, the monthly orders were not included in this process. The DON stated she had changed the color of the monthly order sheet to ensure physician compliance and was not aware the monthly orders were not being signed by the physician.	F 386	
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 431	F431 The multi-dose vial of Vitamin B (cyanocobalam) was discarded on 07/18/11 by the Clinical Case Manager. The Advair inhalers and the Ventolin inhaler on 300 hall were discarded on 06/30/11 by the Director of Nursing Services. The Motillum (100 tabs) were labeled appropriately including the residents name and room number on 07/18/11 by the Clinical Case Manager. The tablets found loose in the drawers on the medication

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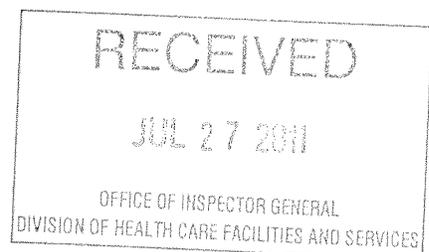
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NAME OF PROVIDER OR SUPPLIER HEARTLAND VILLA CARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 8006 US HWY 60 WEST LEWISPORT, KY 42361	
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F 431	<p>Continued From page 20</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based upon observation, record review, interview and review of the facility's policy it was determined the facility failed to ensure one (1) multidose vial of medication was dated when opened. Four (4) inhalers, stored on the medication cart for resident use, were dated as being opened greater than 30 days. In addition, one (1) medication was stored on the medication cart without a pharmacy label and was labeled with a resident's last name only on the box with no room number. There were four (4) residents at the facility with the same last name. There were loose and unlabeled pills on the medication carts. Two (2) of the medication carts had spillage in the drawers and bottles were sticky to touch.</p> <p>The findings include:</p> <p>Record review of the facility policies for Medication Storage, and Recommended Minimum Medication Storage Parameters, revealed medications are dated when opened, and should be stored in the containers in which they were received with labels. The policy stated</p>	F 431	<p>cart for the 300 hall were discarded on 06/30/11 by the Director of Nursing Services. The unlabeled medications in the bottom of the drawers were discarded on 06/30/11 by the Director of Nursing Services. The spills noted in the drawers of the medication cart for the 300 hall were cleaned immediately on 6/30/11 by the Director of Nursing Services. LPN # 1 was re-educated on how long inhalers could be stored on the cart after opening on 6/30/11 by Assistant Director of Nursing.</p> <p>The medication carts were audited for vials of medication with dates when opened, inhalers not opened greater than 30 days, loose and unlabeled medications and liquid spillage by the Assistant Director of Nursing and the Clinical Case Manager on 07/21/11. Identified issues were corrected immediately.</p>



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F 431	Continued From page 21 inhalers expire thirty (30) days after being opened. Observation of refrigerated medications in the Medication Room, on 06/30/11 at 10:45AM, revealed a one (1) multidose vial of Vitamin B (Cyanocobalam) was not dated as to when the vial was opened. Observation, on 06/30/11 t 10:45AM, of the Medication Cart for the 300 (even) hall, revealed three (3) Advair inhalers opened 05/18/11, 05/18/11, and 05/23/11, and one (1) Ventolin inhaler opened on 05/10/11 had been opened greater than thirty (30) days. The Medication Cart for the 300 (even) hall contained a box of Motilium (100 tabs) which were stored without a label, with a hand-written last name of a resident on the outside of the box, and did not list a room number. The Medication Cart for the 300 (even) halls contained two (2) loose and unlabeled medications in the bottom of the drawers: one (1) white, round tablet, and a half of a white, round tablet. The Medication Cart for the 300 (even) halls revealed the drawers containing elixirs had spillage in the bottom of the drawers and the inside of the drawers and the bottles in the drawer were sticky to touch. Observation, on 06/30/11 at 10:45AM, of the Medication Cart for the 300 (odd) hall, revealed one (1) yellow, round tablet which was loose and unlabeled in the drawer of the cart. Interview with LPN #1, on 06/30/11 at 11:00AM, revealed she was unaware how long the inhalers could be stored on the cart after being opened. LPN #1 did not know how the loose medications	F 431	The Assistant Director of Nursing and Clinical Case Manager re-educated the licensed nurses and certified medication technicians regarding dating vials of medication when opened, expiration dates of inhalers after opening, discarding loose and unlabeled medications and cleaning the medication carts on 07/19/11. The Assistant Director of Nursing, Director of Nursing, or Clinical Case Manager will audit the medication carts for dating/discarding, storage, labeling and cleanliness for four (4) weeks; then monthly for three (3) months. The Administrator will report the results of the audits to the Performance Improvement Committee which includes the Administrator, Medical Director (Quarterly), Director of Nursing, Assistant Director of Nursing, Clinical Case Manager, Maintenance Director, Activity Director, Social Services Director, Business Office Manager, Nutrition	



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F 431	<p>Continued From page 22</p> <p>could have been found in the bottom of the drawer and stated she had never known of loose medications to be found on the medication carts. LPN #1 was unaware of a cleaning schedule for the medication carts, and was not sure when they were last cleaned.</p> <p>Interview with the DON, on 06/30/11 at 5:30PM, revealed inhalers should not be stored on the cart for more than thirty (30) days. The DON stated the Motilium medication was obtained outside the United States, and therefore did not have a pharmacy label. The DON stated the Motilium should be labeled with a complete name and room number since there are four (4) residents with same last name in the facility, and this would assist the staff to avoid confusion. The DON stated the medication carts are inventoried monthly, and she usually assigned the task to the Associate Director of Nursing (ADON). However, no inventory log was maintained. Pharmacy reviews the medication carts either every two (2) months or quarterly, and identifies expired medications and checks the overall status of the cart. The DON did not remember having a problem with loose and unlabeled medications being found in the bottom of the drawers of the medication carts. The DON said, "We noticed some red elixir spilled in the bottom of one of the medication carts last night, and I have contacted the Pharmacy," about the need to review the medication carts.</p>	F 431	<p>Services Director, Therapy Program Manager, Pharmacy General Manager (quarterly) and Environmental Services Director for further review and recommendations.</p> <p>Completion Date: 7/25/11</p>

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105399	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 06/28/2011
NAME OF PROVIDER OR SUPPLIER HEARTLAND VILLA CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 8005 US HWY 60 WEST LEWISPORT, KY 42351	
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K 000	INITIAL COMMENTS	K 000		
K 050 SS=F	<p>A Life Safety Code Survey was initiated and concluded on 06/28/2011. The facility was found not to meet the minimal requirements with 42 Code of the Federal Regulations, Part 483.70. The highest Scope and Severity deficiency identified was an "F".</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review it was determined the facility failed to ensure fire drills were conducted at unexpected times under varied conditions. The deficiency had the potential to affect all smoke compartments, staff and residents. The facility is licensed for forty five (45) beds with a census of forty four (44) residents on the day of the survey.</p> <p>The findings include:</p> <p>Record review, on 06/28/11 at 11:46 AM, with the Maintenance Supervisor revealed the fire drills were not being conducted at unexpected times under varied conditions.</p>	K 050	<p>K050</p> <p>Fire Drills were completed 7/19/11 at 11:10 am, 7/19/11 at 6:00 pm, and 7/19/11 at 11:56 pm by Maintenance Director.</p> <p>The Administrator reviewed logs of fire drills on 6/28/11. Fire drills were conducted on above dates.</p> <p>The Administrator re-educated the Maintenance Director on 07/13/11 that fire drills are to be held at unexpected times under varying conditions at least quarterly on each shift.</p> <p>Fire drill documentation will be recorded in the T.E.L.S. (Total Equipment Life Span preventative maintenance program). The Administrator will audit the system monthly for three months to ensure fire drills are conducted at unexpected times under varying conditions on each shift. The Administrator will report the results of the audit to the Performance Improvement Committee which includes the Administrator, Medical</p>	

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

TITLE

(X8) DATE

Rachael R. ...

Director of Nursing

7/27/11

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.

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K 147	Continued From page 3 (1) Storage in front of electrical panel in Med Room next to Nurses Station. 2) Battery chargers for lift batteries plugged into a power strip located in the Whirlpool Room. 3) Piggy backed power strips plugged into an extension cord located in Physical Therapy. Interview, on 06/28/11, with the Maintenance Director confirmed all observations. Reference: NFPA 99 (1999 edition) 3-3.2.1.2 D Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters. Reference: NFPA 70 (1999 edition) 110-26. Spaces About Electrical Equipment. Sufficient access and working space shall be provided and maintained around all electric equipment to permit ready and safe operation and maintenance of such equipment. Enclosures housing electrical apparatus that are controlled by lock and key shall be considered accessible to qualified	K 147 Manager, Pharmacy General Manager (quarterly) and Environmental Services Director, for further recommendations. Completion Date: 7/25/11 K147 Items stored in front of the electrical panel in med room next to nurse's station were removed on 06/30/11 by Maintenance Director. The power strips in the Whirlpool Room were removed by the Maintenance Director on 7/5/11 and Physical Therapy room on 6/28/11. A receptacle was installed in the whirlpool room on 7/05/11 by the Maintenance Director. The Maintenance Director completed an audit of facility on 6/28/11 to ensure electrical wiring was maintained according to NFPA standards. No other issues were identified. The Maintenance Director was re-educated by the Administrator on 7/14/11 on maintaining electrical wiring according to NFPA standards. Staff were re-educated on 7/19/11 and 07/21/11 by the Assistant Director of Nursing, Clinical	

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<p>K 147 Continued From page 4 persons.</p>	<p>K 147</p>	<p>Case Manager and the Administrator on not using extension cords or power strips and not storing items in front of the electrical panels.</p> <p>The electrical panels, whirlpool room, rehabilitation area and three (3) resident rooms will be monitored weekly for four (4) weeks; then monthly for three months by the Maintenance Director or Administrator. This monitoring will be to ensure that there is: 1). no blockage of the electrical panel in the medication room; 2). no power strip located in the whirlpool room or therapy room; 3). no extension cords being utilized in the facility. The Administrator or Maintenance Director will report the results of the audit to the Performance Improvement Committee which includes the Administrator, Medical Director (Quarterly), Director of Nursing, Assistant Director of Nursing, Clinical Case Manager, Maintenance Director, Activity Director, Social Services Director, Business Office Manager, Nutrition Services Director, Therapy Program Manager, Pharmacy General Manager (quarterly) and Environmental Services Director for further review and recommendations.</p> <p>Completion Date: 7/25/11</p>	
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