

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

PRINTED: 02/16/2011  
FORM APPROVED  
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185142	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  02/04/2011
NAME OF PROVIDER OR SUPPLIER  HERITAGE MANOR HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 401 INDIANA AVE MAYFIELD, KY 42066		
(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 standard recertification survey was conducted on 02/02/11 through 02/04/11 to determine the facility's compliance with Federal requirements. The facility failed to meet minimum requirements for recertification with the highest S/S of "D". Additionally, an abbreviated survey (KY #15461) was conducted on 02/02/11 and was unsubstantiated.	F 000	<i>This Plan of Correction is the center's credible allegation of compliance.</i>  <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  The services provided or arranged by the facility must meet professional standards of quality.  This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure services were provided or arranged to meet professional standards of quality for two residents (#26, #20 &, not in the selected sample.  On 02/02/11 at 4:55 PM, Licensed Practical Nurse (LPN) #1 administered Lopressor (blood pressure medication) to Resident #20, which was ordered and scheduled to be administered at 7:00 PM.  An observation during the medication pass, on 02/02/11 at 11:50 AM, revealed Resident #26 was administered medication through a gastronomy tube, without verifying placement. Findings include:  1. Resident #20 was admitted to the facility with diagnoses to include Depressive Disorder, Hypertensive Heart Disease without Heart	F 281	F-281 The services provided or arranged by this facility will meet professional standards of quality.  1. Resident #20 is now receiving medications within appropriate time frames. Proper tube placement is now being checked before administering medications to resident #26. Performance improvement education was conducted for LPN #1 and RN#2.  2. Nursing Administration, to include the Director of Nursing, Staff Development Coordinator and Unit Managers will conduct medication pass audits for all licensed nurses and all residents, including residents receiving enteral feeding to identify other residents effected by this deficient practice with corrections made as needed by 3/18/2011. 03/17/11/HY/LM  3. All licensed nurses will be in-serviced on proper medication administration, including proper time frames and checking gastric tube placement, by the Staff Development Coordinator by	3/18/2011	

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

TITLE

(X6) DATE

*Ken Reynolds*

*Executive Director*

*2/21/2011*

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  HERITAGE MANOR HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 401 INDIANA AVE MAYFIELD, KY 42066		
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F 281	<p>Continued From page 1</p> <p>Failure, Senile Dementia, and Hypothyroidism.</p> <p>A review of the policy entitled, "Medication Administration" dated 10/31/10 revealed, "Medications are administered within 60 minutes of the scheduled time of administration, except for before and after meals, which are based on scheduled meal times and administered within 30 minutes of the meal".</p> <p>A review of the physician's orders, dated 02/01/2011 through 02/28/2011, revealed an order for Metoprolol (Lopressor) 25 mg by mouth every 12 hours at 9:00 AM and 9:00 PM.</p> <p>Observation during a medication pass, on 02/02/11 at 4:55 PM, revealed LPN #1 administered Lopressor 25 milligrams (mg) tablet to Resident #20.</p> <p>An interview, with LPN #1, on 02/02/11 at 5:45 PM, revealed she gave the medication too early. She had a one hour window before or after the ordered time to give the medication. LPN #1 stated, "Oh, I made a mistake cause it is not due until 9:00 PM. The resident usually gets the Lopressor an another Motrin at 8:00 PM. I messed up".</p> <p>2. A review of the facility policy titled "Enteral Feeding Administration", dated 04/28/09, included "Check the feeding tube placement and gastric residual."</p> <p>Resident #26 was admitted to the facility with diagnoses to include Dysphagia, Senile Delusion, Psychosis, Dyskinesia of Esophagus and Gastrostomy.</p>	F 281	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>3/10/2011 to ensure this deficient practice does not recur.</p> <p>4. Nursing Administration, to include the Director of Nursing, Staff Development Coordinator and Unit Managers will conduct medication pass audits for all licensed nurses and all residents, including residents receiving enteral feeding at least monthly and report to the Performance Improvement Committee for three months and/or until this deficient practice is considered resolved. The Director of Nursing will be responsible for coordinating and monitoring this plan.</p>		

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NAME OF PROVIDER OR SUPPLIER  HERITAGE MANOR HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 401 INDIANA AVE MAYFIELD, KY 42066		
(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 281	<p>Continued From page 2</p> <p>A review of Physician Orders, dated 12/22/10 through 02/28/11, revealed, "Check tube placement before insertion of formula, medication administration and flushing tube or at least every 8 hours." A review of the Medication Administration Record (MAR), dated 02/01/11 through 02/28/11, revealed, "Check tube placement before insertion of formula, medication administration, and flushing tube or at least every 8 hours."</p> <p>An observation during a medication pass, on 02/02/11 at approximately 11:50 AM, revealed Registered Nurse (RN) #2 crushed Tylenol 1000 milligrams (mg), Ativan 0.5 mg, and Sucralfate 1 gram (gm) and mixed the medications with 30 ccs of water. RN #2 instilled 30 ccs of water in the gastronomy tube, administered the medications mixed in 30 ccs of water and instilled an additional 30 ccs of water into the gastronomy tube. The RN did not verify correct placement of the gastronomy tube, prior to administering the medications.</p> <p>An interview with RN #2, revealed she did not verify placement of the gastronomy tube, prior to administering a total of 90 ccs of water and the medications. RN #2 stated the facility policy required verification of the correct placement of the tube, prior to administering the water and medications and she did not follow the procedure.</p> <p>An interview with the Director of Nursing, on 02/02/11 at approximately 5:10 PM, revealed she expected every nurse to verify placement of a gastronomy tube, prior to administration of any water or medications.</p>	F 281			

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NAME OF PROVIDER OR SUPPLIER  HERITAGE MANOR HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 401 INDIANA AVE MAYFIELD, KY 42066		
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K 000	INITIAL COMMENTS  A Life Safety Code survey was initiated and conducted on 02/02/11 to determine the facility's compliance with Title 42, Code of Federal Regulations, 483.70 (Life Safety from Fire) and found the facility to be in compliance with NFPA 101 Life Safety Code 2000 Edition. No deficiencies were identified during this survey.	K 000			



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

*Karen Reynolds*

TITLE

*Executive Director*

(X6) DATE

*2/4/2011*

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