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

PRINTED: 10/04/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185400		09/20/2012

NAME OF PROVIDER OR SUPPLIER: HEARTHSTONE PLACE

STREET ADDRESS, CITY, STATE, ZIP CODE: 608 ALLENSVILLE ROAD, 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 A recertification survey was conducted on 09/18/12 through 09/20/12 to determine the facility's compliance with Federal requirements. The facility failed to meet the minimum requirements for recertification with the highest scope and severity of an "E."	F 000	*Disclaimer: "Hearthstone Place is a facility dedicated to her residents. Furthermore, this plan of correction is not an admission or agreement by Hearthstone Place of the allegations, statements, findings, facts or conclusions that comprise alleged deficiencies and/or in the entire CMS-2567."*	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. 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 assessment. 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). This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy/ procedure, it was determined the facility failed to develop a comprehensive care plan for one resident (#13), in the selected	F 279	F 279 483.20 (d), 483.20 (k) (1) **DEVELOP COMPREHENSIVE CARE PLANS** ***The corrective action accomplished to correct the alleged deficient practice:*** On 10/10/2012, a Restraint/Side Rail/Fall/Device care plan was re-written for resident #13 by an Administrative Nurse. On 10/10/2012, a comprehensive chart audit was conducted by MDS Coordinator reviewing the medical record of resident #13. This audit included, but was not limited to, Physicians Orders, fall history, nursing assessments to include Norton's and Comprehensive Side Rail/Devise/Fall Assessments, current comprehensive care plan including the Norton's/skin and Restraint/Side Rail/Fall/Devise Care Plan, nurse aide care plan, and fall interventions currently in place for resident #13. ***How the facility will identify other areas having the potential to be***	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Katherine C. Evans — TITLE: Administrator — (X6) DATE: 10/12/12

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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NAME OF PROVIDER OR SUPPLIER HEARTHSTONE PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 506 ALLENSVILLE ROAD ELKTON, KY 42220	

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F 279	Continued From page 1 sample of 15 residents. Resident #13 was assessed by the facility to require interventions related to falls; however, there was no evidence a care plan for falls was developed. Findings include: A review of the facility's policy/procedure, "Care Plan - Comprehensive," undated, revealed "an individualized comprehensive care plan is developed for each resident." Additionally, the care plan is developed within 7 days of the resident's comprehensive assessment and revised as changes in the resident's condition indicated. Further review revealed care plans are reviewed at least quarterly. A record review revealed the facility admitted Resident #13 on 11/05/08 and re-admitted on 07/25/12 with diagnoses to include Senile Dementia, Psychosis, Osteoporosis, Subdural Hemorrhage, Transient Ischemic Attack, and Urinary Tract Infection. A review of the quarterly Minimum Data Set (MDS) assessment, dated 08/11/12, revealed the facility assessed Resident #13 to be severely cognitively impaired. Resident #13 was assessed in the CAA areas for the need to be care planned for Delirium, Cognitive Loss/Dementia, Communication, Urinary Incontinence, Indwelling Catheter, Psychosocial Well-Being, Mood State, Behavioral Symptoms, Activities, Falls, Nutritional Status, Dehydration/ Fluid Maintenance, Dental Care, Pressure Ulcer, and Psychotropic Medication Use. Further record review revealed Resident #13 had	F 279	***affected by the same alleged deficient practice:*** On 10/11/2012, a comprehensive audit was concluded by an Administrative Nursing team (comprised of DON, ADON, MDS Coordinator and a PRN Administrative Nurse) to review the comprehensive care plans of Nursing Facility residents. This audit included, but was not limited to, Physicians Orders, fall history, nursing assessments to include Norton's and Comprehensive Side Rail/Devise/Fall Assessments, current comprehensive care plan including the Norton's/skin and Restraint/Side Rail/Fall/Devise Care Plan, nurse aide care plan, and interventions currently in place to identify and immediately address if any other residents needed a fall care plan implemented. On 10/12/2012, Continuing Quality Improvement (CQI) form N-19 "RAI Process (Assessment and Care Planning) was completed under the supervision of the DON to determine comprehensive fall care plans have been developed for Nursing Facility residents. ***What measures or systemic changes were made to ensure that the alleged deficient practice will not recur:*** On 10/10/2012, the Administrator in-serviced Interdisciplinary Team members and management on completing fall assessments and comprehensive fall care plans on Nursing Facility residents and Department Head compliance rounds.	

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F 279	Continued From page 2 a history of falls on 03/24/12, 07/07/12, 07/23/12, and 08/06/12, with interventions put into place after each fall; however, there was no evidence a care plan was developed related to falls. Interview with Licensed Practical Nurse (LPN) #4, on 09/20/12 at 11:10 AM, revealed the process for new residents' care plans began with a temporary care plan determined by the nurse's admission assessment, the diagnoses, risks/benefits assessment, interdisciplinary assessment, and physician's orders. The care plan was to be updated quarterly along with the MDS assessment, and the nursing staff assisted with updates. Care plans were also updated with the annual MDS assessment, a significant change in condition, and as needed. LPN #4 stated the Assistant Director of Nursing (ADON) was responsible for the monthly change-overs and updates. Interview with the Director of Nursing (DON), on 09/20/12 at 12:15 PM, revealed the assessments should be completed upon admission to the facility and quarterly. She stated the ADON was responsible; however, she was just assigned that responsibility recently.	F 279	By 10/17/2012, Director of Nursing (DON) in-serviced Licensed Nurses on completing fall assessments and comprehensive fall care plans on Nursing Facility residents. On 10/11/2012, the Administrator reviewed and revised CQI Tool N-19 and following has been added Norton's and Comprehensive Side Rail/Devise/Fall Assessments completed per protocol; each resident has an appropriate Norton's and Restraint/Side Rail/Fall/Devise Care Plan; interventions from the comprehensive care plan have been transcribed onto the nurse aide care plan; nurse aide care plans are accurate and being followed in accordance with each resident's written plan of care; and services provided meet current professional standards of quality and services are provided by an appropriately qualified person. ***How the facility plans to monitor its plans to monitor its performance to ensure that solutions for the alleged deficient practice are sustained:***	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.	F 282	Beginning 10/12/2012, under the supervision of the DON, CQI Tool N-19 "RAI Process (Assessment and Care Planning)" will be completed monthly for three months and then quarterly per CQI calendar thereafter to determine that the facility develops comprehensive fall care plans for Nursing Facility residents. The Quality Assurance Team will review any deficient practice	

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F 282	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy and procedure, it was determined the facility failed to implement the care plan for one resident (#6), in the selected sample of 15 residents, related to floating the resident's heels while in bed. Findings include: A review of the facility's skin care policy and procedure, last revised 06/18/09, revealed the comprehensive care plan should establish approaches to stabilize or improve comorbidities limiting the effects of risk factors associated with pressure areas and the approaches should be carried out by the staff. A record review revealed the facility admitted Resident #6 on 03/30/12 with diagnoses to include Difficulty Walking, Debility, Diabetes Mellitus Type II, Asbergers and Peripheral Vascular Disease. A review of the Comprehensive Care Plan for Impaired Skin Integrity and Risk for Injury, dated 04/19/12, revealed interventions to elevate/float heels and reduce pressure to any pressure points. A review of the Nurse Aide Care Plan, dated 09/12, revealed to elevate Resident #6's heels off the bed with pillows. Observations, on 09/18/12 at 1:45 PM and 2:50 PM, and on 09/19/12 at 4:35 AM and 9:55 AM, revealed Resident #6 laying in bed with no pillows	F 282	identified and implement new interventions as needed. *Completion Date:* *F 282* 483.20 (k) (3) (ii) **SERVICES BY QUALIFIED PERSONS/PER CARE PLAN** ***The corrective action accomplished to correct the alleged deficient practice:*** On 9/20/2012, resident #6's heels were floated per the Norton's care plan and nurse aide care plan by the DON. Resident #6's heels were assessed, on 9/25/2012, no skin breakdown was present. On 10/10/2012, Director of Nursing completed a comprehensive audit reviewing the medical record of resident #6. This audit included, but was not limited to, Physicians Orders, fall history, nursing assessments to include Norton's and Comprehensive Side Rail/Devise/Fall Assessments, current comprehensive care plan including the Norton's/skin and Restraint/Side Rail/Fall/Devise Care Plan, nurse aide care plan, and interventions currently in place for resident #6 and determined that all interventions were implemented according to the Norton's/skin comprehensive care plan and nurse aide care plan. ***How the facility will identify other areas having the potential to be***	10/20/2012

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F 282	Continued From page 4 to float the resident's heels. Further observation revealed the resident's heels were directly against the mattress. Interview with Certified Nurse Aide (CNA) #1, on 09/20/12 at 10:50 AM, revealed she was unaware the resident's heels were suppose to be floated. She revealed the staff were suppose to look at the CNA care plans on each resident's closet door to see what interventions should be in place. Interview with Licensed Practical Nurse (LPN) #1, at 09/20/12 at 10:55 AM, revealed Department Heads completed rounds each morning to ensure the residents' interventions were in place according to the care plans. Interview with the Staffing Coordinator, on 09/20/12 at 1:00 PM, revealed she completed rounds on the morning of 09/18/12 and 09/19/12 to ensure interventions were in place for the residents in her section, which included Resident #6. She stated Resident #6 was already out of bed when she conducted the compliance round. Interview with the Director of Nursing (DON), on 09/20/12 at 11:10 AM, revealed the Department Heads were assigned to a hall every morning to conduct compliance rounds and ensure interventions were in place according to each resident's plan of care. He stated Resident #6's feet should be elevated while in bed. He was unable to provide an explanation as to why staff were not floating the resident's heels.	F 282	***affected by the same alleged deficient practice:*** On 10/11/2012, a comprehensive audit was concluded by an Administrative Nursing team (comprised of DON, ADON, MDS Coordinator and a PRN Administrative Nurse) reviewing the medical records of Nursing Facility residents. This audit included, but was not limited to Physicians Orders, fall history, nursing assessments to include Norton's and Comprehensive Side Rail/Devise/Fall Assessments, current comprehensive care plan including the Norton's/skin and Restraint/Side Rail/Fall/Devise Care Plan, nurse aide care plan, and interventions currently in place for Nursing Facility residents to identify and immediately address any other residents who have skin interventions per Norton's and nurse aide care plan implement. On 10/12/12, under the supervision of the DON the Continuing Quality Improvement (CQI) form N-19 "RAI Process (Assessment and Care Planning)" was completed to determine if comprehensive Norton's (skin) care plans and nurse aide care plans have been implemented for Nursing Facility residents. ***What measures or systemic changes were made to ensure that the alleged deficient practice will not recur:*** On 10/10/2012, the Administrator in-serviced Interdisciplinary Team members and management on implementing care plans for Nursing Facility residents; location of nurse aide	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident	F 323		

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F 323	Continued From page 5 environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based observation, interview, record review, and review of the facility's policy and procedure, it was determined the facility failed to provide adequate assistive devices to prevent accidents for one resident (#6), in the selected sample of 15 residents. The facility failed to ensure a pressure alarm was in place while Resident #6 was up in a wheelchair or in the bed. Findings include: A review of the Fall Prevention policy and procedure, last revised 08/04/09, revealed residents are comprehensively assessed for falls risk in order to avoid injury related to falls and maintain maximum physical functioning as much as possible. The interdisciplinary care plan is reviewed and revised after a fall to ensure that the identified fall risk issue is identified, that altered interventions are initiated if appropriate, and the preventive measures are addressed. The Nursing Assistant Care Plan is updated to include revised preventative measures. A record review revealed the facility admitted Resident #6 on 03/30/12 with diagnoses to include Difficulty Walking, Debility, and	F 323	care plans; SRNAs should check nurse aide care plans each shift; and Department Head Compliance Rounds Policy. By 10/17/2012, Director of Nursing (DON) in-serviced Licensed Nurses, Certified Medication Aides, and State Registered Nurses Aides on implementing care plans for Nursing Facility residents; location of nurse aide care plans; SRNAs should check nurse aide care plans each shift; and Nurses Compliance Rounds Policy. On 10/11/2012, the Administrator reviewed and revised CQI Tool N-19 and following has been added Norton's and Comprehensive Side Rail/Devise/Fall Assessments completed per protocol; each resident has an appropriate Norton's and Restraint/Side Rail/Fall/Devise Care Plan; interventions form the comprehensive care plan have been transcribed onto the nurse aide care plan; nurse aide care plans are accurate and being followed in accordance with each resident's written plan of care; and services provided meet current professional standards of quality and services are provided by an appropriately qualified person. ***How the facility plans to monitor its plans to monitor its performance to ensure that solutions for the alleged deficient practice are sustained:*** Beginning 10/12/2012, under the supervision of the DON, CQI Tool N-19 "RAI Process (Assessment and Care Planning)" will be completed monthly for three months and then quarterly per	

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F 323	Continued From page 6 Asbergers. A review of the admission Minimum Data Set (MDS) assessment, dated 04/10/12, revealed the facility assessed Resident #6"s cognition as moderately impaired and at risk for falls with a history of one fall at the facility. A review of the Restraint/Side Rail/Fall /Device Care Plan, dated 04/14/12, revealed a clip alarm to the chair and a pressure alarm to the bed was initiated on 04/21/12, after a fall. A review of the Comprehensive Care Plan for Risk for Injury related to generalized weakness, unsteady gait, decreased balance, and attempts at unassisted transfers, dated 04/19/12, revealed an intervention to provide Resident #6 with safety devices as ordered (see Restraint/Side Rail/ Falls, Device care plan if applicable). A review of the Physical Restraint/Device Monitor revealed the clip alarm to the wheelchair was changed to a pressure alarm to the wheelchair on 05/30/12. A review of the physician's order, dated 06/2012, revealed a clip alarm to the wheelchair at all times and a pressure sensor alarm to the bed, and check placement every shift. A review of a quarterly Comprehensive Side Rail/Device Assessment, dated 07/13/12, revealed alarm sensors were in place to alert the staff if the resident attempted to get up per self. A review of the nurse's notes, dated 08/10/12 at 10:25 AM, revealed Resident #6 was found on the floor by a Certified Nurse Aide (CNA). No	F 323	CQI calendar thereafter to determine that care plans are implemented for Nursing Facility residents. The Quality Assurance Team will review any deficient practice identified and implement new interventions as needed. ***Completion Date:*** **F 323** 483.25 (h) **FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES** ***The corrective action accomplished to correct the alleged deficient practice:*** On 10/10/2012, Director of Nursing verified that resident #6's pressure alarm was in place per the Restraint/Side Rail/Fall/Devise Care Plan and nurse aide care plan. On 10/10/2012, a comprehensive chart audit was conducted by the DON reviewing the medical record of resident #6. This audit included, but was not limited to, Physicians Orders, fall history, nursing assessments to include Norton's and Comprehensive Side Rail/Devise/Fall Assessments, current comprehensive care plan including the Norton's/skin and Restraint/Side Rail/Fall/Devise Care Plan, nurse aide care plan, and interventions currently in place for resident #6 and determined that adequate assistive devises were in place to prevent accidents for resident #6.	10/20/2012

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F 323	Continued From page 7 Injuries were noted and a lap buddy was put in place. A review of the Post Fall Assessment, dated 08/10/12, revealed there was no documentation any alarms sounded at the time of the fall. A review of the Nursing Assistant Care Plan, dated 09/2012, revealed interventions for a pressure alarm to the bed and the chair at all times. A review of the nurse's note, dated 09/03/12 at 7:15 AM, revealed Resident #6 had removed the lap buddy and was found on the floor in the restorative dining room. No injuries were noted. A review of the Post Fall Assessment, dated 09/03/12, revealed there was no documentation any alarms sounded at the time of the fall. A review of the nurse's note, dated 09/07/12 at 8:50 AM, revealed Resident #6 was found laying across bed. The resident had removed the lap buddy and attempted to get out of the wheelchair and onto the bed. The resident stated he/she hit his/her face on the bed. The resident's left eye and cheek were red and edematous. Resident #6 was sent to the emergency room and a CT-scan was conducted. A review of the CT scan results, dated 09/07/12, revealed the CT scan was negative. A review of the Post Fall Assessment, dated 09/07/12, revealed there was no documentation any alarms sounded at the time of the fall. A review of the Post Fall Assessment, dated 09/08/12, revealed Resident #6 sustained a fall transferring self from wheelchair to armchair after removing the lap buddy. There was no	F 323	***How the facility will identify other areas having the potential to be affected by the same alleged deficient practice:*** On 10/11/2012, a comprehensive audit was concluded by an Administrative Nursing team (comprised of DON, ADON, MDS Coordinator and a PRN Administrative Nurse) to review the comprehensive care plans of Nursing Facility residents. This audit included, but was not limited to Physicians Orders, fall history, nursing assessments to include Norton's and Comprehensive Side Rail/Devise/Fall Assessments, current comprehensive care plan including the Norton's/skin and Restraint/Side Rail/Fall/Devise Care Plan, nurse aide care plan, and interventions currently in place to identify and immediately correct if residents were identified without implemented adequate assistive devises to prevent accidents. On 10/12/2012, under the supervision of the DON Continuing Quality Improvement (CQI) form N-19 "RAI Process (Assessment and Care Planning)" was completed to determine adequate assistive devices are implemented to prevent accidents for Nursing Facility residents. ***What measures or systemic changes were made to ensure that the alleged deficient practice will not recur:*** On 10/10/2012, the Administrator revised Post-Fall Assessment to include but not limited to interventions present at time of fall, sounding of alarms at	

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F 323	Continued From page 8 documentation any alarms sounded at the time of the fall. Observations, on 09/18/12 at 1:45 PM, 2:50 PM, 3:55 PM, 4:50 PM and 5:40 PM, and on 09/19/12 at 8:40 AM, 9:00 AM and 9:55 AM, revealed Resident #6 was in bed or up in his/her wheelchair with no pressure alarm in place. Interview with CNA #1, on 09/20/12 at 10:50 AM, revealed Resident #6 was suppose to have pressure alarms on his/her wheelchair and bed. She revealed the staff were suppose to look at the CNA care plans on the closet door to see what interventions should be in place for each resident. Interview with Licensed Practical Nurse (LPN) #1, at 09/20/12 at 10:55 AM, revealed Department Heads conducted rounds each morning to ensure the residents' interventions were in place according to the care plans. Interview with the Staffing Coordinator, dated 09/20/12 at 1:00 PM, revealed she conducted rounds on the morning of 09/18/12 and 09/19/12 to ensure interventions were in place for the residents in her section, which included Resident #6. She revealed made observations to ensure safety devices were in place. She was unable to provide an explanation as to why she did not identify Resident #6's pressure alarms were not in place. Interview with the Director of Nursing (DON), on 09/20/12 at 11:10 AM, revealed the Department Heads were assigned a hall to conduct compliance rounds each morning to ensure	F 323	time of fall, root cause of fall, effectiveness and follow up of new intervention. On 10/11/2012, Administrator reviewed and revised CQI Tool N-19 and following has been added Norton's and Comprehensive Side Rail/Devise/Fall Assessments completed per protocol; each resident has an appropriate Norton's and Restraint/Side Rail/Fall/Devise Care Plan; interventions from the comprehensive care plan have been transcribed onto the nurse aide care plan; nurse aide care plans are accurate and being followed in accordance with each resident's written plan of care; and services provided meet current professional standards of quality and services are provided by an appropriately qualified person. On 10/10/2012, the Administrator in-serviced the Interdisciplinary Team members and management on implementing adequate assistive devices in order to prevent accidents; Fall Prevention Policy; revisions made to Post-Fall Assessment and Department Head Compliance Round Policy. By 10/17/2012, DON in-serviced Licensed Nurses on implementing adequate assistive devices in order to prevent accidents; Fall Prevention Policy; revisions made to Post-Fall Assessment and Nursing Compliance Round Policy. ***How the facility plans to monitor its plans to monitor its performance to***	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185400		09/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTHSTONE PLACE	506 ALLENSVILLE ROAD 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 323	Continued From page 9 interventions were in place according to each resident's plan of care. He stated Resident #6 should have pressure alarms in place to the bed and wheelchair. He revealed after reviewing the records, he determined Resident #6 went out to the hospital in July and returned a few days later. He stated the facility did not have the physician to re-order the pressure alarms for the wheelchair and bed, so the pressure alarms were not re-initiated when the resident returned from the hospital in July. He revealed this issue was not identified while conducting the post fall assessments after the resident's return from the hospital.	F 323	***ensure that solutions for the alleged deficient practice are sustained:*** Beginning 10/12/2012, under the supervision of the DON, CQI Tool N-19 "RAI Process (Assessment and Care Planning)" will be completed monthly for three months and then quarterly per CQI calendar thereafter to determine that adequate assistive devices were implemented for Nursing Facility residents in order to prevent accidents. The Quality Assurance Team will review any deficient practice identified and implement new interventions as needed.	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy and procedure, it was determined the facility failed to store and prepare food under sanitary conditions. Unsealed, unlabeled food was being stored in the refrigerator, and further observations revealed a can opener with a build-up of a black substance, and a meat slicer with a build-up of a white	F 371	***Completion Date:*** **F 371** **483.25 (i)** **FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY** ***The corrective action accomplished to correct the alleged deficient practice:*** On 9/18/2012, the Certified Dietary Manager (CDM) completed CQI Tool D-8 "Dietary Department Audit" and determined the can opener and meat slicer were deep cleaned and build up was removed; additionally, the egg salad, pureed meat, shredded cheese, roast beef had been discarded by the cook. ***How the facility will identify other areas having the potential to be***	10/20/2012

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F 371	Continued From page 10 substance. A review of the facility's Census and Condition, dated 09/18/12, revealed there were 57 residents in the building with only one resident who received tube feedings. Findings include: A review of the facility's Sanitation policy and procedure, no date, revealed all kitchen equipment should be kept clean. A review of the facility's Dietary Cleaning Schedule revealed the meat slicer and can opener should be cleaned after each use and weekly. Observations during initial tour of the kitchen, on 09/18/12 at 9:00 AM, revealed the following: 1. The refrigerator contained a plastic container of egg salad and a plastic container of pureed meat with a used by date of 09/16/12, one package of shredded cheese opened and not sealed or dated, and a freezer bag of roast beef not labeled or dated. 2. The counter can opener had a build-up of a black substance around the blade. 3. The meat slicer had a white substance around the blade. An interview with the Dietary Manager, on 09/20/12 at 1:00 AM, revealed the can opener and the meat slicer should be cleaned after each use and weekly. She stated food should be removed from the refrigerator by the date written on the label and should be sealed and dated	F 371	On 9/27/2012, CDM completed CQI Tool D-8 "Dietary Department Audit" and found the kitchen to be compliant with Dietary Sanitation Policy and Cleaning Schedules. ***What measures or systemic changes were made to ensure that the alleged deficient practice will not recur:*** On 9/18/2012, CDM in-serviced dietary staff regarding Dietary Sanitation Policy and Cleaning Schedules which include after each use and deep cleaning for the can opener and meat slicer. ***How the facility plans to monitor its plans to monitor its performance to ensure that solutions for the alleged deficient practice are sustained:*** Starting the week of 10/1/2012, Certified Dietary Manager will complete CQI Tool D-8 weekly for four consecutive weeks and then monthly per Continuing Quality Improvement schedule to monitor department sanitation. The Quality Assurance Team will review any deficient practice identified and implement new interventions as needed. ***Completion Date:***	10/20/2012

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F 371	Continued From page 11 when opened.	F 371		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185400	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 09/19/2012

NAME OF PROVIDER OR SUPPLIER: HEARTHSTONE PLACE

STREET ADDRESS, CITY, STATE, ZIP CODE: 506 ALLENSVILLE ROAD, ELKTON, KY 42220

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K 000	INITIAL COMMENTS CFR: 42 CFR 483.70(a) BUILDING: 01. PLAN APPROVAL: 1965. SURVEY UNDER: 2000 Existing. FACILITY TYPE: SNF/NF. TYPE OF STRUCTURE: One (1) story, Type III (111). SMOKE COMPARTMENTS: Four (4) smoke compartments. FIRE ALARM: Complete fire alarm system installed in in 1965, upgraded in 1994 with 45 smoke detectors and 10 heat detectors. SPRINKLER SYSTEM: Complete automatic dry sprinkler system installed in 1965 and upgraded in 2011. GENERATOR: Type II generator installed in 1972. Fuel source is Natural Gas. A standard Life Safety Code survey was conducted on 09/18/12. Hearthstone Place was found in non-compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for Sixty (60) beds with a census of fifty-seven (57) on the day of the survey. The findings that follow demonstrate noncompliance with Title 42, Code of Federal	K 000	*Disclaimer: "Hearthstone Place is a facility dedicated to her residents. Furthermore, this plan of correction is not an admission or agreement by Hearthstone Place of the allegations, statements, findings, facts or conclusions that comprise alleged deficiencies and/or in the entire CMS-2567."* OCT 2012	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Katherine C. Evans — TITLE: Administrator — (X6) DATE: 10/12/12

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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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTHSTONE PLACE	500 ALLENSVILLE ROAD ELKTON, KY 42220

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K 000	Continued From page 1 Regulations, 483.70(a) et seq. (Life Safety from Fire). Deficiencies were cited with the highest deficiency identified at "F" level.	K 000	*K 18* NFPA 101 LIFE SAFETY CODE STANDARD	
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure doors to resident rooms would latch properly in accordance with NFPA standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, six (6) residents, staff and	K 018	**What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?** On 9/21/2012, door strike plates were installed by Maintenance to ensure doors to resident rooms 221, 226, and 229 would latch properly in accordance with NFPA standards. **How facility will identify other residents/patients having the potential to be affected by the same alleged deficient practice?** On 10/11/2012, Director of Environmental Services inspected facility door latches to identify any further alleged deficient practice. Any deficient areas identified were immediately corrected or scheduled for correction. **What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur?** On 10/10/2012, the Administrator re-educated the Director of Environmental Services (DES) and Maintenance	

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NAME OF PROVIDER OR SUPPLIER HEARTHSTONE PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 506 ALLENSVILLE ROAD ELKTON, KY 42220	

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K 018	Continued From page 2 visitors. The facility is certified for sixty (60) beds with a census of fifty-seven (57) on the day of the survey. The facility failed to ensure three (3) corridor doors to the resident rooms were latching properly. The findings include: Observations, on 09/18/12 between 12:00 PM and 3:30 PM with the Environmental Supervisor, revealed the corridor doors to rooms 221, 226, and 229 would not latch properly. Interview, on 09/18/12 between 12:00 PM and 3:30 PM with the Environmental Supervisor, confirmed the observation of the doors not latching and revealed she was unaware these doors were not latching properly. The Environmental Supervisor was aware that all resident room doors must latch in the event of an emergency. Interview, on 09/18/12 at 3:45 AM with the Administrator, revealed she was unaware the gauges on the sprinkler riser had not been replaced, as well as the corroded sprinkler risers in the facility. She stated she relies on the Environmental Supervisor and CQI tools for Life Safety and they use the OIG newsletter to ensure life safety code. Reference: NFPA 101 (2000 edition) 19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-bonded core wood	K 018	regarding the NFPA requirement of latching doors and corrective measures to be taken on any doors that did not latch properly. By 10/17/2012, under the supervision of the Administrator, Housekeeping, Laundry, Dietary and Nursing Staff were re-educated by the Administrator regarding use of the maintenance log to report any item(s) needing repair. On 10/11/2012 CQI Tool ES-3 "Life Safety" was revised by Administrator and "exterior and interior doors properly latch when closed" was added. On 10/11/2012, the Director of Environmental Services completed CQI Tool ES-3 "Life Safety". **How the facility plans to monitor its performance to ensure that solutions are sustained.** Beginning 11/5/2012, Continuing Quality Improvement (CQI) Tool ES-3 "Life Safety" will be completed monthly. The Quality Assurance Team will review any deficient practice identified and implement new interventions as needed. **Completion Date:**	10/26/2012

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NAME OF PROVIDER OR SUPPLIER HEARTHSTONE PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 506 ALLENSVILLE ROAD ELKTON, KY 42220	

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K 018	Continued From page 3 or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke. 19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. 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. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with NFPA standards.	K 018	***K 025*** NFPA 101 LIFE SAFETY CODE STANDARD **What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?** On 9/18/2012, Maintenance applied 3M Fire Barrier Sealant with four hour fire rating to seal penetrations by piping and wires in the attic penetrating the fire walls and smoke barriers. On 10/17/2012, Maintenance will apply mortar to seal the firewall/smoke barrier in the attic above room #312 and extend it to the roof decking. **How facility will identify other residents/patients having the potential to be affected by the same alleged deficient practice?** On 10/12/2012, Administrator inspected the attic to identify any further alleged deficient practices. Any deficient areas were immediately corrected or were scheduled for correction.	
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass	K 025	**What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur?** On 10/10/2012, Administrator re-educated the Director of Environmental Services (DES) and Maintenance regarding the NFPA requirement of	

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	185400	A. BUILDING 01 - MAIN BUILDING 01 B. WING	09/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTHSTONE PLACE	508 ALLENSVILLE ROAD ELKTON, KY 42220

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K 025	Continued From page 4 panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observations and interview, it was determined the facility failed to maintain smoke barriers that would resist the passage of smoke between smoke compartments in accordance with NFPA standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, all residents, staff and visitors. The facility is certified for sixty (60) beds with a census of fifty-seven (57) on the day of the survey. The facility failed to ensure the smoke barriers were sealed around pipes and wires and extended to the roof decking. The findings include: Observations, on 09/18/12 between 9:45 AM and 11:00 AM with the Environmental Supervisor, revealed the smoke partitions, extending above the ceiling located throughout the facility, were penetrated by pipes and wires. Further observation revealed the fire wall above room#312 did not extend to the roof decking. Interview, on 09/18/12 between 9:45 AM and 11:00 AM with the Environmental Supervisor, revealed she was unaware of the penetrations in the smoke barriers as they have been inspected	K 025	smoke barriers extending to the roof decking, sealing smoke barriers when penetrated by pipes and wires and to inspect smoke barriers after any contracted workman complete repairs/installations in the attic. On 10/11/2012, Administrator revised CQI Tool ES-3 "Life Safety" to incorporate identification and correction of any further smoke barrier penetrations and fire wall/smoke barriers that do not extend to the roof decking. On 10/11/2012, the Director of Environmental Services (DES) completed CQI Tool ES-3 "Life Safety". **How the facility plans to monitor its performance to ensure that solutions are sustained.** Continuing Quality Improvement (CQI) Tool ES-3 "Life Safety" will be completed monthly. The Quality Assurance Team will review any deficient practice identified and implement new interventions as needed. **Completion Date:**	10/26/2012

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NAME OF PROVIDER OR SUPPLIER HEARTHSTONE PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 606 ALLENSVILLE ROAD ELKTON, KY 42220	

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K 025	Continued From page 5 several times since the last survey. Interview, on 09/18/12 at 3:45 AM with the Administrator, revealed she was unaware of the penetrations in the smoke barriers. She had personally gone into the attic to ensure the smoke barriers were sealed after the previous cites and to determine if there were other penetrations that needed repair. They use the CQI tool which covers all smoke barriers in the facility. This is a repeat deficiency. Reference: NFPA 101 (2000 Edition). 8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows: (a) The space between the penetrating item and the smoke barrier shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (c) Where designs take transmission of vibration into consideration, any vibration isolation shall 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for	K 025		

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K 025	Continued From page 6 the specific purpose.	K 025	*K 027* NFPA 101 LIFE SAFETY CODE STANDARD	
K 027 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure cross -corridor doors located in a smoke barrier would resist the passage of smoke in accordance with NFPA standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, no residents, staff and visitors. The facility is certified for sixty (60) beds with a census of fifty-seven (57) on the day of the survey. The facility failed to ensure the cross corridors doors would close properly once the fire alarm released them from the magnetic locks. The findings include: Observation, on 09/18/12 between 12:00 PM and 3:30 PM with the Environmental Supervisor, revealed the cross-corridor doors located at the front of the hall 200 next to room# 218 would not close completely when tested. This was due to	K 027	**What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?** By 10/16/2012, astragals were installed on the cross-corridor doors located at the front 200 Hall next to room #218 to ensure the doors would closed completely when tested and therefore resist the passage of smoke in accordance with NFPA standards. By 10/16/2012, door coordinators will be installed on both entrances to the Dining Room doors and 200 Hall next to room #218 to ensure the cross-corridor doors would close properly once the fire alarm released them from the magnetic locks. **How facility will identify other residents/patients having the potential to be affected by the same alleged deficient practice?** On 10/11/2012, DES inspected cross-corridor doors to ensure the smoke barrier would resist the passage of smoke and cross-corridor doors would close properly once the fire alarm releases in accordance with NFPA standards. Any deficient areas were immediately corrected or were immediately scheduled for correction.	

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NAME OF PROVIDER OR SUPPLIER HEARTHSTONE PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 506 ALLENSVILLE ROAD 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
K 027	Continued From page 7 the doors not having a coordinating device installed on the doors. Further observation revealed the doors at both entrances to the Dining Area would lock once released. The doors at this point would only open by one door. The astragal of the door would hold the door shut until the proper door was opened first. Interview, on 09/18/12 between 12:00 PM and 3:30 PM with the Environmental Supervisor, revealed she was unaware the doors needed a coordinating device to ensure the door without the astragal would always close first. Further interview revealed she was unaware that both cross-corridor doors must always open without using the other door. Interview, on 09/18/12 at 3:45 AM with the Administrator, revealed she was unaware the cross-corridor doors were not operating correctly. She stated she relies on the Environmental Supervisor and CQI tools for Life Safety and they use the OIG newsletter to ensure life safety code. NFPA Standard: NFPA 101, 19.3.7.6*. Requires doors in smoke barriers to be self-closing and resist the passage of smoke. Reference: NFPA 80 (1999 Edition) 2-4.1 Closing Devices. 2-4.1.1 Where there is an astragal or projecting latch bolt that prevents the inactive door from closing and latching before the active door closes and latches, a coordinating device shall be used. A coordinating device shall not be	K 027	**What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur?** On 10/10/2012, Administrator re-educated Director of Environmental Services (DES) and Maintenance regarding cross-corridor door closing completely when tested and resist the passage of smoke in accordance with NFPA standards. On 10/11/2012, CQI Tool ES-3 "Life Safety" was revised by Administrator to incorporate visual inspection of cross-corridor doors for proper closure, less than ¼ gap and to resist the passage of smoke. On 10/11/2012, the Director of Environmental Services (DES) completed CQI Tool ES-3 "Life Safety". **How the facility plans to monitor its performance to ensure that solutions are sustained.** Continuing Quality Improvement (CQI) Tool ES-3 "Life Safety" will be completed monthly. The Quality Assurance Team will review any deficient practice identified and implement new interventions as needed. **Completion Date:**	10/26/2012