

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

PRINTED: 11/17/2015
FORM APPROVED
OMB NO. 0938-0391

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 R 11/21/2015
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	
{F 000}	<p>INITIAL COMMENTS</p> <p>Based on implementation of the acceptable POC the facility was deemed to be compliance on 11/21/15, as alleged.</p>	{F 000}			

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

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.

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26884, Baltimore, MD 21207, and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 185400	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 11/21/2015
Name of Facility HEARTHSTONE PLACE	Street Address, City, State, Zip Code 506 ALLENSVILLE ROAD ELKTON, KY 42220	

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

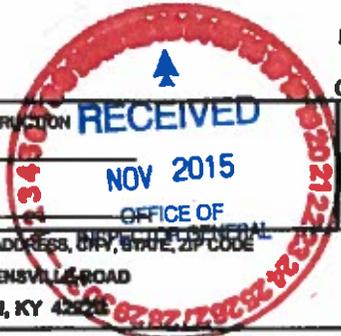
(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix <u>F0282</u> Reg. # <u>483.20(k)(3)(ii)</u> LSC _____	Correction Completed 11/21/2015	ID Prefix <u>F0309</u> Reg. # <u>483.25</u> LSC _____	Correction Completed 11/21/2015	ID Prefix <u>F0315</u> Reg. # <u>483.25(d)</u> LSC _____	Correction Completed 11/21/2015
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By _____ State Agency	Reviewed By <u>CM</u>	Date: <u>11/17/15</u>	Signature of Surveyor: <u>Carol McCintosh ARPM</u>	Date: <u>11/17/15</u>
Reviewed By _____ CMS RO	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____

Followup to Survey Completed on: 10/7/2015	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
---	--

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

PRINTED: 10/15/2015
FORM APPROVED
OMB NO. 0938-0391



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 10/07/2015
--	--	--	--

NAME OF PROVIDER OR SUPPLIER HEARTHSTONE PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 606 ALLENSVILLE ROAD ELKTON, KY 42122
---	---

(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	F 000	F 282 483.20(k)(3)(II) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	
F 282 SS=D	<p>A Recertification Survey was conducted 10/06/15 through 10/07/15 with deficiencies cited at the highest Scope and Severity of a "D".</p> <p>483.20(k)(3)(II) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy review it was determined the facility failed to ensure care was provided in accordance with each resident's written plan of care for one (1) of eleven (11) sampled residents (Resident #7) related to using standard precautions during incontinent care.</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Using the Care Plan", undated, revealed the care plan shall be used in developing the resident's daily care routines and will be available to staff personnel who have responsibility for providing care or services to the resident. This Policy further stated the Nurse Supervisor uses the care plan to complete the Certified Nursing Assistant's daily/weekly work assignment sheets and/or flow sheets.</p> <p>Record review revealed the facility admitted Resident #7 on 07/16/13 with diagnoses which</p>	F 282	<p>The corrective actions taken for those found to be affected by the deficient practice was:</p> <ul style="list-style-type: none"> Body audits were conducted on Resident #7 by the wound/treatment nurse 10/5/15, 10/12/15, 10/21/15 and 10/28/15 with no signs of skin breakdown. Resident #7 has had no signs or symptoms of UTI 10/7/15-11/10/15 as verified through the nurses notes by a Registered Nurse. The aides responsible for Resident #7 were inserviced on Infection Control and Incontinence/perineal care 10/7/15 by the DON. On 10/7/15, the DON inserviced CNA #4 and CNA #5 on Infection Control and Incontinence/perineal care. DON and ADON observed CNA #4 and CNA #5 perform perineal care 10/19/15 to ensure care was provided correctly. <p>How the facility identified others having the potential to be affected by the same deficient practice by:</p> <ul style="list-style-type: none"> An audit was conducted 10/7/15 by a Registered Nurse to identify residents currently receiving incontinent care. Any resident identified as receiving incontinent care were determined to be at risk for improper perineal care. All CNA's were In-serviced on the facility's Infection Control and Incontinence/Pericare policy from 10/7/15-10/23/15 by the DON. 	11-21-15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Diane Miller TITLE: Interim Administrator (X6) DATE: 11-12-15

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

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

PRINTED: 10/15/2015
FORM APPROVED
OMB NO. 0938-0391

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 10/07/2015
--	--	--	--

NAME OF PROVIDER OR SUPPLIER HEARTHSTONE PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 605 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 282	<p>Continued From page 1</p> <p>included Diabetes, Type 2; Morbid Obesity, Cerebrovascular Accident with Hemiplegia, and Dementia without Behaviors and Psychosis. Review of the quarterly Minimum Data Set (MDS) assessment, dated 05/08/15, revealed the facility assessed Resident #7 as having a Urinary Tract Infection (UTI) in the last thirty (30) days.</p> <p>Review of the Comprehensive Care Plan titled, "At risk for infections related to history of Urinary Tract Infections (UTI'S)", initiated on 04/11/14, revealed staff should practice standard precautions including good hand hygiene while providing incontinent care and provide perineal wash with each incontinent episode.</p> <p>Observation of Perineal Care, on 10/07/15 at 1:55 PM, revealed Certified Nursing Assistant (CNA) #4 cleaned Resident #7's rectal area first and brown material was observed on the washcloth. The CNA did not put any water in the wash basin but wet washcloths at sink and put them in dry basin. CNA #4 then cleaned Resident #7's vaginal area without changing gloves.</p> <p>Interview with CNA #4, on 10/07/15 at 2:00 PM, revealed this CNA cleaned the way she normally does and CNA #4 revealed she has worked at this facility for eight (8) years.</p> <p>Interview with CNA #5 who assisted CNA #4, on 10/07/15 at 2:08 PM, revealed she has worked at this facility for four (4) years. CNA #5 stated she would have put water in the wash basin, cleaned the vaginal area first and then the rectal area. She further revealed she would have changed gloves after cleaning rectal area.</p> <p>Interview with the Charge Nurse, Licensed</p>	F 282	<ul style="list-style-type: none"> The DON mailed a copy of the Infection Control, Incontinence & Pericare policy to the PRN CNA's that he was unable to contact by phone 10/23/15. The PRN CNA's that failed to respond to the DON about the in-service training were removed from the PRN staffing list 11/10/15 until they receive the Infection Control, Incontinence & Pericare policy inservice. The DON is responsible for ensuring the PRN CNA's receive the Infection Control, Incontinence & Pericare policy in-service immediately after clocking in for work and prior to working with residents. <p>The measures put into place to ensure the deficient practice does not recur were:</p> <ul style="list-style-type: none"> The Infection Control, Incontinence /Perineal policies were reviewed by the Administrator 10/12/15. On 10/21/15, the Administrative Assistant revised the Infection Control Section on the DON's QAPI/Monthly Report to include the task of observing staff perform pericare on a resident. <p>The facility plans to monitor its performance to ensure the solutions are sustained by:</p> <ul style="list-style-type: none"> The DON will complete the Infection Control section on his QAPI/Monthly Report twice weekly for 2 weeks, then monthly thereafter. The Administrator will review all monthly reports monthly for problems identified and ensure action plans are completed and implemented. 	
-------	---	-------	---	--

The corrective action will be completed: 11/21/15.

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

PRINTED: 10/15/2015
FORM APPROVED
OMB NO. 0938-0391

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 10/07/2015
NAME OF PROVIDER OR SUPPLIER HEARTHSTONE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 606 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 282	Continued From page 2 Practical Nurse #1, on 10/07/15 at 2:10 PM, revealed she would expect her staff to clean front to back, change gloves when going from dirty to clean and to change gloves when going from back side (rectal area) to front (vaginal) side.	F 282			
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of facility's policy, it was determined the facility failed to ensure the necessary care and services to maintain the optimum health care needs for two (2) of eleven (11) sampled residents (Residents #5 and #8. The facility failed to follow policy and procedure to provide proper Gastrostomy Tube (G-Tube) site care for Resident #5. In addition, the facility failed to communicate, establish, and agree upon a coordinated plan of care between the facility and Hospice Services, based on the individual's needs and unique living situation in the facility, for Resident #8. The findings include: 1. Review of facility's Policy and Procedure	F 309	F 309 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING The corrective action taken for those found to be affected by the deficient practice was: <u>G-Tube</u> <ul style="list-style-type: none"> On 10/7/15, LPN #1 immediately provided proper g-tube care to Resident #5 by cleaning under and around the disc shaped bolster at the insertion site and applying a drainage sponge. LPN #1 was in-serviced and received a copy of the Gastrostomy/Jejunostomy Site Care" guidelines 10/7/15 by the Wound Nurse. <u>Hospice</u> <ul style="list-style-type: none"> On 10/7/15, the MDS Coordinator revised Resident #8's care plan to include the care Hospice provides. How the facility identified others having the potential to be affected by the same deficient practice by: <u>G-Tube</u> <ul style="list-style-type: none"> On 10/7/15, the DON inspected all residents with g-tubes to ensure the site was intact and cleaned properly. <u>Hospice</u> <ul style="list-style-type: none"> Resident #8 is the only resident with Hospice services at this time. 	11-21-15	

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

PRINTED: 10/15/2015
FORM APPROVED
OMB NO. 0938-0391

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 10/07/2015
NAME OF PROVIDER OR SUPPLIER HEARTHSTONE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 606 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 309	<p>Continued From page 3</p> <p>"Gastrostomy/Jejunostomy Site Care", Step Four (4), revised 2011, revealed "Be sure to clean under bolster." The "disc shaped" bolster was where the G-Tube Site is located.</p> <p>Record review revealed the facility admitted Resident #5 on 08/05/15 with diagnoses which included Breast Cancer, Anemia, Dysphagia, Cardiovascular Disease, Urinary Tract Infection, Dementia, Pneumonia and a history of G-Tube placement on 07/24/15. Review of the admission Minimum Data Set (MDS) assessment, dated 08/12/15, revealed the facility assessed Resident #5's cognition as severely impaired with a Brief Interview for Mental Status (BIMS) score of five (5), which indicated this resident was not interviewable.</p> <p>Observation of Licensed Practical Nurse (LPN) #1 performing G-Tube site care for Resident #5, on 10/06/15 at 9:42 AM, revealed the LPN used gauze and normal saline to cleanse the skin area out and around the G-Tube Bolster and did not cleanse under the disc, then proceeded to dispose of her gloves and soiled gauze. The LPN stated at the time she was finished with the resident's care and was asked if cleaning under the "disc shaped" Bolster would be considered part of the G-Tube site care. LPN #1 stated she was unsure as she was not real familiar with Resident #5 and the facility wound care nurse normally did the G-Tube site care. LPN #1 left the room, then returned with more gauze and normal saline and proceeded to perform G-Tube site care again and this time cleaned under the Bolster and removed brownish crusted and creamy materiel which was visible on the gauze she was using for this second episode of G-Tube site care.</p>	F 309	<p>The measures put into place to ensure the deficient practice does not recur were:</p> <p><u>G-Tube</u></p> <ul style="list-style-type: none"> The DON in-serviced all full time /part time and PRN licensed staff on the Gastrostomy/Jejunostomy Site Care" policy & guidelines 10/7/15-11/10/15. The Administrative Assistant revised the DON's QAPI/Monthly Report 10/21/15 to include "Observing staff performing G-tube Site Care" <p><u>Hospice</u></p> <ul style="list-style-type: none"> The DON and Administrator met with the Hospice nurse 10/20/15 to discuss new plan of care for Resident #8 and any future Hospice patients. The Hospice nurse and CNA attended Resident #8 care plan conference 10/20/15. The MDS Coordinator will personally inform Hospice of scheduled Care Conferences. On 10/21/15, the MDS Coordinator re-revised Resident #8 care plan and added Hospice to the list of disciplines and the care they are responsible for providing. On 10/21/15, The DON & MDS Coordinator developed and implemented a form that will be utilized by Hospice at the end of each visit. The form describes the type of care they provided to the resident. The form will be Initialed by the charge nurse and maintained in the resident's medical record under the Hospice tab. 	

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

PRINTED: 10/15/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 188400	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/07/2015
NAME OF PROVIDER OR SUPPLIER HEARTHSTONE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 806 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 309	Continued From page 4 Interview with Registered Nurse (RN) #2, on 10/07/15 at 9:48 AM, revealed she expected all licensed staff to know how to perform appropriate G-Tube site care and that cleaning under the disc is essential, because that was where the site of the tube was going, into the body. Interview with RN #1, on 10/07/15 at 04:00 PM, revealed she expected G-Tube site care to consist of cleaning under the disc, at the G-Tube site and would expect that Licensed Nurses to know how to do proper G-Tube site care as they were taught this in nursing school. Interview with Director of Nursing (DON), on 10/07/15 at 4:48 PM, revealed he expected proper G-Tube site care to be done and the nurses would follow the protocol and or policy and procedure in regards to G-Tube site care. 2. Review of the facility and Hospice agreement, "Agreement for the Provision of Hospice Services to Residents of Hearthstone Place Nursing Home" dated 03/24/10, revealed the hospice and facility's interdisciplinary teams were responsible for coordinating, providing, and revising the residents' Plan of Care. "In order to ensure coordination and communication, each party shall be advised of any changes or revisions to the plan of care by one or both parties, either in person or by calling the other within one (1) hour of said change, or sooner in case of emergency." Further review of the agreement, revealed the agreement did not define the roles the facility and hospice would maintain in the care of the resident. Record review revealed the facility admitted	F 309	<ul style="list-style-type: none"> The Administrator revised the MDS Coordinators QAPI/Monthly reports 10/21/15 with a new section that ask questions pertaining to Hospices' involvement in the plan of care, completing the form at each visit and attending care plan conferences. <p>The facility plans to monitor its performance to ensure the solutions are sustained by:</p> <p><u>G-Tube</u></p> <ul style="list-style-type: none"> The DON will complete the Infection Control section on the QAPI/Monthly Report twice weekly for 2 weeks, then monthly thereafter. The Administrator will review all monthly reports monthly for problems identified and ensure action plans are completed and implemented. <p><u>Hospice</u></p> <ul style="list-style-type: none"> The MDS will complete the QAPI Monthly Report form monthly and turn it in to the Administrator for review. The Administrator will review the MDS monthly reports monthly for problems identified and ensure action plans are completed and implemented. <p>The corrective action will be completed: 11/21/15.</p>		

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

PRINTED: 10/15/2015
FORM APPROVED
OMB NO. 0938-0391

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 10/07/2015
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	
F 309	Continued From page 5 Resident #8 on 07/24/15 with diagnoses to include Stage Four (4) Colon Cancer, Malignant Neoplasm of the Colon, and Chronic Pain. Review of Resident #8's admission MDS assessment, dated 07/31/15, revealed the facility assessed Resident #8's cognition as cognitively intact with a BIMS score of thirteen (13), which indicated the resident was interviewable. Review of the current Interdisciplinary Care Plans, dated 07/24/15, revealed there was no care plan related to the coordination of the care provided by Hospice and facility and who was responsible for what care. Interview with MDS Coordinator, on 10/07/15 at 4:30 PM, revealed there was not a Plan of Care from Hospice that defined the role Hospice would play in the care of the resident. Interview with the DON, on 10/07/15 at 04:48 PM, revealed there was not a collaborative care plan developed with Hospice to define the roles, goals and interventions of Hospice, in caring for the resident.	F 309			
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, 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 infections and to restore as much normal bladder function as possible.	F 315	F 315 483.25(d) NO CATHETER, PREVENT UTI, RESTOR BLADDER The corrective actions taken for those found to be affected by the deficient practice was: • Resident #5's medical record was audited 11/10/15 by an LPN. No signs or symptoms of UTI identified in the nurses notes since 10/7/15. • Resident #7's medical record nurse's notes were audited 11/10/15 by an LPN with no signs or symptoms identified that would indicate a UTI since 10/7/15.	11-21-15	

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

PRINTED: 10/15/2015
FORM APPROVED
OMB NO. 0938-0391

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 10/07/2015
NAME OF PROVIDER OR SUPPLIER HEARTHSTONE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 606 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 315	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of facility policy, it was determined the facility failed to provide appropriate treatment and services to prevent urinary tract infections for two (2) of eleven (11) sampled residents (Residents #5 and #7). CNAs failed to provide incontinent care to Resident #5 and Resident #7 according to the facility's procedure for perineal care. The findings include: 1. Review of the facility's policy on Perineal Care, Mosby's Textbook for Long Term Care Nursing Assistance, Seventh Edition, undated, revealed the procedure for giving perineal care for females to include: Fill the wash basin with warm water, place basin on over bed table, wet the wash cloths and squeeze out excess water from a washcloth, make a mitted wash cloth and apply soap, clean the labia from front to back with soap on washcloth, rinse in same manner and dry, then clean the rectal area in the same manner, pat dry area from vagina to anus (front to back) with a towel. Record review revealed the facility admitted Resident #5 on 08/05/15 with diagnoses which included Breast Cancer, Anemia, Dysphagia, Cardiovascular Disease, Urinary Tract Infection, Dementia, Pneumonia and Peg Tube placement on 07/24/15.	F 315	<ul style="list-style-type: none"> CNA #2, CNA #3, CNA #4, and CNA #5 were in-serviced on proper perineal care 10/7 /15 by the DON. DON observed CNA #2 and CNA #3, CNA #4, and CNA #5 perform perineal care 10/19 /15 to ensure care was completed appropriately. <p>How the facility identified others having the potential to be affected by the same deficient practice by:</p> <ul style="list-style-type: none"> An audit was conducted 10/7/15 by a Registered Nurse to identify residents currently receiving incontinent care. Any resident identified as receiving incontinent care were determined to be at risk for improper perineal care and UTI. All CNA's were in-serviced on the facility's Infection Control and Incontinence/ Pericare policy from 10/7/15-10/23/15 by the DON. The DON mailed a copy of the Infection Control, Incontinence & Pericare policy to the PRN CNA's that he was unable to contact by phone 10/23/15. The PRN CNA's that failed to respond to the DON about the in-service training were removed from the PRN staffing list 11/10/15 until they receive the Infection Control, Incontinence & Pericare policy inservice. The DON is responsible for ensuring the PRN CNA's receive the Infection Control, Incontinence & Pericare policy in-service immediately after clocking in for work and prior to working with residents. 		

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

PRINTED: 10/15/2015
FORM APPROVED
OMB NO. 0938-0391

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 10/07/2015
NAME OF PROVIDER OR SUPPLIER HEARTHSTONE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 888 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 315	<p>Continued From page 7</p> <p>Review of Resident #5's admission Minimum Data Set (MDS) assessment, dated 08/12/15, revealed the facility assessed Resident #5's cognition as severely impaired with a Brief Interview for Mental Status (BIMS) score of five (5), which indicated this resident was not interviewable.</p> <p>Observation of Perineal Care given to Resident #5 by Certified Nurse Aide (CNA) #2 and CNA #3, on 10/07/15 at 10:45 AM, revealed CNA #2 placed multiple soaked wet wash cloths directly on the top of Resident #5's bedside table and no wash basin was used. SRNA #3 grabbed a wash cloth from those which were placed on the bedside table and proceeded to clean the rectal area first, cleaning from back to front toward the vaginal area. SRNA #3 then started to clean Resident #5's vaginal area using additional washcloths from the ones SRNA #2 placed on the resident's bedside table prior to the start of perineal care. After SRNA #3 completed washing the vaginal area, Resident #5's vaginal or rectal area were not dried off and were visibly very wet from the perineal care given. SRNA's #2 and #3 repositioned Resident #5 and then covered the resident.</p> <p>Interview with SRNA #2, on 10/07/15 at 11:00 AM, revealed she knew that the perineal care had been done wrong and when doing perineal care you start at the front and work towards the back. She further stated it was not appropriate to place wet wash cloths on the surface of a bedside table and a basin should have been used.</p>	F 315	<p>The measures put into place to ensure the deficient practice does not recur were:</p> <ul style="list-style-type: none"> The Infection Control, Incontinence and Perineal policies were reviewed by the Administrator 10/12/15. On 10/21/15, the Administrative Assistant revised the Infection Control Section on the DON's QAPI/Monthly Report to include the task of observing staff perform pericare on a resident. <p>The facility plans to monitor its performance to ensure the solutions are sustained by:</p> <ul style="list-style-type: none"> The DON will complete the Infection Control section on his QAPI/Monthly Report twice weekly for 2 weeks, then monthly thereafter. The Administrator will review all monthly reports monthly for problems identified and ensure action plans are completed and implemented. <p>The corrective action will be completed: 11/21/15.</p>		

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

PRINTED: 10/15/2015
FORM APPROVED
OMB NO. 0938-0391

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 10/07/2015
NAME OF PROVIDER OR SUPPLIER HEARTHSTONE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 806 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 315	Continued From page 8 Interview with SRNA #3, on 10/07/15 at 11:05 AM, revealed she expected herself to do better and that she had messed up with the perineal care and when doing perineal care you start at the front and work towards the back. She stated that it was inappropriate to place the wet wash cloths directly on the bedside table. 2. Review of the facility's Policy on Gloves, last revised, 08/2001, revealed when gloves are indicated they shall be used only once and discarded into the appropriate receptacle. Policy further revealed employees must receive training relative to the use of gloves and other protective equipment prior to being assigned tasks that involve potential exposure to blood or body fluids. Record Review revealed the facility admitted Resident # 7 on 07/16/13 with diagnoses which included Hemiplegia due to Cerebrovascular Accident (CVA), Unspecified Psychosis, Unspecified Dementia without behavioral disturbance, Type 2 Diabetes, Morbid Obesity, and Major Depressive Disorder. Review of the quarterly Minimum Data Set (MDS) assessment, dated 07/03/15, revealed the facility assessed Resident #7's cognition as severely impaired with a BIMS score of six(6) which indicated the resident was not interviewable. In addition, Resident #7 required extensive assistance of two persons for toileting, frequently incontinent of bowel and bladder. Review of the Comprehensive Care Plan, initiated on 04/11/14, revealed the resident was at risk for infections related to history of Urinary Tract Infections with an intervention for staff to use	F 315			

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

PRINTED: 10/15/2015
FORM APPROVED
OMB NO. 0938-0391

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 10/07/2015
NAME OF PROVIDER OR SUPPLIER HEARTHSTONE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 508 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 315	<p>Continued From page 9</p> <p>standard precautions including good hand hygiene while providing incontinent care.</p> <p>Observation of perineal care by CNA #4 and CNA #5, on 10/07/15 at 1:55 PM revealed CNA #4 washed the rectal area of Resident # 7 and brown material was observed on the washcloth after CNA #4 wiped the rectal area. CNA #4 did not change gloves and then washed the resident's vaginal area. CNA #4 did not put water in wash basin but wet washcloths at sink and put washcloths in basin.</p> <p>Interview with CNA #4, on 10/07/15 at 2:00 PM, revealed CNA #4 cleaned the way she normally would and stated she has worked at this facility for eight (8) years.</p> <p>Interview with CNA #5, on 10/07/15 at 2:08 PM, revealed this CNA has worked at the facility for four (4) years. CNA #5 stated she would clean from front to back, doing the front side first and she would have changed gloves after cleaning the back side of resident and would have put water in the wash basin.</p> <p>Interview with Registered Nurse (RN) #1, on 10/07/15 at 04:00 PM, revealed she expected staff to perform perineal care as per policy and procedure and that SRNA's are trained how to do appropriate perineal care in school.</p> <p>Interview with Director of Nursing (DON), on 10/07/15 at 04:48 PM, revealed he expected staff to know what the step by step protocol was for perineal care and to follow it precisely. He further stated the SRNA's are taught this in their training to become certified and they receive ongoing training throughout the year at the facility.</p>	F 315			

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

PRINTED: 11/17/2015
FORM APPROVED
OMB NO. 0938-0391

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 R 11/21/2015
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 000}	INITIAL COMMENTS Based on implementation of the acceptable POC the facility was deemed to be compliance on 11/21/15, as alleged.	{K 000}			

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

TITLE

(X6) DATE

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.

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P. O. Box 26884, Baltimore, MD 21207, and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D. C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 185400	(Y2) Multiple Construction A. Building B. Wing 01 - MAIN BUILDING 01	(Y3) Date of Revisit 11/21/2015
Name of Facility HEARTHSTONE PLACE		Street Address, City, State, Zip Code 506 ALLENSVILLE ROAD ELKTON, KY 42220

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix _____ Reg. # NFPA 101 LSC K0038	Correction Completed 11/21/2015	ID Prefix _____ Reg. # NFPA 101 LSC K0046	Correction Completed 11/21/2015	ID Prefix _____ Reg. # NFPA 101 LSC K0050	Correction Completed 11/21/2015
ID Prefix _____ Reg. # NFPA 101 LSC K0056	Correction Completed 11/21/2015	ID Prefix _____ Reg. # NFPA 101 LSC K0076	Correction Completed 11/21/2015	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By _____ State Agency	Reviewed By <i>CM</i>	Date: <i>11/17/15</i>	Signature of Surveyor: <i>Carol Wickert ARPM</i>	Date: <i>11/17/15</i>
Reviewed By _____ CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 10/7/2015	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
---	--

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

PRINTED: 10/15/2015
FORM APPROVED
OMB NO. 0938-0391

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 10/07/2015
NAME OF PROVIDER OR SUPPLIER HEARTHSTONE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 606 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 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01.</p> <p>PLAN APPROVAL: 1985.</p> <p>SURVEY UNDER: 2000 Existing.</p> <p>FACILITY TYPE: SNF/NF.</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (211).</p> <p>SMOKE COMPARTMENTS: Four (4) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system installed in 1965, upgraded in 1994 with 43 smoke detectors and 9 heat detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system installed in 1965 and upgraded in 2011.</p> <p>GENERATOR: Type II generator installed in 1972. Fuel source is Natural Gas.</p> <p>A standard Life Safety Code Survey was conducted on 10/07/15. The facility was found not to be in 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.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal</p>	K 000		

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

TITLE

(X6) DATE

Diane Miller

Interim Administrator

11-12-15

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

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

PRINTED: 10/15/2015
FORM APPROVED
OMB NO. 0938-0391

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 10/07/2015
NAME OF PROVIDER OR SUPPLIER HEARTHSTONE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 606 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 000	Continued From page 1 Regulations, 483.70(a) et seq. (Life Safety from Fire).	K 000		
K 038 SS=D	Deficiencies were cited with the highest deficiency identified at "F" level. NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that access to exits was readily accessible at all times. This deficient practice affected one (1) of four (4) smoke compartments, staff and other occupants of the building. The facility has the capacity for sixty (60) beds with a census of fifty-seven (57) the day of survey. The findings include: During the Life Safety Code tour, on 10/07/15 at 9:40 AM with the Director of Maintenance (DOM), an exit door leading through the Therapy Gym was observed to have a magnetic locking device. Interview with the DOM, on 10/07/15 at 9:40 AM, revealed this door would lock if a resident with a security bracelet tried to exit. The DOM stated the	K 038	K 038 NFPA 101 LIFE SAFETY CODE STANDARD The corrective actions taken for those found to be affected by the deficient practice was: <u>Therapy Door</u> <ul style="list-style-type: none"> A temporary sign was placed on the exit door that lead into the Therapy gym that says, "Hold door handle down for 15 seconds to open" on 10/19/15 by the Office Manager door. <u>Linen Room Door</u> <ul style="list-style-type: none"> The Maintenance Director installed a self closing door device to the Linen door 10/19/15. How the facility identified others having the potential to be affected by the same deficient practice by: <u>Therapy Door</u> <ul style="list-style-type: none"> The Maintenance Director audited all Secure Care exit doors equipped with the safety locking system to ensure there was sign that informs the public how to unlock the door on 10/19/15. The Office Manager order the standardized sign for the therapy door 10/21/15. <u>Linen Room Doors</u> <ul style="list-style-type: none"> The Maintenance Director audited all storage closets 10/19/15 for the need of self closing door devices. The Maintenance Director ordered self closing door devices 10/19/15. 	11-21-15

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

PRINTED: 10/15/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186400	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/07/2016
NAME OF PROVIDER OR SUPPLIER HEARTHSTONE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 606 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 038	Continued From page 2 door would fully lock down at night. Exits are required to be accessible at all times. Occupants of the building should be able to exit the building with no special knowledge of operating the door. The DOM stated he was not aware of this requirement. On 10/07/15 at 9:50 AM, a door to the Linen Room was observed to open and project more than seven (7) inches into the corridor in the fully opened position. This condition could impede egress in an emergency and requires a door-closing device to remedy the situation. Interview with the DOM, on 10/07/15 at 9:50 AM, revealed he was unaware the door needed a door closing device. The findings were revealed to the Administrator on exit. Reference: NFPA 101 2000 edition 7.2.1.5.1 Doors shall be arranged to be opened readily from the egress side whenever the building is occupied. Locks, if provided, shall not require the use of a key, a tool, or special knowledge or effort for operation from the egress side.	K 038	The measures put into place to ensure the deficient practice does not recur were: <u>Therapy Door</u> <ul style="list-style-type: none"> A permanent sign was placed on the exit door 10/23/15 that leads into the Therapy gym that says, "Hold door handle down for 15 seconds to open" by the Office Manager. On 10/19/15, the Administrator revised the Exit, Exit ways and Exit Signs section on QAPI form titled, Life Safety to include the question: "All exit doors open and close properly." <u>Linen Room Doors</u> <ul style="list-style-type: none"> The Maintenance Director installed closing devices on storage door that opened into the hallway on 10/21/15. On 10/19/15, the Administrator revised the "Fire & Smoke Partition Door & Fire Area Separations section on the QAPI Life Safety report to include, "Doors are kept closed as not to impede evacuation from the building." <p>The facility plans to monitor its performance to ensure the solutions are sustained by:</p> <ul style="list-style-type: none"> The Maintenance Director will complete the Exit, Exit ways and Exit Signs section of the QAPI Life Safety report weekly for 2 weeks, then monthly for 2 months, then quarterly thereafter. The Maintenance Director will complete the "Fire & Smoke Partition Door & Fire Area Separations section on the QAPI Life Safety report weekly for 2 weeks, then monthly for 2 months, then quarterly thereafter. 	
K 046 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by:	K 046		11-21-15

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

PRINTED: 10/16/2015
FORM APPROVED
OMB NO. 0938-0391

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 10/07/2015
NAME OF PROVIDER OR SUPPLIER HEARTHSTONE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 606 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 046	<p>Continued From page 3</p> <p>Based on an interview the facility failed to ensure that emergency exterior lighting was provided as required according to National Fire Protection Association (NFPA) standards. This condition affected four (4) of four (4) smoke compartments, staff, and all the residents. The facility has a capacity for sixty (60) beds with a census of fifty-seven (57) the day of the survey.</p> <p>The findings include:</p> <p>Interview, on 04/16/14 at 10:05 AM with the Director of Maintenance (DOM), revealed he was unaware if the exterior lights to the facility were connected to the emergency generator. The DOM called someone on the telephone and he stated that the person he called said the exterior lighting was not on the emergency generator. Emergency lighting is required to the public way in case an emergency situation should arise.</p> <p>The findings were revealed to the Administrator on exit.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>7.9.1.1* Emergency lighting facilities for means of egress shall be provided in accordance with Section 7.9 for the following: (1) Buildings or structures where required in Chapters 11 through 42 (2) Underground and windowless structures as addressed in Section 11.7 (3) High-rise buildings as required by other sections of this Code (4) Doors equipped with delayed egress locks (5) The stair shaft and vestibule of smokeproof enclosures, which shall be permitted to include a</p>	K 046	<p>K 046 NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>The corrective actions taken for those found to be affected by the deficient practice was:</p> <ul style="list-style-type: none"> Solar Lights were installed along the walkways around the facility 10/26/15 by the Maintenance Staff. Emergency exterior lights will be installed at each exit and will be connected to the generator no later than 11/19/15. <p>How the facility identified others having the potential to be affected by the same deficient practice by:</p> <ul style="list-style-type: none"> Solar Lights were installed along the walkways the begins at the Sun Room and leads to the parking lot; along side of the dining room, the walk way that begins at the front parking and leads to the back of the building and the walkway from the parking lot to the time clock door in the back of the building 10/ 26/15 by the Maintenance Staff. <p>The measures put into place to ensure the deficient practice does not recur were:</p> <ul style="list-style-type: none"> The Administrator revised the Maintenance Daily Check Sheet 10/19/15 to include, "Checking the Solar Lights for proper functioning and replacing as needed." The Check Sheet already contained the question, "Check exit signs, outside lights and security lights." The Administrator revised the Maintenance Monthly Report 10/19/15 to include the question, "Any issues with the Solar Lights." 	11-21-15

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

PRINTED: 10/15/2015
FORM APPROVED
OMB NO. 0938-0391

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 10/07/2015
NAME OF PROVIDER OR SUPPLIER HEARTHSTONE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 606 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 048	Continued From page 4 standby generator that is installed for the smokeproof enclosure mechanical ventilation equipment and used for the stair shaft and vestibule emergency lighting power supply For the purposes of this requirement, exit access shall include only designated stairs, aisles, corridors, ramps, escalators, and passageways leading to an exit. For the purposes of this requirement, exit discharge shall include only designated stairs, ramps, aisles, walkways, and escalators leading to a public way.	K 048	<ul style="list-style-type: none"> The Administrator revised the "Emergency Equipment" section on QAPI form titled "Life Safety" on 10/19/15 to include questions pertaining to the functional Solar Lights. <p>The facility plans to monitor its performance to ensure the solutions are sustained by:</p> <ul style="list-style-type: none"> The Maintenance Director will complete "Emergency Equipment" section on QAPI form titled, "Life Safety weekly for 2 weeks, then monthly for 2 months, then quarterly thereafter. <p>The corrective action will be completed: 11/21/15.</p>	11-21-15
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD 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 This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to conduct fire drills to ensure that staff was prepared for response to incidence of fire under different staffing levels and conditions to include resident levels of alertness. This failure affected all residents and staff in the facility. The facility has the capacity for sixty (60) beds with a census of fifty-seven (57) the day of survey. The findings include:	K 050	<p>K 050 NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>The corrective actions taken for those found to be affected by the deficient practice was:</p> <ul style="list-style-type: none"> The Administrator in-serviced the Maintenance Director 10/12/15 on the K 050 standard of conducting fire drills at unexpected times and under varying conditions. <p>How the facility identified others having the potential to be affected by the same deficient practice by:</p> <ul style="list-style-type: none"> A Fire Drill was conducted on 2nd shift, 10/19/ 15 at 7:00 p.m. right after supper by the Maintenance Director. The previous quarter's drill on 2nd shift was conducted at 3:07 p.m. at shift change. 	

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

PRINTED: 10/15/2015
FORM APPROVED
OMB NO. 0938-0391

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 10/07/2015
NAME OF PROVIDER OR SUPPLIER HEARTHSTONE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 606 ALLENSVILLE ROAD ELKTON, KY 42228		
(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 056	<p>Continued From page 6</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview the facility failed to ensure that the building sprinkler system was installed throughout the facility according to National Fire Protection Association (NFPA) standards. This deficient practice affected two (2) of four (4) smoke compartments, staff and other occupants of the building. The facility has the capacity for sixty (60) beds with a census of fifty-seven (57) the day of survey.</p> <p>The findings include:</p> <p>During the Life Safety Code survey on 10/07/15 at 9:00 AM, with the Director of Maintenance (DOM), a resident shower room located in the PC section of the facility was observed to have a single sprinkler head located in the center of the shower room. If the sprinkler system activated it could not cover some areas of the shower room due to the configuration of the shower walls.</p> <p>Interview with the DOM, on 10/07/15 at 9:00 AM, revealed he was not aware the shower room did not have adequate sprinkler coverage.</p> <p>On 10/07/15 at 10:15 AM an outside canopy located at the Sun Room was measured to be over four (4) foot (48 inches) in width. The canopy measured approximately eighty one (81) inches. Canopies over four (4) foot in width are required to be sprinkler protected unless they are made of non or limited combustible material.</p> <p>Interview with the DOM, on 10/07/15 at 10:20 AM, revealed the canopy material did contain wood construction. The DOM was not aware the canopy should be sprinkler protected.</p>	K 056	<p>How the facility identified others having the potential to be affected by the same deficient practice by:</p> <ul style="list-style-type: none"> The Maintenance Director audited the other shower rooms and canopies /overhangs in the facility 10/19/15 to ensure that an adequate number of sprinklers were installed. <p>The measures put into place to ensure the deficient practice does not recur were:</p> <ul style="list-style-type: none"> The Administrator revised the Maintenance Director's QAPI Monthly report 10/19/15 that contains the question, "Is the Administrator aware of any issues with the Sprinkler or Alarm System. The Administrator revised QAPI form titled, "Preventative Maintenance Review" 10/19/15 to include observing the Sprinklers for dust, dirt, rust or repairs. The Administrator reviewed the QAPI form titled, "Life Safety" 10/19/15 and found it contained sufficient information to comply with K056. <p>The facility plans to monitor its performance to ensure the solutions are sustained by:</p> <ul style="list-style-type: none"> The Maintenance Director will complete the Maintenance Monthly Report and turn it in to the Administrator every month. The report contains the question, "Is the Administrator aware of any issues with the Sprinkler or Alarm System and the QAPI form titled, "Preventative Maintenance Review" that includes observing the Sprinklers for dust, dirt, rust or repairs. 		

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

PRINTED: 10/15/2015
FORM APPROVED
OMB NO. 0938-0391

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 10/07/2015
NAME OF PROVIDER OR SUPPLIER HEARTHSTONE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 606 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 056	Continued From page 7 The findings were revealed to the Administrator on exit. Reference: NFPA 13 1999 edition 5-6.5.3* Obstructions that Prevent Sprinkler Discharge from Reaching the Hazard. Continuous or noncontinuous obstructions that interrupt the water discharge in a horizontal plane more than 18 in. (457 mm) below the sprinkler deflector in a manner to limit the distribution from reaching the protected hazard shall comply with this section. Exception: The requirements of this section shall also apply to obstructions 18 in. or less below the sprinkler for light and ordinary hazard occupancies 5-13.8.1 Sprinklers shall be installed under exterior roofs or canopies exceeding 4 ft. (1.2 m) in width. Exception: Sprinklers are permitted to be omitted where the canopy or roof is of noncombustible or limited combustible construction.	K 056	<ul style="list-style-type: none"> The Administrator will review both reports each month to determine if any areas of concerns were addressed or an action plan implemented. <p>The corrective action will be completed: 11/21/15.</p>	
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than	K 076	<p>F 076 NFPA 101 LIFE SAFETY CODE STANDARD The corrective actions taken for those found to be affected by the deficient practice was:</p> <ul style="list-style-type: none"> The Maintenance Director removed the cardboard boxes from the oxygen storage room 10/7/15. <p>How the facility identified others having the potential to be affected by the same deficient practice by:</p> <ul style="list-style-type: none"> The Maintenance Director and Environmental Supervisor checked all other storage rooms to ensure they only contained non combustible supplies 10/7/15. 	11-21-15

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

PRINTED: 10/15/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 188400	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 10/07/2015
NAME OF PROVIDER OR SUPPLIER HEARTHSTONE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 606 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 076	<p>Continued From page 8 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain oxygen storage rooms as required. This deficient practice affected one (1) of four (4) smoke compartments, staff and approximately twenty (20) residents. The facility has the capacity for sixty (60) beds with a census of fifty-seven (57) the day of survey.</p> <p>The findings include:</p> <p>During the Life Safety Code Survey, on 10/07/15 at 9:35 AM with the Director of Maintenance (DOM), combustible storage (cardboard boxes) was observed to be within five (5) feet of oxygen tanks in the oxygen storage room.</p> <p>Interview with the DOM, on 10/07/15 at 9:35 AM, revealed he was not aware of the requirement that combustible supplies should not be stored within five (5) feet of oxygen tanks.</p> <p>The findings were revealed to the Administrator on exit.</p> <p>Reference: NFPA 99 1999 edition 8-3.1.11.2 c. Oxidizing gases such as oxygen and nitrous</p>	K 076	<p>The measures put into place to ensure the deficient practice does not recur were:</p> <ul style="list-style-type: none"> The Administrator added "Check oxygen storage room for combustibles" to the Maintenance Weekly Compliance Checks form 10/19/15. On 10/7/15, the Director of Nursing educated the contracted supplier that combustibles could not be stored in the oxygen storage room. Maintenance QAPI form titled, "Preventative Maintenance was revised 10/19 /15 by the Administrator to include the question, "No combustible in Oxygen storage room." On 10/19/15, the Administrator revised the a section titled, "Combustible Storage and Waste Materials on the QAPI Life Safety report to Included, "No combustibles are stored in oxygen storage rooms" <p>The facility plans to monitor its performance to ensure the solutions are sustained by:</p> <ul style="list-style-type: none"> The Maintenance Director will complete the Combustible Storage and Waste Material Section of the QAPI Life Safety report weekly for 2 weeks, then monthly for 2 months, then quarterly thereafter. <p>The corrective action will be completed: 11/21/15.</p>		

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

PRINTED: 10/15/2015
FORM APPROVED
OMB NO. 0938-0391

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 10/07/2015
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 076	Continued From page 9 oxide shall be separated from combustibles or incompatible materials by either: 1. A minimum distance of 20 ft (6.1 m), or 2. A minimum distance of 5 ft (1.5 m) if the entire storage location is protected by an automatic sprinkler system designed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, or Storage for nonflammable gases greater than 3000 ft ³ (85 m ³) shall comply with 4-3.1.1.2 and 4-3.5.2.2.	K 076		