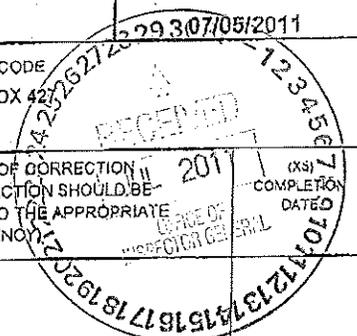


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/19/2011
FORM APPROVED
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185400 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 07/05/2011 C |
| NAME OF PROVIDER OR SUPPLIER HEARTHSTONE PLACE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 506 ALLENSVILLE ROAD, P.O. BOX 427 ELKTON, KY 42220 | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING 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 Abbreviated surveys (KY #15790, KY #16052 and KY #16461) were conducted on 06/29/11 through 07/05/11. KY #15790 was substantiated with no deficiencies cited. KY #16052 was unsubstantiated with no deficiencies cited. KY #16461 was substantiated with a deficiency cited related to the allegation. | F 000 | | |
| F 201 SS=0 | 483.12(a)(2) REASONS FOR TRANSFER/DISCHARGE OF RESIDENT The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; The safety of individuals in the facility is endangered; The health of individuals in the facility would otherwise be endangered; The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a nursing facility, the nursing facility may charge a resident only allowable charges under Medicaid; or The facility ceases to operate. | F 201 | 483.12(a)(2) REASONS FOR TRANSFER/DISCHARGE OF RESIDENT 1. Resident #1 was discharged home on 5/7/2011, 2. A chart audit will be completed 8/2/2011 on current residents with behaviors and Care Trak monitoring system to ensure interventions are care planned to permit the resident to remain in the facility, and not transfer or discharge the resident from the facility unless the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility. | 8/10/2011 |



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

Kathleen C. Evans

TITLE

NHA

(X6) DATE

7/29/11

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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| F 201 | Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on closed record review and interviews, it was determined the facility failed to permit one resident (#1), in the selected sample of three, to remain in the facility and not transfer or discharge the resident from the facility unless the resident's needs could not be met. Resident #1 attempted to exit the building two times and removed the care trek bracelet. The facility placed the resident on one to one (1:1) supervision, notified the family and informed the family the resident would be discharged because the facility did not provide 1:1 services. Findings include: A closed record review revealed Resident #1 was admitted to the facility, on 05/05/11, with diagnoses to include Dementia and Alzheimer's Disease. A review of an elopement assessment, dated 05/05/11, revealed the facility assessed the resident as an elopement risk and review of the nurse's note, dated 05/05/11 at 12:15 PM, revealed a care trek bracelet was placed on the resident, which would alert staff of the resident's attempt to exit the building. A review of the interim care plan, no date, revealed interventions included redirection as needed and encourage diversional activities. A review of the behavior monitoring form, no date, revealed no evidence the resident wandered, was combative or exhibited exit seeking behaviors. A review of the nurses' notes, dated 05/06/11 at 12:15 AM, and interviews with Licensed Practical | F 201 | Behavior Monitoring Forms and Care Plans of current residents will be audited, to be completed (date), to ensure they are dated appropriately. 3. Transfer and Discharge Policy was developed and implemented 7/29/2011. Administrator was in-serviced 7/29/2011 on the new Transfer and Discharge Policy by the Corporate Officer (Attachment #1) Facility Department Managers were in-serviced on 7/29/2011 on the new Transfer and Discharge Policy by the Administrator (Attachment #2). Licensed Nurses will be in-serviced 8/9/2011 on documentation requirements to include Transfer and Discharge Policy, the dating of care plan, Behavior Monitoring Form, and Medication Administration (Attachment #3) | |

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| F 201 | <p>Continued From page 2</p> <p>Nurse (LPN) #1 and LPN #2, on 07/01/11 at 7:30 AM and 8:10 AM, revealed the resident exhibited increased anxiety related to the absence of his/her significant other and refusal to change his/her clothes for bed. The resident told staff he/she did not intend to stay there, however, he/she went to bed and went to sleep. At 4:00 AM, the lab technician entered the resident's room and the resident became agitated. The staff left the room to allow the resident to calm down. The LPNs revealed the resident was restless throughout the night and expressed the desire to call his/her significant other and have someone come get him/her. LPN #2 stated by the next morning the resident packed his/her clothes and the resident was redirected from the door one time and the resident became argumentative, but was not combative.</p> <p>A review of a nurse's note, dated 05/06/11 at 10:00 AM, revealed Resident #1 became upset and stated he/she wanted to go home. The staff explained his/her need to stay at the facility and the resident agreed, however, after a short time, the resident became upset again. The nurse called the physician and received an order for Xanax 0.25 milligrams (mg) two times a day (BID), as needed (PRN) for anxiety. However, a review of the Medication Administration Record (MAR) and Controlled Drug Record, dated May 2011, revealed no documented evidence the resident received Xanax and there was no additional documented evidence of exit seeking behaviors.</p> <p>Further review of nurses' notes, dated 05/06/11 at 3:45 PM and 4:00 PM, and an interview with the Director of Nursing (DON), on 06/29/11 at 3:30</p> | F 201 | <p>Medication Aides will be in-serviced 8/9/2011 on documenting and dating behaviors, behavior interventions, and PRN medication when administered (Attachment #4).</p> <p>Certified Nursing Assistants will be in-serviced 8/9/2011 on documenting and dating behaviors and behavior interventions (Attachment #5).</p> <p>4. CQI form SS-10, Discharge Planning, was developed and implemented 7/29/2011. CQI SS-10 will be completed monthly for three (3) months, then quarterly thereafter by a CQI committee member.</p> <p>Completion Date: 8/10/2011</p> | |

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| F 201 | Continued From page 3 PM, revealed she entered the resident's room and observed the resident, holding the Care Trek bracelet in his/her hand. When she tried to take the bracelet from the resident's hand, the resident raised his/her arm, as if to strike. The DON stated she backed off and initiated 1:1 supervision. The DON returned approximately 30 minutes later and replaced the care trek bracelet on the resident's ankle and continued 1:1 supervision. The physician and the resident's significant other were notified. The resident's significant other was made aware of the resident's behavior and that the facility did not provide 1:1 supervision. She asked the significant other if he/she could come and sit with the resident. The significant other stated he/she could not sit with the resident, due to health reasons and cried stating, "What am I going to do?" The significant other stated he/she had to call his/her son and would call back later. At 7:00 PM, the DON received a call from the resident's son and was told the family was uncertain as to what they would do about the resident. She told the son the facility was sorry, however, they were unable to meet the resident's needs. The son told the DON they could not meet the resident's needs either, and that was why the resident was placed in the facility. The DON told the son they would work on a referral, however, they could not keep the resident at the facility, because the facility did not provide 1:1 services. The son informed the facility he would not be able to come and get the resident that night, because phone calls for other placement had to be made. The son further stated, the resident could not return to his/her home, because it would put his other parent in danger. The DON told the son they would provide 1:1 supervision for the night. The | F 201 | | |

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| F 201 | <p>Continued From page 4</p> <p>son stated his brother would come the next day and get the resident. The DON notified the physician of the family's hesitancy. The physician told the DON that if the resident became anxious and upset to the point interventions would not calm him/her down, they could send the resident to the hospital for treatment. The resident remained on 1:1 supervision, sitting in his/her room quietly. Further review of the nurses' notes, dated 05/06/11 at 11:50 PM and 05/07/11 at 2:00 AM, and interviews with the Staffing Coordinator and Certified Nurse Aide (CNA) #1, on 06/30/11 at 2:30 PM and 2:45 PM, revealed the resident had received his/her medications, went to bed and slept well, the night before the discharge. The Staffing Coordinator made no further attempts to exit the facility and exhibited no combative behaviors. CNA #1 revealed Resident #1 slept through the night and sat in the recliner when he/she awakened the next morning. The CNA stated the resident, at one time, stated he/she needed to check on his/her significant other, but made no attempts to exit the building and no combative behaviors were noted.</p> <p>An interview with the DON and Admissions Coordinator, on 06/29/11 at 3:30 PM and on 06/30/11 at 12:55 PM, revealed that on 05/07/11, the discharge paperwork and referral were completed. At approximately 9:30 AM, she attempted to call the family and received no answer. She called the Administrator and was told that legally, by law, they could not meet the resident's needs and they could not hold the resident against his/her rights, due to the fact the resident did have a guardian. The DON stated the Administrator told her to have the Admissions Coordinator go with her and to take the resident</p> | F 201 | | |
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| F 201 | <p>Continued From page 5</p> <p>to his/her home. She took the discharge paperwork, state and federal regulations and the paperwork the family needed to sign, as instructed by the Administrator.</p> <p>A review of the nurse's notes, dated 05/07/11 at 10:15 AM, revealed Resident #1 was discharged home and left the facility with the DON and the Admissions Coordinator.</p> <p>A review of a General Power of Attorney, dated 02/20/98, revealed Resident #1 designated his/her significant other and stepchildren as his/her health care surrogates to enable them to make health care decisions, when he/she no longer had decisional capacity. Further review of the record revealed Resident #1's significant other signed all admission paperwork, to include a Do Not Resuscitate (DNR) order.</p> <p>An interview with Resident #1's son, on 06/30/11 at 2:15 PM, revealed Resident #1 chased his/her significant other out of the home and threatened to kill the significant other, on 04/26/11. The police were notified and Resident #1 was hospitalized, at that time. The family determined Resident #1's significant other could no longer meet the resident's care needs and a decision was made to place the resident in a nursing home. The significant other was unable to sit with the resident the evening/night of 05/06/11, due to his/her own health issues. He stated the family was told that the resident would be discharged, because they did not provide 1:1 services, however, the facility would make a referral to another facility. The next morning, on 05/07/11, two staff pulled up in a car with the resident and brought the resident in the house</p> | F 201 | | |

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| F 201 | <p>Continued From page 6 with discharge paperwork to be signed.</p> <p>A review of the facility's notice for transfer or discharge revealed the resident was discharged, due to the facility's inability to meet the resident's needs. It revealed Resident #1 attempted to leave the facility unattended and became aggressive when staff redirected or provided care for the resident. However, a review of the record and interviews with staff revealed there were only two incidents when the resident attempted to walk toward the exit door and one incident when the resident raised his/her arm, as if to strike someone.</p> | F 201 | | |