

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

PRINTED: 01/23/2012
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 01/06/2012
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NAME OF PROVIDER OR SUPPLIER HEARTHSTONE PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 506 ALLENSVILLE ROAD, P.O. BOX 427 ELKTON, KY 42220
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS A recertification survey was conducted on 01/04/12 through 01/06/12 and a Life Safety Code survey was conducted on 01/04/12 to determine the facility's compliance with Federal requirements. The facility failed to meet minimum requirements for recertification with the highest scope and severity of an "F."	F 000	Revised 2/14/2012 "Hearthstone Place is a facility dedicated to her residents. This plan of correction has been completed and submitted in accordance with State and Federal Regulations, not as an admission of non-compliance, guilt or wrongdoing in anyway; it is being submitted because it is required by law. Furthermore, this plan of correction is not an admission or agreement by Hearthstone Place of the allegations, statements, findings, facts or conclusions that are comprised alleged deficiencies and/or in the entire CMS-2567."	
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to conduct a significant change assessment for one resident (#4), in the selected sample of fifteen, after a decline in mood, physical condition and weight loss. The findings include:	F 274	F 274 483.20(b)(2)(ii) COMPREHENSIVE ASSESSMENT AFTER SIGNIFICANT CHANGE What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice? On 1/24/2012, an MDS Nurse scheduled significant change assessment for Resident #4 with an Assessment Reference Date (ARD) of 1/30/2012 for a decline in mood, physical condition and weight loss. How the facility will identify other residents having the potential to be affected by the same alleged deficient practice? On 1/25/2012, an audit was conducted by an Administrative Nurse to review MDS assessments completed in last 30 days to determine if a significant change assessment	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kathleen C. Evans TITLE: Administrator (X6) DATE: 2/14/12

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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F 274	<p>Continued From page 1</p> <p>A record review revealed Resident #4 was admitted to the facility on 08/12/11 with diagnoses to include Congestive Heart Failure, Diabetes Mellitus, Cerebral Vascular Accident, Left-sided Hemiplegia, Chronic Obstruction Pulmonary Disease, Depression and Mood Disorder.</p> <p>A review of the admission Minimum Data Set (MDS), dated 08/22/11, revealed the resident to have a Brief Interview for Mental Status (BIMS) score of nine. Further review revealed the resident was free of mood symptoms with a severity score of zero. The resident required limited assistance with bed mobility, transfer, walk in room and corridor, dressing, toilet use and personal hygiene. Resident #4 was continent of bowel, and the resident's weight was 148 pounds.</p> <p>A review of the quarterly MDS, dated 11/22/11, revealed the resident to have a BIMS score of eight. Further review revealed the resident experienced a decline in mood, bed mobility, transfer, walk in room and corridor, dressing, toilet use, personal hygiene, bowel continence and weight loss, as evidenced by the resident requiring extensive assistance with bed mobility, transfer, walk in room and corridor, dressing, toilet use and personal hygiene. He/she was frequently incontinent of bowel. A review of the MDS documentation revealed, over the last two weeks, the resident experienced, "little interest or pleasure in doing things (two to six days); feeling tired or having little energy (seven to eleven days); poor appetite or overeating, (never or one day)" and a severity score of three. The quarterly MDS noted weight loss - "not on a physician-prescribed weight-loss regimen."</p>	F 274	<p>was indicated. On 2/2/2012, an Administrative Nurse completed CQI Tool N-19 "RAI Process". No later than 2/9/2012, any resident addressed will be reviewed by an interdisciplinary team and an ARD will be set.</p> <p>What measures will be put into place or systemic changes made to ensure that the alleged deficient practice will not recur? On 2/9/2012, Interdisciplinary Team members will be in-serviced on how to identify change in resident status per MDS 3.0 criteria and how to conduct a significant change check on completed MDS Assessments.</p> <p>How does the facility plan to monitor its performance to ensure that solutions are sustained? CQI Tool N-19 will be completed monthly for three consecutive months and then as per quarterly Continuing Quality Improvement schedule under the supervision of the Director of Nursing (DON) to ensure the facility identifies and conducts significant change assessments as indicated. The Quality Assurance Team will review any deficient practice identified and implement new interventions as needed.</p> <p style="text-align: right;">Compliance Date:</p>	2/10/2012
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F 274	<p>Continued From page 2</p> <p>A review of the "Weight Log" for Resident #4 revealed, on admission, the resident's weight was 151 pounds, on 11/17/11 his/her weight was 135.1 pounds, and on 12/29/11 his/her weight was 132.8 pounds.</p> <p>A review of the "Urinary Output and Bowel Movement (BM) Record," dated November 2011, revealed Resident #4 had ten episodes of bowel incontinence. Review of the December 2011 record revealed the resident had 20 episodes of bowel incontinence.</p> <p>A review of the "Mood/Behavior Monitoring Log," dated December 2011, revealed Resident #4 exhibited "little interest or pleasure doing things" for 22 days out of 31 days; "feeling or appearing down, depressed, or hopeless" for 24 days; and "poor appetite or overeating" for 21 days.</p> <p>An interview with Certified Nurse Aide (CNA) #1, on 01/06/12 at 8:36 AM, revealed Resident #4 currently exhibited an increase in his/her mood and appeared to be more confused later in the afternoon. She further stated some days he/she required more assistance with activities of daily living (ADLs).</p> <p>An interview with the Certified Dietary Manager, on 01/05/12 at 3:20 PM, revealed Resident #4's admission weight was 151 pounds. She stated the resident's weight, on 11/17/11, which was the look-back reference period, was 135.1 pounds, and this calculated to be a 10.5 percent significant weight loss since August 2011.</p> <p>An interview with the MDS Coordinator, on 01/05/12 at 2:40 PM, revealed after a review of</p>	F 274		
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<p>F 274</p> <p>F 281 SS=D</p>	<p>Continued From page 3</p> <p>the resident's admission and quarterly MDS's, there should be a significant change MDS completed whenever there is a decline in two or more care areas.</p> <p>An interview with the Director of Nursing (DON), on 01/05/12 at 3:45 PM, revealed it was the MDS Coordinator's responsibility to review all sections of the MDS and to make the determination if a significant change assessment was required.</p> <p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to ensure services provided by the facility met professional standards of quality for two residents (#9 and #15), in the selected sample of fifteen residents, related to the failure to administer medications per the physician's orders.</p> <p>The findings include:</p> <p>A review of the facility's policy/procedure, "Administering Medications," revised 11/15/11, revealed, "medications will be administered in a timely manner and as prescribed by the resident's attending physician or the facility's Medical Director."</p> <p>A review of the facility's policy/procedure,</p>	<p>F 274</p> <p>F 281</p>	<p>F 281 <u>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</u></p> <p>What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice? On 2/2/2012, Medication Errors, Unusual Occurrence Reports to include family and physician notification, clarification orders and updates medication administration records were completed under the supervision of the DON on Residents #9 and #15.</p> <p>How the facility will identify other residents having the potential to be affected by the same alleged deficient practice? On 1/27/2012, an audit was conducted under the supervision of the DON to review new admissions and readmissions to verify that hospital discharge orders were properly transcribed to Physician's Order Sheet and Medication Administration Record. On 2/2/2012, an Administrative Nurse completed CQI Tool N-29 "New Admissions and Hospital Return Review" and N-16 "Med Pass Review".</p> <p>What measures will be put into place or systemic changes made to ensure that the alleged deficient practice will not recur? On 1/27/2012, Charge Nurses, Medication Nurses and Certified Medication Technicians were in-serviced by Assistant Director of</p>	
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F 281	<p>Continued From page 4</p> <p>"Physician Orders Nursing Facility," revised 10/16/11, revealed, "physician's orders must be given and managed in accordance with applicable laws and regulations." Further review revealed "The nurse receiving a physician's order is responsible for transcribing the order onto the Medication Administration Record (MAR), Treatment Administration Record (TAR), flow sheet, lab book, etc. The 7 PM - 7 AM Charge nurse is responsible for reviewing the physician's orders written each day and for making sure that orders were transcribed correctly. Check to see that the order was transcribed on the MAR, TAR, Insulin book, appointment book, lab tracking book/NPO sheet, etc., correctly. After checking the physician's order, the nurse should initial and date the yellow copy and place it in the Assistant Director of Nursing's (ADON) box. The ADON will review orders the next day to make sure the order was completely followed through."</p> <p>1. A record review revealed Resident #9 was admitted to the facility on 02/17/11 with diagnoses to include Coronary Artery Disease, Peripheral Vascular Disease, Sleep Apnea, Diabetes Mellitus, Transient Ischemic Accident and Hypertension.</p> <p>A review of the hospital's Medication Reconciliation Orders, dated 12/29/11, revealed Resident #9 was to receive "Potassium Chloride (Klor-Con) 10 milliequivalents (mEq) two pills by mouth (po) daily."</p> <p>A review of the admission physician's orders and the MAR, both dated 12/29/11, revealed the order was transcribed to read "Klor-Con 10 mEq po twice daily." A review of the physician's order and</p>	F 281	<p>Nursing (ADON) on Administering Medications and Physician's Order Policies regarding following physician's orders to include dilution of medications and on flushing of gastrostomy tube prior to the administration of medication (licensed staff only). On 2/9/2012, an in-service will be concluded regarding an admission/readmission checklist to be completed by licensed staff for facility admission/readmission this will include reconciling hospital discharge orders to facility admission orders and medication administration records. How does the facility plan to monitor its performance to ensure that solutions are sustained?</p> <p>Effective 2/2/2012, within 72 hours of admission or readmission to facility, an MDS Nurse will utilize an Admission/Readmission Checklist to verify accurate completion of medical record to include physician's orders, medication administration records, and other pertinent documentation. CQI Tool N-29 and N-16 will be completed weekly for four consecutive weeks, monthly for three consecutive months and then as per quarterly Continuing Quality Improvement schedule under the supervision of the DON to ensure the facility administers medications in accordance with MD orders. The Quality Assurance Team will review any deficient practice identified and implement new interventions as needed.</p> <p style="text-align: right;">Compliance Date:</p>	2/10/2012
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F 281	<p>Continued From page 5</p> <p>MAR, dated January 2012, revealed the resident was currently receiving Klor-Con 10 mEq po twice daily.</p> <p>An interview with Licensed Practical Nurse (LPN) #1, on 01/06/12 at 2:40 PM, revealed the day shift nurse initiated the admission orders for Resident #9 and then he completed them. He stated upon new admission orders or any other new orders, there was to be double checks completed to ensure nothing was missed.</p> <p>An interview with LPN #3, on 01/06/12 at 3:12 PM, revealed she initiated the orders for Resident #9 and the evening nurse finished them. She stated it was the facility's policy for the same nurse who admitted the resident to complete the nursing assessment and physician's orders. She stated the same nurse should have completed all of the paperwork.</p> <p>An interview with the Assistant Director of Nursing (ADON), on 01/06/12 at 1:55 PM, revealed paperwork was placed in her box after new physician's orders to check for accuracy. She stated she was not aware of this medication discrepancy, and she expected the staff to place copies of the physician's orders in her box.</p> <p>2. A record review revealed Resident #15 was admitted to the facility on 08/24/09 and readmitted to the facility on 05/18/11 with diagnoses to include Cerebral Vascular Accident, Multi-Infarct Dementia, Hypertension and Atrial Fibrillation.</p> <p>A review of the physician's order, dated January 2012, revealed "Potassium SF 10% solution 20</p>	F 281		

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F 281	<p>Continued From page 6</p> <p>mEq/15 ml, give 7.5 ml (10 mEq) per tube at bedtime for Potassium replacement (dilute with 3-8 ounces of water or juice before administration)."</p> <p>An observation of a medication pass, on 01/05/12 at 5:15 PM, revealed LPN #4 administered Potassium solution 7.5 milliliters (ml) into a syringe via gravity into the resident's gastromy tube (g-tube).</p> <p>An interview with LPN #4, on 01/05/12 at 5:15 PM, revealed he did not dilute the Potassium in the water or juice before administration of the medication. He stated he was expected to follow the physician's orders as they were written. LPN #4 revealed he was trying to complete the medication pass in a timely manner.</p> <p>An Interview with Resident #15's primary care physician, on 01/06/12 at 11:27 AM, revealed the absorption of the medication would not be affected by giving it directly into the g-tube; however, the staff were to administer the medication as ordered.</p> <p>An interview with the Director of Nursing (DON), on 01/06/12 at 4:15 PM, revealed she expected the nurses to pass the medications right. She stated the nurses are expected to give the residents medications as ordered by the physician.</p>	F 281	<p style="text-align: center;"><u>F 322</u> <u>483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS</u></p> <p>What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice? On 1/27/2012, LPN #4 was educated regarding flushing a gastrostomy tube prior to the administration of medication and following a physician order to include dilution of medications, as indicated.</p> <p>How the facility will identify other residents having the potential to be affected by the same alleged deficient practice? There are no other residents with a gastrostomy tube in the facility to be affected by the alleged deficient practice.</p> <p>What measures will be put into place or systemic changes made to ensure that the alleged deficient practice will not recur? On 1/27/2012, Charge Nurses, Medication Nurses and Certified Medication Technicians were in-serviced by Assistant Director of Nursing (ADON) on Administering Medications and Physicians Order Policies, regarding following physician's orders to include dilution of medications and on flushing of gastrostomy tube prior to the administration of medication (licensed staff only). On 2/2/2012, an Administrative Nurse</p>
F 322 SS=D	<p>483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube</p>	F 322	

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F 322	<p>Continued From page 7</p> <p>receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy/procedure, it was determined the facility failed to provide appropriate treatment and services for one resident (#15), in the selected sample of fifteen residents, related to not flushing the gastrostomy tube (g-tube) prior to the administration of his/her medications.</p> <p>The findings include:</p> <p>A review of the facility's policy/procedure, "Administering Medications," dated 11/15/11, revealed "medications must be administered in a timely manner in accordance with the attending physician's written/verbal orders. The individual administering the medication must ensure that the right medication, right dosage, right time and right method of administration are verified before the medication is administered."</p> <p>A record review revealed Resident #15 was admitted to the facility on 08/24/09 and readmitted to the facility on 05/18/11 with diagnoses to include Cerebral Vascular Accident, Multi-Infarct Dementia, Hypertension and Atrial Fibrillation.</p> <p>A review of the physician's order, dated January</p>	F 322	<p>completed CQI Tool N-11 "Tube Feedings" and N-16 "Med Pass Review".</p> <p>How does the facility plan to monitor its performance to ensure that solutions are sustained?</p> <p>CQI Tool N-11 and N-16 will be completed weekly for four consecutive weeks, monthly for three consecutive months and then as per quarterly Continuing Quality Improvement schedule under the supervision of the DON to ensure the facility administers medications via gastrostomy tube according to MD orders. The Quality Assurance Team will review any deficient practice identified and implement new interventions as needed.</p> <p style="text-align: right;">Compliance Date: 2/10/2012</p>	

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F 322	Continued From page 8 2012, revealed an order for enteral feedings, "flush PEG tube with 30 milliliters (ml) of water prior to administration of medications and flush PEG tube with 60 ml water after administration of medications." An observation of a medication pass, on 01/05/12 at 5:20 PM, revealed Licensed Practical Nurse (LPN) #4 administered Resident #15's medications via g-tube without flushing the g-tube with water prior to the administration of his/her medications. An interview with LPN #4, on 01/05/12 at 5:25 PM, revealed he was aware he was suppose to complete a flush prior to and after administration of the g-tube medications; however, he stated he did not have an extra medication cup to measure 30 ml of water. LPN #4 revealed he was "nervous" and was trying to complete the medication pass in a timely manner. He stated he was expected to follow the physician's orders as they were written. An interview with the Director of Nursing (DON), on 01/06/12 at 4:15 PM, revealed LPN #4 informed her he did not flush the resident's g-tube tube before administration of the resident's medications. She revealed she expected the nurses to pass the medications correctly, which meant the nurses were to administer the residents' medications as ordered by the physician.	F 322		
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive	F 364	<u>F 364</u> <u>483.35(d)(1)-(2) NUTRITIVE</u> <u>VALUE/APPEAR, PALATABLE/PREFER</u> <u>TEMP</u> What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice? On 1/13/2012, Nursing Home Administrator (NHA) ordered insulated domes and bases for Dietary staff to utilize to maintain food temperatures during meal service. On 1/20/2012, Certified Dietary Manager (CDM) received and implemented use of the purchased equipment. How the facility will identify other residents having the potential to be affected by the same alleged deficient practice? Any resident who eats meal(s) in their room has the potential to be effected by the alleged deficient practice. What measures will be put into place or systemic changes made to ensure that the alleged deficient practice will not recur? On 1/20/2012, CDM in-serviced dietary staff regarding use of insulated domes and bases to improve food temperatures. On 2/1/2012, CDM completed CQI Tool D-3 "Customer Satisfaction" and D-7 "Tray Accuracy". On 2/2/2012, Activity Director and facility management were in-serviced	

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NAME OF PROVIDER OR SUPPLIER HEARTHSTONE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 506 ALLENSVILLE ROAD, P.O. BOX 427 ELKTON, KY 42220	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 364	<p>Continued From page 9</p> <p>value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to serve food that was at the proper temperatures.</p> <p>A review of the Census and Condition, dated 01/04/12, revealed there were 54 residents in the building and 52 of those residents received their meals from the kitchen.</p> <p>The findings include:</p> <p>An interview with the Dietary Manager, on 01/06/12 at 2:15 PM, revealed the facility had no policy/procedure which addressed food temperatures.</p> <p>An observation of a meal pass, on 01/06/12 at 11:30 AM, revealed the meal trays were passed to all residents. Food temperatures were taken of a test tray right after the last tray was served. The food temperature revealed the pork rib was 84 degrees Fahrenheit (F), green beans and potatoes was 90 degrees F and the pudding was 70 degrees F.</p> <p>During the group interview, on 01/05/12 at 10:30 AM, eight out of eleven residents revealed the food was not hot when served.</p> <p>An interview with the Dietary Manager, on 01/06/12 at 2:15 PM, revealed she expected the</p>	F 364	<p>regarding resident counsel, concerns expressed by resident council and addressing those concerns.</p> <p>How does the facility plan to monitor its performance to ensure that solutions are sustained? Resident counsel will continue to be held monthly and AD or designee will continue to allow residents to voice concerns related to dietary and other facility services to include but not limited to food temperature and palatability. CQI Tools D-3 and D-7 will be completed weekly for four consecutive weeks and then monthly per Continuing Quality Improvement schedule to monitor for proper temperatures of meals served at the facility. The Quality Assurance Team will review any deficient practice identified and implement new interventions as needed.</p> <p style="text-align: right;">Compliance Date:</p>	2/10/2012

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NAME OF PROVIDER OR SUPPLIER HEARTHSTONE PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 606 ALLENSVILLE ROAD, P.O. BOX 427 ELKTON, KY 42220
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<p>F 364</p> <p>F 371 SS=E</p>	<p>Continued From page 10</p> <p>hot food temperatures to be at least 110 degrees F when served, and the cold food temperatures to be around 55 degrees F.</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>The facility must -</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, review of the facility's dietary cleaning schedule, and a review of the facility's policy/procedure, it was determined the facility failed to prepare food under sanitary conditions.</p> <p>A review of the Census and Condition, dated 01/04/12, revealed there were 54 residents in the building, and 52 of those residents received his/her meals from the kitchen.</p> <p>The findings include:</p> <p>A review of the facility's "Sanitation" policy/procedure, undated, revealed "all equipment shall be kept clean."</p> <p>Observations conducted during an initial tour of the kitchen, on 01/04/12 at 9:05 AM, revealed</p>	<p>F 364</p> <p>F 371</p>	<p><u>F 371</u></p> <p><u>483.35(i) FOOD PROCURE, STORE, PREPARE, SERVICE - SANITARY</u></p> <p>What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice?</p> <p>On 1/4/2012, under the supervision of CDM, the can opener, toaster, and oven drip pans were deep cleaned, immediately, and build up was removed.</p> <p>How the facility will identify other residents having the potential to be affected by the same alleged deficient practice?</p> <p>On 1/13/2012, NHA completed CQI Tool D-8 "Department Audit" and found can opener, toaster and oven drip pans to be clean and free of build up.</p> <p>What measures will be put into place or systemic changes made to ensure that the alleged deficient practice will not recur?</p> <p>On 2/2/2012, CDM in-serviced dietary staff regarding Dietary Sanitation Policy and Cleaning Schedules.</p> <p>How does the facility plan to monitor its performance to ensure that solutions are sustained?</p> <p>Certified Dietary Manager will complete CQI Tool D-8 weekly for four consecutive weeks and then monthly per Continuing Quality</p>	

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F 371	Continued From page 11 there was a build-up of a pink substance on the blade of the can opener, there was a thick build-up of crumbs on the inside of the toaster, and the oven drip pans had a build-up of brown-black substance on them. A review of the "Dietary Cleaning Schedule," dated January 2012, revealed the can opener should be cleaned after each use and the toaster and oven drip pans should be deep cleaned weekly. Further review revealed initials on the cleaning schedule indicated the can opener was cleaned daily and the toaster and oven drip pans were cleaned that week. An interview with the Dietary Manager, on 01/16/12 at 2:15 PM, revealed the can opener was not used that morning, and the oven drip pans and toaster did not look like they were cleaned in the past week.	F 371	Improvement schedule to monitor department sanitation. The Quality Assurance Team will review any deficient practice identified and implement new interventions as needed. Compliance Date: 2/10/2012	
F 372 SS=C	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure trash and refuse was disposed of properly. The facility failed to ensure dumpsters were placed on a smooth, washable, nonabsorbent surface, as required by the Kentucky Retail Food Code (KRS 217.127), and failed to ensure trash was properly contained.	F 372	<u>F 372</u> <u>483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY</u> What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice? No later than 2/9/2012, the facility will have a smooth, nonabsorbent and washable surface for dumpsters to conform to Kentucky Retail Food Code on garbage and refuse storage. How the facility will identify other residents having the potential to be affected by the same alleged deficient practice? On 1/6/2012, Food Related Garbage and Rubbish Disposal Policy was drafted and included with Dietary Policies in the facility policy manual. What measures will be put into place or systemic changes made to ensure that the alleged deficient practice will not recur? On 1/13/2012, NHA completed CQI Tool D-8 "Department Audit" to monitor and identify potential deficient sanitation practices for Dietary department. On 2/2/2012, facility management and dietary staff were in-serviced on the Food Related Garbage and Rubbish Policy.	

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F 372	Continued From page 12 The findings include: An observation, on 01/06/12 at 9:55 AM, revealed three (3) dumpsters were located outside the facility on a loose gravel surface. An interview with the facility Maintenance Director, on 01/06/12 at 1:20 PM, revealed she did not know the dumpsters were supposed to be placed on a smooth, nonabsorbent, washable surface. Additionally, the facility did not have a policy/procedure on disposal of waste and refuse. An interview with the Administrator, on 01/06/12 at 4:35 PM, revealed she was unaware the dumpsters were required to be placed on a smooth, nonabsorbent, washable surface.	F 372	How does the facility plan to monitor its performance to ensure that solutions are sustained? 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. Compliance Date: 2/10/2012	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of	F 514	F 514 <u>483.75(l)(1) RESIDENT RECORDS - COMPLETE, ACCURATE, ACCESSIBLE</u> What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice? On 2/2/2012, Medication Errors, Unusual Occurrence Reports to include family and physician notification, clarification orders and updates medication administration records were completed under the supervision of the DON on Residents #9. How the facility will identify other residents having the potential to be affected by the same alleged deficient practice? On 1/27/2012, an audit was conducted under the supervision of the DON to review new admissions and readmissions to verify that hospital discharge orders were properly transcribed to Physician's Order Sheet and Medication Administration Record. On	

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F 514	<p>Continued From page 13</p> <p>the facility's policy/procedure, it was determined the facility failed to maintain clinical records on each resident in accordance with accepted professionals standards and practices that are accurately documented for one resident (#9), in the selected sample of fifteen residents, related to transcription of physician's orders upon re-admission to the facility.</p> <p>The findings include:</p> <p>A review of the facility's policy/procedure, "Physician Orders Nursing Facility," revised 10/16/11, revealed, "Physician orders must be given and managed in accordance with applicable laws and regulations."</p> <p>A record review revealed Resident #9 was admitted to the facility on 02/17/11 with diagnoses to include Coronary Artery Disease, Peripheral Vascular Disease, Sleep Apnea, Diabetes Mellitus, Transient Ischemic Accident and Hypertension.</p> <p>A review of the hospital's Medication Reconciliation Orders, dated 12/29/11, revealed Resident #9 was to receive "Potassium Chloride (Klor-Con) 10 milliequivalents (mEq) two tablets, by mouth (po) daily."</p> <p>A review of the facility's admission orders and Medication Administration Record (MAR), both dated 12/29/11, revealed the order was transcribed as "Klor-Con 10 mEq by mouth (po) twice daily."</p> <p>An interview with Licensed Practical Nurse (LPN) #1, on 01/05/12 at 4:25 PM, revealed the nurse</p>	F 514	<p>2/2/2012, an Administrative Nurse completed CQI Tool N-29 "New Admissions and Hospital Return Review" and N-16 "Med Pass Review".</p> <p>What measures will be put into place or systemic changes made to ensure that the alleged deficient practice will not recur? On 1/27/2012, Charge Nurses, Medication Nurses and Certified Medication Technicians were in-scrviced by Assistant Director of Nursing (ADON) on Administering Medications and Physicians Order Policies regarding following physician's orders to include dilution of medications and on flushing of gastrostomy tube prior to the administration of medication (licensed staff only). On 2/9/2012, an in-service will be concluded regarding an admission/readmission checklist to be completed by licensed staff for facility admission/readmission this will include reconciling hospital discharge orders to facility admission orders and medication administration records.</p> <p>How does the facility plan to monitor its performance to ensure that solutions are sustained? Effective 2/2/2012, within 72 hours of admission or readmission to facility, an MDS Nurse will utilize an Admission/Readmission Checklist to verify accurate completion of medical record to include physician's orders, medication administration records, and other pertinent documentation. CQI Tool</p>	
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F 514	Continued From page 14 who admitted the resident should have completed the admission orders and transcribe the orders to the MAR. A second nurse was to check the physician's orders and MARs for accuracy. An interview with LPN #2, on 01/06/12 at 2:43 PM, revealed the facility's policy/procedure stated the nurse who admitted the resident should complete both the nursing assessment and physician's orders, followed by a second check by another nurse to ensure accuracy. An interview with the Assistant Director of Nursing (ADON), on 01/08/12 at 1:55 PM, revealed the nurse who transcribed the admission orders should take the MAR/physician's order and have a second nurse verify them for accuracy.	F 514	N-29 and N-16 will be completed weekly for four consecutive weeks, monthly for three consecutive months' under the supervision of the DON and then as per quarterly Continuing Quality Improvement schedule to ensure the facility administers medications in accordance with MD orders. The Quality Assurance Team will review any deficient practice identified and implement new interventions as needed. Compliance Date:	2/10/2012	

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NAME OF PROVIDER OR SUPPLIER HEARTHSTONE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 606 ALLENSVILLE ROAD, P.O. BOX 427 ELKTON, KY 42220	
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1985, 1994</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type V (111)</p> <p>SMOKE COMPARTMENTS: Six (6) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system.</p> <p>GENERATOR: Type II generator. Fuel source is natural gas.</p> <p>A standard Life Safety Code survey was conducted on 01/04/12. Hearthstone Place was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for sixty (60) beds with a census of fifty four (54) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)</p>	K 000	<p>Revised 2/16/2012</p> <p>"Hearthstone Place is a facility dedicated to her residents. This plan of correction has been completed and submitted in accordance with State and Federal Regulations, not as an admission of non-compliance, guilt or wrongdoing in anyway; it is being submitted because it is required by law. Furthermore, this plan of correction is not an admission or agreement by Hearthstone Place of the allegations, statements, findings, facts or conclusions that are comprised alleged deficiencies and/or in the entire CMS-2567."</p>	

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CENTERS FOR MEDICARE FACILITIES AND SERVICES

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

Katherine C. Evans, NHA

TITLE

Administrator

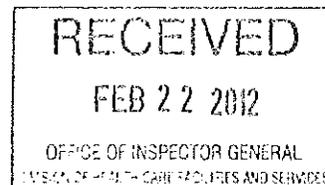
(X6) DATE

2/22/12

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.

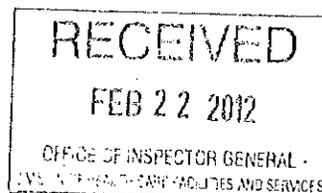
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K 000	Continued From page 1	K 000		
K 025 SS=F	<p>Deficiencies were cited with the highest deficiency identified at "F" level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Smoke barriers are constructed to provide at least a one half hour fire 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 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</p> <p>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 six (6) of six (6) smoke compartments, residents, staff and visitors. The facility is licensed for sixty (60) beds with a census of fifty four (54) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 01/04/12 at 4:30 PM, with the Maintenance Director revealed the smoke partition extending above the ceiling located above the cross corridor doors throughout the</p>	K 025	<p><u>K 025</u> <u>NFPA 101 LIFE SAFETY CODE STANDARD</u></p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? On 1/24/2012 - 2/7/2012, 3M Fire Barrier Sealant with four hour fire rating was purchased and applied to seal penetrations by 4 inch piping in the attic fire walls and smoke barriers.</p> <p>How facility will identify other residents/patients having the potential to be affected by the same alleged deficient practice? On 2/1/2012, Administrator completed a tour of the facility to include the attic to identify any further deficient practices. Any deficient areas were immediately corrected or were immediately scheduled for correction.</p> <p>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 1/31/2012, CQI Tool BS-3 "Life Safety" was revised by Administrator to incorporate visual inspection to identify and correct any present barrier penetrations, open junctions, storage of items in front of electrical panels and interfering with means of egress, portable heating devices, adequate coverage of sprinkler system, properly closing fire doors and to verify new constructions</p>	



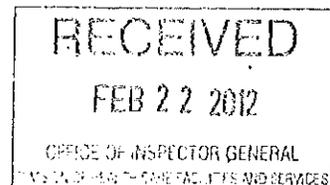
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K 025	Continued From page 2 facility, were noted to have penetrations by 4 " piping through the smoke partitions with wires passing through. The area inside the piping did not have a material rated or equal to the wall that would resist the passage of smoke. Interview, on 01/04/12 at 4:30 PM, with the Maintenance Director revealed they were not aware of the penetrations. Reference: NFPA 101 (2000 Edition). 8.3.8.1 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 the specific purpose.	K 025	have appropriate fire rating. On 2/1/2012, CQI Tool ES-3 "Life Safety" was completed by the Director of Environmental Services (DES). How the facility plans to monitor its performance to ensure that solutions are sustained. Continuing Quality Improvement schedule has been changed to complete CQI Tool ES-3 monthly during 2012 and reevaluated in 2013 to monitor and ensure smoke barriers that will resist the passage of smoke between smoke compartments and remain in accordance to NFPA standards. The Quality Assurance Team will review any deficient practice identified and implement new interventions as needed. Completion Date: 2/10/12 <u>K 027</u> <u>NFPA 101 LIFE SAFETY CODE</u> <u>STANDARD</u> What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? On 1/27/2012 under the supervision of the Director of Environmental Services, the cross corridor doors in the smoke partition by rooms 302 and 320 have been adjusted to ensure doors close in proper fashion and allow for full and complete closure. By 2/19/2012, the access doors in the	



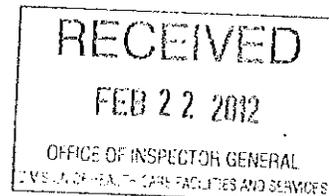
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NAME OF PROVIDER OR SUPPLIER HEARTHSTONE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 505 ALLENSVILLE ROAD, P.O. BOX 427 ELKTON, KY 42220	
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K 027 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1 1/2-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</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure access doors in smoke barriers were installed in accordance with NFPA Standards. The deficiency had the potential to affect six (6) of six (6) smoke compartments, residents, staff, and visitors. The facility is licensed for sixty (60) beds with a census of fifty four (54) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 01/04/12 between 12:30 PM and 6:00 PM, with the Maintenance Director revealed unrated homemade smoke barrier access doors located in the attic.</p> <p>Interview, on 01/04/12 between 12:30 PM and 6:00 PM, with the Maintenance Director revealed they were not aware the doors in the attic must be</p>	K 027	<p>smoko barrier located in the attic will be sealed.</p> <p>How facility will identify other residents/patients having the potential to be affected by the same alleged deficient practice? On 2/1/2012, Administrator completed a tour of the facility to include attic to identify any further deficient practices which will be addressed when product is available.</p> <p>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 1/5/2012, Director of Environmental Services (DES), Housekeeper and Floor Tech were educated by the Administrator regarding the requirement fire rated doors for smoke barriers and cross corridor doors must completely close to be effective and that although doors to smoke corridors in the attic are not required, if installed they should be fire rated. On 1/31/2012, CQI Tool ES-3 "Life Safety" was revised by Administrator to incorporate visual inspection to identify and correct any present barrier penetrations, open junctions, storage of items in front of electrical panels and interfering with means of egress, portable heating devices, adequate coverage of sprinkler system, properly closing fire doors and to verify new constructions have appropriate fire rating. On 2/1/2012, CQI Tool ES-3 "Life Safety" was</p>	



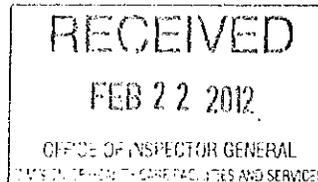
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 01/04/2012
NAME OF PROVIDER OR SUPPLIER HEARTHSTONE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 606 ALLENSVILLE ROAD, P.O. BOX 427 ELKTON, KY 42220	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 027	Continued From page 4 rated for use. Observation, on 01/04/12 at 2:00 PM, with the Maintenance Director revealed the cross corridor doors in the smoke partition by room 302, and 320, would not close all the way. Interview, on 01/04/12 at 2:00 PM, with the Maintenance Director revealed they were not aware the doors would not close all the way. Reference: NFPA 101 (2000 Edition) 19.3.7.3 Any required smoke barrier shall be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than 1/2 hour. Reference: NFPA 101 (2000 Edition) Continually 8.3.2 Smoke barriers required by this Code shall be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier or a combination thereof. Such barriers shall be continuous through all concealed spaces, such as those found above a ceiling, including interstitial spaces. Reference: NFPA 101 (2000 edition) 8.3.4.1* Doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation and shall be without undercuts, louvers, or grilles.	K 027	completed by the Director of Environmental Services (DES). How the facility plans to monitor its performance to ensure that solutions are sustained. Continuing Quality Improvement schedule has been changed to complete CQI Tool ES-3 monthly during 2012 and reevaluated in 2013 to be scheduled no less than quarterly to ensure Protection of Hazards requirements meet and are in accordance with NFPA standards. The Quality Assurance Team will review any deficient practice identified and implement now interventions as needed. Completion Date: 2/20/12	
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with 3/4 hour	K 029	<u>K 029</u> <u>NFPA 101 LIFE SAFETY CODE</u> <u>STANDARD</u> What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? On 1/5/2012, esoutcheon caps and Mylar rings were ordered from sprinkler contractor to correct the penetration in the O2 storage room. On 1/24/2012, the 8 inch by 8 inch penetration in the wall in the kitchen chemical storage closet was repaired with dry wall. On 1/25/2012, DES ordered self closing devices for door to the kitchen and kitchen storage. Self closing brackets will be installed no later than 2/7/2012. Repairs in the 200 Hall	



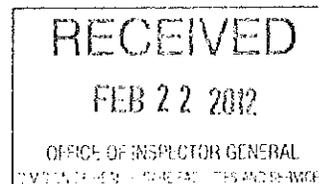
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 01/04/2012
NAME OF PROVIDER OR SUPPLIER HEARTHSTONE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 806 ALLENSVILLE ROAD, P.O. BOX 427 ELKTON, KY 42220	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 029	Continued From page 5 fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements of Protection of Hazards in accordance with NFPA Standards. The deficiency had the potential to affect two (2) of six (6) smoke compartments, residents, staff and visitors. The facility is licensed for sixty (60) beds with a census of fifty four (54) on the day of the survey. The findings include: Observation, on 01/04/12 between 12:30 PM and 5:00 PM, with the Maintenance Director revealed the door to the Kitchen from the Dining Room did not have a self closing device. A hazardous storage closet in the Kitchen had a 8" x 8" penetration in the wall, and had no self closing device on the door. Further observation revealed a penetration around the light fixture and the sprinkler escutcheon in the 200 Hall oxygen	K 029	Central Bath were completed on 1/2/15/2012, under the supervision of the Director of Environmental Services. How facility will identify other residents/patients having the potential to be affected by the same alleged deficient practice? On 2/1/2012, Administrator completed a tour of the facility to include the attic to identify any further deficient practices. Sprinkler contractors will re-inspect and correct any further penetrations around sprinklers. Any deficient areas were immediately corrected or were immediately 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 1/5/2012, Director of Environmental Services (DES), Housekeeper and Floor Tech were educated by the Administrator regarding the NFPA requirement of self closing devices on doors and corrective measures to be taken on any penetrations in smoke barriers since penetrations in smoke barriers are prohibited by Life Safety Code. On 1/31/2012, CQI Tool ES-3 "Life Safety" was revised by Administrator to incorporate visual inspection to identify and correct any present barrier penetrations, open junctions, storage of items in front of electrical panels and interfering with means of egress, portable heating devices, adequate coverage of sprinkler system, properly closing fire doors and to verify.	



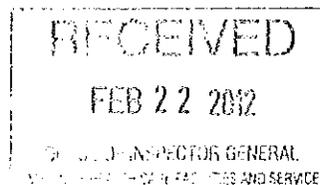
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 01/04/2012
NAME OF PROVIDER OR SUPPLIER HEARTHSTONE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 508 ALLENSVILLE ROAD, P.O. BOX 427 ELKTON, KY 42220	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X4) COMPLETION DATE
K 029	Continued From page 6 storage room, and in the 200 Hall Central Bathing Room. Interview, on 01/04/12 between 12:30 PM and 5:00 PM, with the Maintenance Director revealed they were not aware the self closing devices were required, and not aware of the penetrations in the walls, and ceilings. Reference: NFPA 101 (2000 Edition). 19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft ² (9.3 m ²) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft ² (4.6 m ²), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous	K 029	new constructions have appropriate fire rating. On 2/1/2012, CQI Tool ES-3 "Life Safety" was completed by the Director of Environmental Services (DES). How the facility plans to monitor its performance to ensure that solutions are sustained. Continuing Quality Improvement schedule has been changed to complete CQI Tool ES-3 monthly during 2012 and reevaluated in 2013 to monitor and to ensure Protection of Hazards requirements meet and are in accordance with NFPA standards. The Quality Assurance Team will review any deficient practice identified and implement new interventions as needed. Completion Date: 2/14/12 <u>K 056</u> <u>NFPA 101 LIFE SAFETY CODE</u> <u>STANDARD</u> What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? On 1/5/2012, sprinkler contractor conducted a quarterly inspection and prepared an estimate to complete addition of identified sprinklers. Repairs were initiated on 2/6/2012. The facility is installing six sprinklers to the front canopy, two sprinklers to the 200 Hall Central Bath, one sprinkler to the rear entry porch, and	



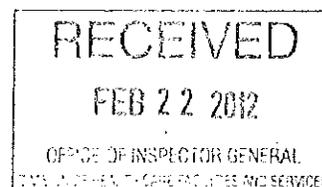
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 01/04/2012
NAME OF PROVIDER OR SUPPLIER HEARTHSTONE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 606 ALLENSVILLE ROAD, P.O. BOX 427 ELKTON, KY 42220	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
K 029	Continued From page 7 by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door. NFPA 101 LIFE SAFETY CODE STANDARD	K 029	one sprinkler to the rear entry porch to courtyard. How facility will identify other residents/patients having the potential to be affected by the same alleged deficient practice? On 1/5/2012, sprinkler contractor conducted an audit of facility to identify if any additional sprinklers were needed.	
K 056 SS=D	If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.6 This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure the building had a complete sprinkler system, in accordance with NFPA Standards. The deficiency had the potential to affect two (2) of six (6) smoke compartments, residents, staff, and visitors. The facility is licensed for sixty (60) beds with a census of fifty four (54) on the day of the survey.	K 056	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 1/5/2012, Director of Environmental Services (DES), Housekeeper and Floor Tech were educated by the Administrator regarding the NFPA requirement having a complete sprinkler system in accordance with Life Safety code and to verify system needs with quarterly sprinkler inspections. On 1/31/2012, CQI Tool ES-3 "Life Safety" was revised by Administrator to incorporate visual inspection to identify and correct any present barrier penetrations, open junctions, storage of items in front of electrical panels and interfering with means of egress, portable heating devices, adequate coverage of sprinkler system, properly closing fire doors and to verify new constructions have appropriate fire rating. On 2/1/2012, CQI Tool ES-3 "Life Safety" was completed by the Director of Environmental Services (DES).	



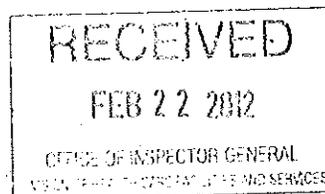
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185400	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 01/04/2012
NAME OF PROVIDER OR SUPPLIER HEARTHSTONE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 500 ALLENSVILLE ROAD, P.O. BOX 427 ELKTON, KY 42220	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 066	Continued From page 8 The findings include: Observation, on 01/04/12 between 12:30 PM and 5:00 PM, with the Maintenance Director revealed three (3) porches located outside exit doors throughout the facility to extend out four (4) foot or greater, made of combustible materials, and were not sprinkler protected. The porches are located at the Rear Entry, the Courtyard Entry, and the Front Porch over driveway. Interview, on 01/04/12 between 12:30 PM and 5:00 PM, with the Maintenance Director revealed they were not aware the porches needed to be sprinkler protected. Observation, on 01/04/12 at 1:02 PM, with the Maintenance Director revealed the sprinkler coverage in the 200 Hall Central bathing room was not adequate to cover all areas of the room. Areas were blocked from coverage by walls. Interview, on 01/04/12 at 1:02 PM, with the Maintenance Director confirmed the observation. Reference: NFPA 13 (1999 Edition) 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. Reference: NFPA 13 (1999 Edition) NFPA 101 LIFE SAFETY CODE STANDARD	K 066	How the facility plans to monitor its performance to ensure that solutions are sustained. Continuing Quality Improvement schedule has been changed to complete CQI Tool ES-3 monthly during 2012 and reevaluated in 2013 to ensure facility has a complete sprinkler system in accordance with NFPA Standards. The Quality Assurance Team will review any deficient practice identified and implement new interventions as needed. Completion Date: 2/29/12 <u>K 070</u> <u>NFPA 101 LIFE SAFETY CODE</u> <u>STANDARD</u> What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? On 1/4/2012, DES removed any portable heating devices identified in administrative areas. How facility will identify other residents/patients having the potential to be affected by the same alleged deficient practice? On 1/4/2012, DES inspected administrative areas in facility and removed any identified portable heating devices. No portable heating devices were identified in resident areas.	
K 070 SS=D		K 070		



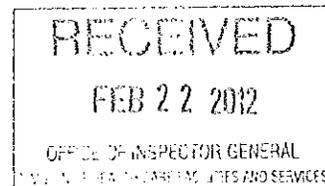
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NAME OF PROVIDER OR SUPPLIER HEARTHSTONE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 806 ALLENSVILLE ROAD, P.O. BOX 427 ELKTON, KY 42220	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 070	<p>Continued From page 9</p> <p>Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure, portable space heaters used in the facility were in accordance with NFPA standards. The deficiency had the potential to affect one (1) of six (6) smoke compartments, residents, staff and visitors. The facility is licensed for sixty (60) beds with a census of fifty four (54) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 01/04/12 at 2:35 PM, with the Maintenance Director revealed two (2) portable space heaters located in the Dietary Managers Office.</p> <p>Interview, on 01/04/12 at 2:35 PM, with the Maintenance Director revealed they were aware the heaters were not permitted in patient care areas, but not aware the heating element could not exceed, 212°F (100°C) when used in non-sleeping staff and employee areas.</p> <p>Reference: NFPA 101 (2000 edition) 19.7.8 Portable Space-Heating Devices. Portable space-heating</p>	K 070	<p>What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not occur?</p> <p>On 1/5/2012, Director of Environmental Services (DES), Housekeeper and Floor Tech were educated by the Administrator regarding the NFPA requirement prohibiting use of portable space heaters and extension cords in the facility as well as plugging medical equipment directly into outlet and non-medical equipment may be plugged into an approved power strip. On 1/5/2012, Director of Environmental Services (DES), Housekeeper and Floor Tech were educated by the Administrator regarding the NFPA requirement prohibiting use of portable space heaters and extension cords in the facility as well as plugging medical equipment directly into outlet and non-medical equipment may be plugged into an approved power strip. On 1/31/2012, CQI Tool ES-3 "Life Safety" was revised by Administrator to incorporate visual inspection to identify and correct any present barrier penetrations, open junctions, storage of items in front of electrical panels and interfering with means of egress, portable heating devices, adequate coverage of sprinkler system, properly closing fire doors and to verify new constructions have appropriate fire rating. On 2/1/2012, CQI Tool ES-3 "Life Safety" was completed by the Director of Environmental Services (DES).</p>	



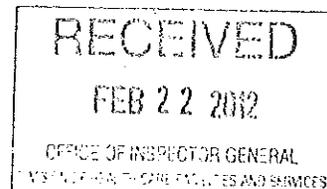
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NAME OF PROVIDER OR SUPPLIER HEARTHSTONE PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 506 ALLENSVILLE ROAD, P.O. BOX 427 ELKTON, KY 42220		
(K4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(K5) COMPLETION DATE
K 070 K 072 SS=E	<p>Continued From page 10 devices shall be prohibited in all health care occupancies. Exception: Portable space-heating devices shall be permitted to be used in nonsleeping staff and employee areas where the heating elements of such devices do not exceed 212°F (100°C).</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain exit access in accordance with NFPA standards. The deficiency had the potential to affect three (3) of six (6) smoke compartments, residents, staff, and visitors. The facility is licensed for sixty (60) beds with a census of fifty four (54) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 01/04/12 between 12:30 PM and 6:00 PM, with the Maintenance Director revealed linen carts, wheelchairs, lifts, and trash carts were being stored in the 100, and 200 Halls.</p> <p>Interview, on 01/04/12 between 12:30 PM and 6:00 PM, with the Maintenance Director revealed</p>	K 070 K 072	<p>How the facility plans to monitor its performance to ensure that solutions are sustained. Continuing Quality Improvement schedule has been changed to complete CQI Tool ES-3 monthly during 2012 and reevaluated in 2013. The Quality Assurance Team will review any deficient practice identified and implement now interventions as needed.</p> <p>Completion Date: 2/10/12</p> <p><u>K 072</u> <u>NFPA 101 LIFE SAFETY CODE STANDARD</u></p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? On 2/8/2012, all items stored in hallway were removed and permanent storage placement was obtained.</p> <p>How facility will identify other residents/patients having the potential to be affected by the same alleged deficient practice? On 2/1/2012, Administrator completed a tour of the facility to include the attic to identify any further deficient practices. Any deficient areas were immediately corrected or were immediately scheduled for correction.</p> <p>What measures will be put into place or what systemic changes will be made to</p>	2/10/12



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NAME OF PROVIDER OR SUPPLIER HEARTHSTONE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 506 ALLENSVILLE ROAD, P.O. BOX 427 ELKTON, KY 42220	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 147	<p>Continued From page 12</p> <p>strip located in the NF Nurses Station.</p> <p>4) An oxygen concentrator and a mini nebulizer were plugged into a power strip located in room #316.</p> <p>5) A mini nebulizer and a BPAP machine were plugged into a power strip located in room #311.</p> <p>6) Storage in front of electrical panels in the Electrical Room located in the Dining Room.</p> <p>7) Open junction boxes located in the attic above room 230.</p> <p>Interview, on 01/04/12 between 12:30 PM and 5:00 PM, with the Maintenance Director revealed they were not aware of the extension cords and power strips being misused. Further interview revealed they were also not aware of the storage in front of the electrical panels, or the open junction boxes in the attic.</p> <p>Reference: NFPA 99 (1999 edition)</p> <p>3-3.2.1.2 D</p> <p>Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.</p> <p>370.28(o) Covers.</p>	K 147	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?</p> <p>On 1/4/2012, DES removed extension cords in the NF Medication Room and Billing Office. Medical Equipment in Room 311 and 316 were pulled into wall outlet. On 1/31/2012, all items were removed from in front of the electrical panels located in the dining room closet. On 2/1/2012 open wire junctions not contained by a junction box identified in the attic were disconnected from the electric panel and are no longer in use.</p> <p>How facility will identify other residents/patients having the potential to be affected by the same alleged deficient practice?</p> <p>On 2/1/2012, Administrator completed a tour of the facility to include the attic to identify any further deficient practices. Any deficient areas were immediately corrected or were immediately scheduled for correction.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur?</p> <p>On 1/5/2012, Director of Environmental Services (DES), Housekeeper and Floor Tech were educated by the Administrator regarding the NFPA requirement prohibiting use of portable space heaters and ex-</p>	



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

PRINTED: 01/23/2012
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 01/04/2012
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K 147	Continued From page 13 All pull boxes, junction boxes, and conduit bodies shall be provided with covers compatible with the box or conduit body construction and suitable for the conditions of use. Where metal covers are used, they shall comply with the grounding requirements of Section 250-110. An extension from the cover of an exposed box shall comply with Section 370-22, Exception. 110-26. Spaces About Electrical Equipment. Sufficient access and working space shall be provided and maintained around all electric equipment to permit ready and safe operation and maintenance of such equipment. Enclosures housing electrical apparatus that are controlled by lock and key shall be considered accessible to qualified persons.	K 147	tension cords in the facility as well as plugging medical equipment directly into outlet and non-medical equipment may be plugged into an approved power strip. On 1/31/2012, CQI Tool ES-3 "Life Safety" was revised by Administrator to incorporate visual inspection to identify and correct any present barrier penetrations, open junctions, storage of items in front of electrical panels and interfering with means of egress, portable heating devises, adequate coverage of sprinkler system, properly closing fire doors and to verify new constructions have appropriate fire rating. On 2/1/2012, CQI Tool ES-3. "Life Safety" was completed by the Director of Environmental Services (DES). How the facility plans to monitor its performance to ensure that solutions are sustained. On 2/1/2012, CQI Tool ES-3 "Life Safety" was completed by the Director of Environmental Services (DES). Continuing Quality Improvement schedule has been changed to complete CQI Tool ES-3 monthly during 2012 and reevaluated in 2013 to identify any electrical wiring and equipment meets NFPA standards. The Quality Assurance Team will review any deficient practice identified and implement new interventions as needed. Completion Date: 2/10/12	

