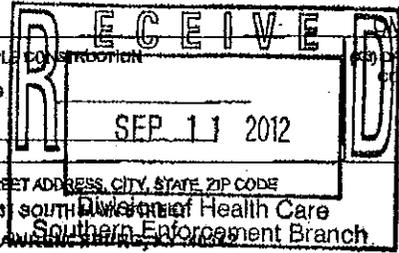


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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0381



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186277	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED R-C 08/01/2012
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NAME OF PROVIDER OR SUPPLIER HERITAGE HALL HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 331 SOUTH DAWSON ST Lawrenceville, GA 30046 Division of Health Care Southern Enforcement Branch
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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
(F 000)	INITIAL COMMENTS	(F 000)		
(F 323) SS-E	<p>A noncompliance revisit was conducted on 07/31-08/01/12. Tag F279 was determined to be corrected but noncompliance continued at F323 at 'E' level. Additional deficient practice was identified at 'E' level (F490 and F520).</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and a review of facility policy and Material Safety Data Sheets it was determined the facility failed to ensure the residents' environment remained as free from accident hazards as possible. Cabinets in four community bathrooms were observed to contain denture cleansing tablets, Cucumber Melon body wash/shampoo, deodorant, manicure sticks with sharp points, razors, sharp containers, Barbasol shaving cream, and body and baby lotion. All of the cabinets observed were locked; however, all of the locks had the keys stored in the locks and were accessible to residents. In addition, the key to the Biohazard room was attached to an expandable key ring that was within reach of the lock and was also accessible to residents.</p>	(F 323)	<p>The preparation and execution of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiency. This Plan of Correction is prepared and executed solely because it is required by Federal and State Law.</p> <p>F323</p> <p>#1 On 8-6-12 the nursing staff removed all potentially hazardous materials such as razors, denture cleaners, manicure sticks, deodorant, shaving cream, lotions, etc. and were instructed that potentially hazardous materials could no longer be stored in the shower rooms.</p>	8-24-12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dana Grant Administrator TIME: _____ DOB DATE: 9-10-12

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

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NAME OF PROVIDER OR SUPPLIER HERITAGE HALL HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 331 SOUTH MAIN STREET LAWRENCEBURG, KY 40342		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
(F 323)	<p>Continued From page 1</p> <p>The findings include:</p> <p>A review of the Chemical Safety and Storage policy, dated 2008, revealed chemicals that were hazardous and/or toxic were to be stored in a secured area.</p> <p>Observations on 07/31/12, at 1:00 PM, 1:10 PM, and 1:20 PM, and on 08/01/12, at 11:00 AM, revealed chemicals and bathing supplies were stored inside cabinets located in the shower rooms. Although each cabinet was locked, the key was in the lock and was accessible to residents.</p> <p>Observation of shower room "D" on 07/31/12, at 1:00 PM, revealed the cabinet contained six bottles of baby lotion, three spray antiperspirant containers, two containers of body wash, three disposable razors, one can of Barbasol shave cream, and one box of manicure sticks with sharp points. The E Wing shower room cabinet was observed to contain five gallon-size containers of Cucumber Melon Body Wash/Shampoo, a sharps container, three bottles of perineal wash, one can of Barbasol shaving cream, four containers of spray deodorant, one bottle of baby lotion, and one gallon-size container of bleach.</p> <p>Observation of the Pink Wing women's shower room on 07/31/12, at 1:10 PM, revealed the cabinet had one box of denture cleaning tablets, one bottle of Avon lotion, two bottles of Senal Care lotion, eight containers of perineal wash, one bottle of mouthwash, one Cotton Candy Body Fantasy lotion, one box of manicure sticks, and one sharps container.</p>	(F 323)	<p>This was also instructed to all nursing staff by a message placed on Caretracker for all nursing staff to read. This was done by the Director of Nursing.</p> <p>On 8-6-12 the bleach was removed from the biohazard room by the Housekeeping Supervisor and it was placed in a locked/secure housekeeping supply closet. The Housekeeping Supervisor informed her staff at that time that potentially hazardous materials were not to be kept in the biohazard room. She reiterated this at a Housekeeping meeting on 8-24-12.</p>	8-24-12	

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(F 323)	<p>Continued From page 2</p> <p>Observation of the men's shower cabinet on the Pink Wing on 07/31/12, at 1:20 PM, revealed the cabinet contained one box of disposable razors, one box of denture cleaning tablets, one bottle of Cetaphil lotion, three bottles of shampoo, six containers of deodorant, one bottle of mouthwash, and one bottle of hand gel sanitizer. An additional observation of the men's shower room on the Pink Wing on 08/01/12, at 11:00 AM, revealed the key was in the lock to the door.</p> <p>Review of the Material Safety Data Sheet (MSDS) for Cucumber Melon Conditioning Shampoo and Body Wash revealed the product had the potential to cause mild eye irritation with prolonged exposure to the concentrate and may be harmful if swallowed.</p> <p>Review of the MSDS for Hand and Body Lotion revealed the lotion had the potential to cause eye irritation and the need for possible medical attention.</p> <p>Review of the MSDS for Performance Plus Baby Lotion revealed the product could cause eye irritation and could be harmful if swallowed.</p> <p>Review of the MSDS for Barbasol Non-Aerosol Therapeutic Shave Cream revealed the product contained a hazardous ingredient, Boric Acid, with a potential health hazard that included acute caustic burns, severe gastrointestinal difficulty if ingested, and inflammation of the skin or scalp. Labeling stated "Precautions to be taken in handling & storage."</p> <p>Observation on 07/31/12, at 1:10 PM, revealed the key to the Biohazard room was attached to an</p>	(F 323)	<p>#2 On 8-1-12 members of the Safety Committee met to discuss possible options for locking cabinet doors in the shower rooms and to discuss alternate options for locking biohazard room and other rooms that may need to be assessed for safety and security. On 8-2-12 the Administrator contacted the Regional Director of Maintenance to discuss options for the door locks. The key to the biohazard room was removed on 8-16-12. An access key pad lock was installed at that time.</p> <p>In-services for the nursing staff was conducted by the Director of Nursing on 8-16-12 regarding identification of potentially hazardous materials, and proper</p>	8-24-12

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(F 323)	<p>Continued From page 3</p> <p>expandable key chain that was attached to the wall adjacent to the door of the room, and was easily accessible to the lock on the door. There were five gallon-size bottles of bleach in the Biohazard room.</p> <p>Review of the MSDS for Clorox liquid bleach revealed the product could cause eye injury, irritate the skin, cause nausea and vomiting if ingested, and may irritate nose, throat, and lungs with exposure to the vapor or mist.</p> <p>An interview with Certified Nursing Assistant (CNA) #1 on 07/31/12, at 2:45 PM, revealed the staff had been in-serviced to make sure the bath items and supplies were to be locked in the bathroom cabinets. The CNA further stated she was aware the keys were in the cabinets but since the cabinets were locked it was "okay."</p> <p>An interview with the facility Administrator and the Director of Nursing (DON) on 07/31/12, at 3:20 PM, revealed the facility had "always" locked the cabinets and left the keys in the locks. In addition, the Administrator stated they have always kept the key adjacent to the Biohazard door. The DON stated there were no residents who exhibited wandering behaviors in the facility. Documentation provided by the facility on the Resident Census and Conditions of Residents (completed on 07/31/12) revealed there were two residents in the facility that exhibited behaviors, however, the documentation was not specific as to the type of behaviors the residents exhibited. In addition, a review of the Roster/Sample Matrix completed by the facility on 07/31/12, revealed there were 62 cognitively impaired residents in the facility.</p>	(F 323)	<p>storage of same, and that as of this date forward no items are to be stored in the shower rooms. Each resident was provided a mesh bag for personal shower items such as body wash, lotion, and deodorant. These items are marked with the individual resident name on them and stored securely in the resident's bedside table with their other personal belongings to ensure that the environment remains as free of accident/hazards as possible.</p> <p>Education regarding identification of potentially hazardous materials and storage of same will be repeated monthly for 6 months then quarterly for one year then no less than annually. Director of Nursing will be responsible to ensure</p>	8-24-12	

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{F 323}	Continued From page 4 An Interview with Licensed Practical Nurse (LPN) #1 on 07/31/12, at 5:45 PM, revealed there was only one resident who "wanders some" and he/she was usually looking for a place to smoke. Observation on 08/01/12, at 12:30 PM, revealed Resident #7, who was assessed by the facility to be cognitively impaired, was ambulating in the hallway with the assistance of a walker. In addition, Resident #7's room was observed to be near the E Wing shower room. The cabinets in the shower rooms and the door to the Biohazard room were observed to be accessible to all residents in the facility. F 490 SS=E 483.76 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's Plan of Correction, it was determined the facility's Administration failed to ensure the facility was administered in a manner to ensure the residents' environment remained as free from accident hazards as possible. The facility's Administration failed to have an effective system in place to ensure procedures and the facility's Plan of Correction	{F 323}	this education is completed. All newly hired staff will be educated during orientation by the staffing coordinator on identification of potentially hazardous materials, proper storage of potentially hazardous materials and that no item that is potentially hazardous is to be stored in the shower room. On 8-16-12 the Director of Nursing and Maintenance Supervisor educated staff on the use of the access pad lock that had been installed on the biohazard door. As of 8-23-12 all shower room doors have access pad locks.	8-24-12

F 323 Continued

On 8-8-12 the Safety Committee met again to discuss the use of the mesh bags for personal items, the access pad locks and safety rounds. The committee will continue to meet monthly and will make rounds monthly to identify any other safety hazards to ensure that the environment remains as free of accident hazards as possible and that each resident receives adequate supervision and assistive devices to prevent accidents. In addition the facility will continue to follow its policies regarding Elopements, smoking, use of restraints and falls management to ensure the environment remains as free of accident hazards as possible and identify any risks to ensure that each resident receives adequate supervision and assistive devices to prevent accidents.

On 8-16-12 the Regional Director of Facilities Management visited the facility and made rounds with the Maintenance Director and the Director of Nursing to identify areas where potentially hazardous items may be stored and to identify any additional areas

F 323 Continued

that may require locks. On 8-22-12 the Corporate Clinical Consultant visited the facility, met with the DON and the Administrator to review facility audits and made rounds to ensure all potentially hazardous areas were secured. On 8-23-12 the Corporate Vice President of Operations met with the DON and the Administrator to review the Statement of Deficiencies, the Plan of Correction and made rounds to ensure all potentially hazardous areas were secure. DON and Administrator were re-educated on F323, F490 and F520 to ensure understanding of the regulation and their role in Administration and Quality Assurance to ensure compliance with the regulation. This was provided by the Corporate Vice President of Operations.

To ensure sustained compliance, rounds will

F 323 Continued

continue to be made two times daily by the floor nurse and one time per day by the unit coordinators to audit shower rooms, biohazard room and other locked areas to ensure that all areas are secure and that personal care items are not left in the shower rooms. Any non-compliance will be corrected immediately and the DON will be notified. The DON will report on the daily audit to the Safety Committee and the facility Quality Assurance Committee. The Corporate Clinical Consultant will visit the facility no less than two times monthly for three months then monthly for three months to review audit procedures to ensure compliance. All findings will be reported to the facility Quality Assurance Committee and the Corporate Vice President of Operations.

The Safety Committee will continue to meet monthly and will make rounds monthly to identify any other safety hazards to ensure that the environment remains as free of accident hazards as possible and that each resident receives adequate

F323 Continued

supervision and assistive devices to prevent accidents. In addition the facility will continue to follow its policies regarding Elopements, Smoking, use of restraints, and falls management to ensure the environment remains as free of accident hazards as possible and to identify any risks to residents to ensure that each resident receives adequate supervision and assistive devices to prevent accidents.

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NAME OF PROVIDER OR SUPPLIER HERITAGE HALL HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 031 SOUTH MAIN STREET LAWRENCEBURG, KY 40342		
(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 490	<p>Continued From page 5</p> <p>were implemented to correct deficiencies cited during an abbreviated standard survey concluded on 08/13/12. This failure resulted in continued noncompliance at 42 CFR 483.25 Quality of Care (F323) and two additional deficiencies at 42 CFR 483.75 Administration (F490 and F520). Cabinets in four community bathrooms and the Biohazard room were observed to contain products that, according to the Material Safety Data Sheets (MSDS), could be harmful if swallowed, if came into contact with skin/eyes, and/or was inhaled. Although the cabinets contained locks that were in the locked position, the key to each lock was located in the lock. In addition, the key to the lock on the Biohazard room was attached to an expandable key ring which was easily within reach of the lock on the door.</p> <p>The findings include:</p> <p>The facility's Administration failed to have an effective system in place to ensure all potentially hazardous items were stored in a secure area. According to the Plan of Correction with an effective completion date of 07/19/12, facility staff would conduct rounds three times a day for two weeks, beginning 07/05/12 until 07/18/12, and then rounds were to be conducted twice a day.</p> <p>On 07/31/12, at 1:00 PM and 1:10 PM, and on 08/01/12, at 11:00 AM, observations of the facility's shower rooms revealed chemicals and bathing supplies stored inside the cabinets located in the shower rooms. Continued observations revealed the cabinets in the shower rooms were locked; however, the locks on the cabinets all had keys in place in the locks and</p>	F 490	<p>F490</p> <p>#1 On 8-6-12 the nursing staff removed all potentially hazardous materials such as razors, denture cleaners, manicure sticks, deodorant, shaving cream, lotions, etc. and were instructed that potentially hazardous materials could no longer be stored in the shower rooms. This was also instructed to all nursing staff by a message placed on Caretracker for all nursing staff to read. This was done by the Director of Nursing.</p>	8-24-12	

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F 490	Continued From page 6 were accessible to residents. In addition, although the door to the Biohazard room was locked, the key to the lock was attached to an expandable key chain that was adjacent to the lock in the door and was easily accessible to residents. The Material Safety Data Sheet (MSDS) from the products revealed the products could be harmful if swallowed, came into contact with skin/eyes, and/or were inhaled. An interview with the facility's Administrator on 08/01/12, at 12:50 PM, revealed she was aware the keys to the locked cabinets were stored in the locks and that the key to the lock on the Biohazard room door was adjacent to the door of the room. The Administrator stated she had difficulty getting the staff to lock the doors and keep them locked. According to the Administrator, even though the keys to the locks on the cabinets were stored in the locks and the Biohazard room door key was accessible, the cabinets and door were "locked" and there was a "low risk" that any unauthorized person would access the cabinets/Biohazard room. Observation on 08/01/12, at 12:30 PM, revealed Resident #7, who was assessed by the facility to be cognitively impaired, was ambulating in the hallway near the E Wing shower room.	F 490	On 8-6-12 the bleach was removed from the biohazard room by the Housekeeping Supervisor and it was placed in a locked/secure housekeeping supply closet. The Housekeeping Supervisor informed her staff at that time that potentially hazardous materials were not to be kept in the biohazard room. She reiterated this at a Housekeeping meeting on 8-24-12. #2 On 8-1-12 members of the Safety Committee met to discuss possible options for locking cabinet doors in the shower rooms and to discuss alternate options for locking biohazard room and other rooms that may need to be assessed for safety and security. On 8-2-12 the	8-24-12
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the	F 520		

F 490 Continued

Administrator contacted the Regional Director of Maintenance to discuss options for the door locks.

The key to the biohazard room was removed on 8-16-12. An access key pad lock was installed at that time.

In-services for the nursing staff was conducted by the Director of Nursing on 8-16-12 regarding identification of potentially hazardous materials, and proper storage of same, and that as of this date forward no items are to be stored in the shower rooms. Each resident was provided a mesh bag for personal shower items such as body wash, lotion, and deodorant. These items are marked with the individual resident name on them and stored securely in the resident's bedside table with their other personal belongings to ensure that the environment remains as free of accident/hazards as possible.

Education regarding identification of potentially hazardous materials and storage of same will be repeated monthly for 6 months then quarterly for one year then no less than

F 490 Continued

annually. Director of Nursing will be responsible to ensure this education is completed. All newly hired staff will be educated during orientation by the staffing coordinator on identification of^P potentially hazardous materials, proper storage of potentially hazardous materials and that no item that is potentially hazardous is to be stored in the shower room.

On 8-16-12 the Director of Nursing and Maintenance Supervisor educated staff on the use of the access pad lock that had been installed on the biohazard door. As of 8-23-12 all shower room doors have access pad locks.

On 8-8-12 the Safety Committee met again to discuss the use of the mesh bags for personal items, the access pad locks and safety rounds. The committee will continue to meet monthly and will make rounds monthly to identify any other safety hazards to ensure that the environment remains as free of accident hazards as possible and that each resident receives adequate supervision and assistive

F 490 Continued

devices to prevent accidents. In addition the facility will continue to follow its policies regarding elopements, smoking, use of restraints and falls management to ensure the environment remains as free of accident hazards as possible and identify any risks to ensure that each resident receives adequate supervision and assistive devices to prevent accidents.

On 8-16-12 the Regional Director of Facilities Management visited the facility and made rounds with the Maintenance Director and the Director of Nursing to identify areas where potentially hazardous items may be stored and to identify any additional areas that may require locks.

On 8-22-12 the Corporate Clinical Consultant visited the facility, met with the DON and the Administrator to review facility audits and made rounds to ensure all potentially hazardous areas were secured. On 8-23-12 the Corporate Vice President of Operations met with the DON and the Administrator to review the Statement of Deficiencies, the Plan of Correction and made rounds

F 490 Continued

to ensure all potentially hazardous areas were secure. DON and Administrator were re-educated on F323, F490 and F520 to ensure understanding of the regulation and their role in Administration and Quality Assurance to ensure compliance with the regulation. This was provided by the Corporate Vice President of Operations.

To ensure sustained compliance, rounds will continue to be made two times daily by the floor nurse and one time per day by the unit coordinators to audit shower rooms, biohazard room and other locked areas to ensure that all areas are secure and that personal care items are not left in the shower rooms.

Any non-compliance will be corrected immediately and the DON will be notified. The DON will report on the daily audit to the Safety Committee and the facility Quality Assurance Committee. The Corporate Clinical Consultant will visit the facility no less than two times monthly for three months then monthly for three months to review audit

F490 Continued

procedures to ensure compliance. All findings will be reported to the facility Quality Assurance Committee and the Corporate Vice President of Operations.

The Safety Committee will continue to meet monthly and will make rounds monthly to identify any other safety hazards to ensure that the environment remains as free of accident hazards as possible and that each resident receives adequate supervision and assistive devices to prevent accidents.

In addition the facility will continue to follow its policies regarding elopements, smoking, use of restraints, and falls management to ensure the environment remains as free of accident hazards as possible and to identify any risks to residents to ensure that each resident receives adequate supervision and assistive devices to prevent accidents.

The facility Quality Assurance Committee will meet monthly for six months to review the Plan of Correction and the implementation of same to ensure that the environment remains as free

F 490 Continued

of accident hazards as possible and that each resident receives adequate supervision and assistive devices to prevent accidents.

The Quality Assurance Committee will review all reports of incidents that occur monthly to ensure that any identified hazard or risk has been addressed. The QA Committee will review the Safety Committee reports to ensure that any identified hazard has been addressed appropriately. The Corporate Clinical Consultant will attend these meetings monthly for six months to monitor compliance and effectiveness of the committee in identifying and addressing Quality Assurance issues.

The Consultant will report no less than quarterly to the Corporate Vice President of Operations any findings.

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NAME OF PROVIDER OR SUPPLIER HERITAGE HALL HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 331 SOUTH MAIN STREET LAWRENCEBURG, KY 40342	
(C4) 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)	(C5) COMPLETION DATE
F 520	<p>Continued From page 7 facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policies and the facility's Plan of Correction (POC) with a compliance date of 07/19/12, it was determined the facility failed to maintain a Quality Assessment and Assurance (QA) Program that implemented appropriate plans of action to correct quality deficiencies. This was evidenced by a repeat deficiency cited at 42 CFR 483.26 Quality of Care (F323) during the noncompliance revisit conducted on 07/31-08/01/12.</p> <p>The findings include: A review of the facility's POC, with a compliance</p>	F 520	<p>F520</p> <p>#1 On 8-6-12 the nursing staff removed all potentially hazardous materials such as razors, denture cleaners, manicure sticks, deodorant, shaving cream, lotions, etc. and were instructed that potentially hazardous materials could no longer be stored in the shower rooms. This was also instructed to all nursing staff by a message placed on Caretracker for all nursing staff to read. This was done by the Director of Nursing.</p> <p>On 8-6-12 the bleach was removed from the biohazard room by the Housekeeping Supervisor and it was placed in a locked/secure housekeeping supply closet. The Housekeeping Supervisor informed her staff at that time that potentially hazardous materials were</p>	8-24-12

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 116277	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 08/01/2012
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 331 SOUTH MAIN STREET LAWRENCEBURG, KY 40342		
(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 520	<p>Continued From page 8</p> <p>date of 07/19/12, revealed all potentially hazardous materials would be removed or secured in all bathrooms. The POC further indicated the staff was to keep the cabinets locked. The floor nurses were to make community bathroom rounds three times a day for two weeks, beginning 07/05/12, and then to continue rounds twice daily by the same staff as an ongoing process. The findings were to be reported to both the Safety and QA committees for any further recommendations.</p> <p>A review of the Chemical Safety and Storage policy, dated 2008, revealed chemicals that were hazardous and/or toxic were to be stored in a secured area.</p> <p>Observations conducted on 07/31/12, at 1:00 PM and 1:10 PM, and on 08/01/12, at 11:00 AM, revealed cabinets in four community bathrooms contained denture cleansing tablets, Cucumber Melon body wash/shampoo, deodorant, manicure sticks with sharp points, razors, sharps containers, Barbasol shaving cream, and body and baby lotion. All of the cabinets observed were locked, however, all of the locks had the keys stored in the locks. In addition, observation of the Biohazard room revealed the room contained five gallon-size bottles of bleach. Although the door to the room was locked, the key to the Biohazard room door was hung adjacent to the room with an expandable key ring which was easily within reach of the lock.</p> <p>A review of the audit documents revealed the staff had observed and documented the resident bathrooms as indicated in the POC. However, a review of the documentation revealed staff failed</p>	F 520	<p>not to be kept in the biohazard room. She reiterated this at a Housekeeping meeting on 8-24-12.</p> <p>#2 On 8-1-12 members of the Safety Committee met to discuss possible options for locking cabinet doors in the shower rooms and to discuss alternate options for locking biohazard room and other rooms that may need to be assessed for safety and security. On 8-2-12 the Administrator contacted the Regional Director of Maintenance to discuss options for the door locks.</p> <p>The key to the biohazard room was removed on 8-16-12. An access key pad lock was installed at that time.</p>	8/24/12	

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NAME OF PROVIDER OR SUPPLIER HERITAGE HALL HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 331 SOUTH MAIN STREET LAWRENCEBURG, KY 40342	
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F 520	Continued From page 9 to identify or document that, although the cabinets in the bathrooms that contained various hazardous products were locked, the keys to the locks were located in the locks, and not secured, and were accessible to the residents. An interview with the Director of Nursing (DON) on 07/31/12, at 3:20 PM, and on 08/01/12, at 12:40 PM, revealed the DON and assistant DON had conducted the audits, not the floor nurses per the POC. Per interview, the facility had "always" locked the cabinets and left the keys in the locks. Even though the DON stated there were no residents who exhibited wandering behaviors in the facility, the cabinets in the shower rooms and the door to the Biohazard room were observed to be easily accessible to all residents in the facility, and Resident #7 was observed wandering the hallway near the E Wing shower room.	F 520	In-services for the nursing staff was conducted by the Director of Nursing on 8-16-12 regarding identification of potentially hazardous materials, and proper storage of same, and that as of this date forward no items are to be stored in the shower rooms. Each resident was provided a mesh bag for personal shower items such as body wash, lotion, and deodorant. These items are marked with the individual resident name on them and stored securely in the resident's bedside table with their other personal belongings to ensure that the environment remains as free of accident/hazards as possible.	8-24-12

F520 Continued

Education regarding identification of potentially hazardous materials and storage of same will be repeated monthly for 6 months then quarterly for one year then no less than annually.

Director of Nursing will be responsible to ensure this education is completed. All newly hired staff will be educated during orientation by the staffing coordinator on identification of potentially hazardous materials, proper storage of potentially hazardous materials and that no item that is potentially hazardous is to be stored in the shower room.

On 8-16-12 the Director of Nursing and Maintenance Supervisor educated staff on the use of the access pad lock that had been installed on the biohazard door. As of 8-23-12 all shower room doors have access pad locks.

On 8-8-12 the Safety Committee met again to discuss the use of the mesh

10-A

F 520 Continued

bags for personal items, the access pad locks and safety rounds.

The committee will continue to meet monthly and will make rounds monthly to identify any other safety hazards to ensure that the environment remains as free of accident hazards as possible and that each resident receives adequate supervision and assistive devices to prevent accidents. In addition the facility will continue to follow its policies regarding elopements, smoking, use of restraints and falls management to ensure the environment remains as free of accident hazards as possible and identify any risks to ensure that each resident receives adequate supervision and assistive devices to prevent accidents.

On 8-16-12 the Regional Director of Facilities Management visited the facility and made rounds with the Maintenance Director and the Director of Nursing to identify areas where potentially hazardous items may be stored and to identify any additional areas that may require locks.

F 520 Continued

On 8-22-12 the Corporate Clinical Consultant visited the facility; met with the DON and the Administrator to review facility audits and made rounds to ensure all potentially hazardous areas were secured. On 8-23-12 the Corporate Vice President of Operations met with the DON and the Administrator to review the Statement of Deficiencies, the Plan of Correction and made rounds to ensure all potentially hazardous areas were secure.

DON and Administrator were re-educated on F323, F490 and F520 to ensure understanding of the regulation and their role in Administration and Quality Assurance to ensure compliance with the regulation. This was provided by the Corporate Vice President of Operations.

To ensure sustained compliance, rounds will continue to be made two times daily by the floor nurse and one time per day by the unit coordinators to audit shower rooms, biohazard room and other locked areas to ensure that all areas are secure and that personal

F 520 Continued

care items are not left in the shower rooms.

Any non-compliance will be corrected immediately and the DON will be notified.

The DON will report on the daily audit to the Safety Committee and the facility Quality Assurance Committee. The Corporate Clinical Consultant will visit the facility no less than two times monthly for three months then monthly for three months to review audit procedures to ensure compliance. All findings will be reported to the facility Quality Assurance Committee and the Corporate Vice President of Operations.

The Safety Committee will continue to meet monthly and will make rounds monthly to identify any other safety hazards to ensure that the environment remains as free of accident hazards as possible and that each resident receives adequate supervision and assistive devices to prevent accidents.

In addition the facility will continue to follow its policies regarding elopements, smoking, use of restraints,

F 520 Continued

and falls management to ensure the environment remains as free of accident hazards as possible and to identify any risks to residents to ensure that each resident receives adequate supervision and assistive devices to prevent accidents.

The facility Quality Assurance Committee will meet monthly for six months to review the Plan of Correction and the implementation of same to ensure that the environment remains as free of accident hazards as possible and that each resident receives adequate supervision and assistive devices to prevent accidents.

The Quality Assurance Committee will review all reports of incidents that occur monthly to ensure that any identified hazard or risk has been addressed. The QA Committee will review the Safety Committee reports to ensure that any identified hazard has been addressed appropriately. The Corporate Clinical Consultant will attend these meetings monthly for six months to monitor compliance and effectiveness of the committee in identifying and

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NAME OF PROVIDER OR SUPPLIER HERITAGE HALL HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 331 SOUTH MAIN STREET LAWRENCEBURG, KY 40342
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F 279	<p>Continued From page 1</p> <p>review of the facility's policy, it was determined the facility failed to develop a comprehensive plan of care to maintain a resident's highest practicable physical well-being for one (1) of three (3) sampled residents, (Resident #1).</p> <p>The facility assessed Resident #1 for being at risk for falls, upon admission on 03/12/12, related to his/her bilateral foot drop, decline in functional status due to an extended hospitalization, history of psychiatric problems, decreased safety awareness, and decreased mobility. However, the risk factor of Resident #1 standing from his/her wheelchair on his/her own (unassisted transfer) was not addressed in Resident #1's "Risk for Falls" Plan of Care to remind staff to ensure the resident's wheelchair was locked when dressing/undressing the resident. On 06/07/12, a facility staff member was assisting Resident #1 with undressing in the shower room while the resident was in his/her unlocked wheelchair. Resident #1 stood up out of the unlocked wheelchair unassisted. As Resident #1 fell back towards the unlocked wheelchair, the wheelchair rolled backwards with the resident approximately five (5) feet before the wheelchair hit the wall and Resident #1 fell out of the wheelchair onto his/her right side. An mobile x-ray was obtained which revealed Resident #1 had sustained a right hip fracture. Resident #1 was sent to the hospital and required an Open Reduction Internal Fixation (ORIF) surgery of the right hip. (Refer to F-323)</p> <p>The findings include:</p> <p>Review of the facility's policy entitled 'Comprehensive Care Plans', undated, revealed a comprehensive care plan shall be developed for</p>	F 279	<p>#2 Falls Committee reviewed all Comprehensive Care Plans and Nurse Aide Care Plans for all residents who have fallen in the past 30 days on 6-15-12 to immediately identify any other resident with falls that may need care plan revisions related to safety issues. The Falls Committee will review all residents identified as at risk for falls to ensure that the care plans are appropriate and contain directions related to safety measures that apply to the individual resident.</p> <p>Falls Committee will review for a second time all falls for the past 30 days to ensure the root cause of the fall had been identified and that the interventions put in place were appropriately care planned and were communicated to staff by</p>	7-14-12

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F 279	<p>Continued From page 2</p> <p>each resident that included measurable objectives to meet the resident's medical, nursing, and psychological needs. Further review of the policy revealed the comprehensive care plan was designed to incorporate risk factors associated with identified problems, identify the professional services that were responsible for each element of care, and to prevent decline in the resident's functional status and/or functional levels.</p> <p>Medical record review revealed the facility admitted Resident #1 on 03/12/12, with diagnoses which included Bipolar Disorder, Depressive Disorder, Psychosis, Schizophrenia, Acute Respiratory failure, Bronchopneumonia, Renal Failure, and Sepsis. Review of an admission Minimum Data Set (MDS) Assessment, dated 03/21/12, revealed the facility assessed Resident #1 to have a Brief Interview Mental Status of four (4), indicating the resident was cognitively impaired. Further review of the MDS revealed Resident #1 required extensive assistance of two (2) people for transfers, dressing and personal hygiene, and utilized a wheelchair for mobility. Review of Resident #1's Care Area Assessment (CAA) Summary related to falls, dated 03/23/12, revealed Resident #1 was admitted to the facility for rehabilitation purposes, required extensive assistance from staff for Activities of Daily Living (ADLs) which included balance during transfers and maintaining standing. Further review of the CAA revealed Resident #1 had a sensor pad alarm to his/her wheelchair and bed to alert staff of attempted unassisted transfers.</p> <p>Review of the Comprehensive Care Plan, dated</p>	F 279	<p>way of the Nurse Aide Care Plan. DON and ADON will review all residents with identified behaviors to ensure appropriate care plans are in place and that they address safety measures as they relate to other risk areas for the resident. Any issues identified will be corrected. This will be completed on 7-13-12</p> <p>#3 In-services presented by DON and ADON beginning 6-14 and continuing through 6-19-12 to nursing staff on safety measures that should be in place for residents at risk for falls and for residents with behaviors that may place them at risk for falls or injury. Discussed the communication of these safety measures via the care plan and the nurse aide care plan and the responsibility to ensure these safety</p>	7-14-12

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NAME OF PROVIDER OR SUPPLIER HERITAGE HALL HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 331 SOUTH MAIN STREET LAWRENCEBURG, KY 40342
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F 279	<p>Continued From page 3</p> <p>03/30/12, revealed Resident #1 was at risk for falls related to his/her bilateral foot drop, decreased safety awareness and decreased mobility. Approaches to the plan of care included, assistance from staff for ADLs, monitor for correct position when in bed or in the wheelchair, monitor for safety needs and sensor pad alarm to bed and wheelchair to alert staff of attempted unassisted transfers. The facility failed to include in the comprehensive care plan to ensure the wheelchair was locked while providing care to Resident to prevent accidents.</p> <p>Review of Physician's Orders, dated 05/02/12 and 05/03/12, revealed Resident #1 was discontinued from Physical Therapy and Occupational Therapy due to the resident reaching his/her maximum potential at that time. Further review of Physician's orders revealed Resident #1 was to have one (1) person assist with transfers and was to have supervision with skills due to safety deficit and functional transfers.</p> <p>Review of Nurse's Notes and the facility's investigative report, dated 06/07/12, revealed Resident #1 became agitated while he/she was being assisted with undressing for a shower by Certified Nursing Assistant (CNA) #1. Resident #1 stood up out of his/her wheelchair unassisted, became unsteady and fell back towards the wheelchair which rolled backwards with the resident approximately five (5) feet. Resident #1 fell to the floor on his/her right side. It was determined in the investigative report Resident #1's wheelchair was not locked. Review of an x-ray report, dated 06/08/12, revealed Resident #1 had sustained a Right Hip Fracture. Resident #1 was sent to the hospital and required Open</p>	F 279	<p>measures are implemented. Discussed the use of brakes whenever a resident is in the wheelchair except when resident is in motion. This re-education will be repeated monthly for 3 months then annually and will be included in the new employee orientation.</p> <p>MDS and floor nursing staff were in serviced on updating care plans with falls interventions by the DON and ADON. This began on June 14, 2012 and continued through June 19, 2012. This information will be included in new nurse orientation. This in service for MDS and floor nurses on Care planning and updating will be completed again August 2012.</p>	7-14-12

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F 279	<p>Continued From page 4</p> <p>Reduction Internal Fixation (ORIF) surgery of the right hip.</p> <p>Interview with CNA #1, on 06/12/12 at 4:15 PM, revealed Resident #1 had a frequent behavior of just standing up out of his/her wheelchair unassisted. CNA #1 indicated she knew Resident #1 was at risk for falls as stated in the CNA care plan/assignment sheet. CNA #1 stated she had not locked Resident #1's wheelchair because she was only undressing the resident and not transferring him/her. She indicated the care plan/assignment sheet did not direct her to ensure Resident #1's wheelchair was locked while providing care, such as when she undressed the resident.</p> <p>Interview with LPN #1, on 06/13/12 at 9:45 AM, revealed she completed the the inal investigative report when Resident #1 had a fall on 06/07/12 and noted the resident's wheelchair was not locked while CNA was undressing the resident. She indicated even though it was not on Resident #1's plan of care to lock the wheelchair while providing care, it was "common sense" to lock it to prevent accidents from occurring.</p> <p>Interview with the Minimum Data Set Coordinator, on 06/13/12 at 11:45 AM, revealed she had seen Resident #1 stand up unassisted on several occasions. She stated a resident's wheelchair does not necessarily have to be locked while a CNA is providing care to a resident. She indicated; however, since Resident #1 was known to stand up unassisted then the wheelchair should be locked and it should have been addressed in the plan of care for Resident #1.</p>	F 279	<p>It remains the responsibility of the nursing staff to investigate all falls to determine the root cause of the fall, to put interventions in place to ensure the safety of the resident immediately, including updating the care plan and nurse aide care plan. It is the role of the falls committee to review each fall to ensure that the conclusions are logical and accurate to the best of our knowledge and that the interventions are appropriate and sufficient to ensure the ongoing safety of the resident and that the interventions are effective.</p>	7-14-12
F 323	483.25(h) FREE OF ACCIDENT	F 323		

F 279 Continued...

#4 Falls Committee will review the care plans and nurse aide care plans for all residents at risk for falls and all residents with falls monthly for 3 months then quarterly for 2 quarters. They will audit the care plans for appropriate interventions related to safety measures. They will report their findings to the DON for review by the facility QA Committee to determine the need for additional review or education.

ADON will review care plans and nurse aide care plans for all residents with behaviors that place them at risk for falls or injury to ensure appropriate safety measures are in place. The reviews will be completed monthly for 3 months then quarterly for 2 quarters. Finding will be reported to DON for review by the facility QA Committee to determine the need for additional reviews or education.

Unit Coordinators/ Floor Nurses will make rounds daily to observe the use of safety measures per the resident care plan. They will observe no less than 3 residents per shift per day for 2 weeks then will continue making rounds with observations of no less than 3 residents per day for 2 weeks. Any issues will be identified and corrected immediately but reported to the DON for review by the facility QA Committee to determine the need for additional review or education.

Completion date 7-14-12

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F 323 SS=G	<p>Continued From page 5 HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, review of the facility's Census and Condition Report, review of facility's policy, review of the facility's investigation report and review of the equipment users manual, it was determined the facility failed to ensure each resident received adequate supervision to prevent accidents for one (1) of three (3) sampled residents (Resident #1).</p> <p>On 08/07/12, at approximately 4:10 PM, a facility staff member was assisting Resident #1 with undressing to take a shower while the resident was in his/her wheelchair. At 4:15 PM, Resident #1 stood up out of the wheelchair unassisted. As Resident #1 fell back towards the wheelchair, the wheelchair rolled backwards with the resident approximately five (5) feet before the wheelchair hit the wall and Resident #1 fell out of the wheelchair onto his/her right side. It was determined the wheelchair was not locked. Resident #1 sustained a right hip fracture and required an Open Reduction Internal Fixation (ORIF) surgery of the right hip.</p>	F 323	<p>F323</p> <p>1</p> <p>#1 Resident #1's Comprehensive Care plan and Nurse Aide assignment sheets were reviewed by DON and ADON upon return from the hospital and revisions were made pertaining to level of assistance provided by staff, evaluated by PT/OT and locking wheel chair when providing care. This was completed on June 15, 2012.</p> <p>#2 Falls Committee reviewed all Comprehensive Care Plans and Nurse Aide Care Plans for all residents who have fallen in the past 30 days on 6-15-12 to immediately identify any other resident with falls that may need care plan revisions related to safety issues.</p>	7-19-12

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NAME OF PROVIDER OR SUPPLIER HERITAGE HALL HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 331 SOUTH MAIN STREET LAWRENCEBURG, KY 40342
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F 323	<p>Continued From page 6</p> <p>In addition, the facility failed to ensure the residents' environment remained as free from accident hazards as possible when observations during the initial tour revealed the facility failed to ensure denture cleaning tablets, disposable razors, shampoo, body wash, shaving cream, body lotion, antiperspirant, manicure sticks with sharp points, and Calazime lotion were secured/locked and not accessible to residents. The facility failed to ensure a hair dryer was unplugged and not located in a sink and a red box sharps container (with used sharps) was sitting in an upright position to prevent contaminated sharps from being removed from the container.</p> <p>The findings include:</p> <p>1. Review of the facility's policy entitled "Falls Management", dated 01/01/10, revealed the purpose of the policy was to establish a program to identify residents with risk factors that may place them at risk for falls and to manage those residents who experience a fall to minimize the risk of the fall reoccurring to minimize the risk of injury related to a fall.</p> <p>Review of Resident #1's medical record revealed the facility admitted Resident #1 on 03/12/12, with diagnoses which included Bipolar Disorder, Depressive Disorder, Psychosis, Schizophrenia, Acute Respiratory failure, Bronchopneumonia, Renal Failure, and Sepsis.</p> <p>Review of the admission Minimum Data Set (MDS) Assessment, dated 03/21/12, revealed the facility assessed Resident #1 to have a Brief</p>	F 323	<p>The Falls Committee will review all residents identified as at risk for falls to ensure that the care plans are appropriate and contain directions related to safety measures that apply to the individual resident. Falls Committee will review for a second time all falls for the past 30 days to ensure the root cause of the fall had been identified and that the interventions put in place were appropriately care planned and were communicated to staff by way of the Nurse Aide Care Plan. DON and ADON will review all residents with identified behaviors to ensure appropriate care plans are in place and that they address safety measures as they relate to other risk areas for the resident. Any issues identified will be corrected. This will be completed on 7-13-12</p>	7-19-12
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186277	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X9) DATE SURVEY COMPLETED C 06/13/2012
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NAME OF PROVIDER OR SUPPLIER HERITAGE HALL HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 331 SOUTH MAIN STREET LAWRENCEBURG, KY 40342
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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)	(X6) COMPLETION DATE
F 323	<p>Continued From page 7</p> <p>Interview Mental Status (BIMS) score of four (4), indicating the resident was cognitively impaired. In addition, the MDS revealed Resident #1 required extensive assistance of two (2) people for transfers, dressing and personal hygiene, and utilized a wheelchair for mobility. Review of Resident #1's Care Area Assessment (CAA) Summary related to falls, dated 03/23/12, revealed Resident #1 was admitted to the facility for rehabilitation purposes and the goal was for the resident to return home. Further review of the CAA summary revealed Resident #1 required extensive assistance from staff for Activities of Daily Living (ADLs) including balance during transfers and maintaining standing. Additional review of the CAA summary revealed Resident #1 had a sensor pad alarm to his/her wheelchair and bed to alert staff of attempted unassisted transfers.</p> <p>Review of the Comprehensive Care Plan, dated 03/30/12, revealed Resident #1 was at risk for falls related to his/her bilateral foot drop, decreased safety awareness and decreased mobility. Approaches to the plan of care included, assistance from staff for ADLs, monitor for correct position when in bed or in the wheelchair, monitor for safety needs and sensor pad alarm to bed and wheelchair to alert staff of attempted unassisted transfers.</p> <p>Review of Physical Therapy (PT) Notes and Physician's Orders, dated 05/02/12, revealed Resident #1 had just completed six (6) weeks of PT and skilled PT services and the services would be discontinued due to the resident reaching his/her maximum potential at that time. Review of Occupational Notes (OT), dated</p>	F 323	<p>#3 In-services presented by DON and ADON beginning 6-14 and continuing through 6-19-12 to nursing staff on safety measures that should be in place for residents at risk for falls and for residents with behaviors that may place them at risk for falls or injury. Discussed the communication of these safety measures via the care plan and the nurse aide care plan and the responsibility to ensure these safety measures are implemented. Discussed the use of brakes whenever a resident is in the wheelchair except when resident is in motion. This re-education will be repeated monthly for 3 months then annually and will be included in the new employee orientation.</p>	7-19-12

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F 323	<p>Continued From page 8</p> <p>06/03/12, revealed Resident #1 had completed six (6) weeks of OT therapy and the resident would be discontinued from OT due to meeting goals and maximum potential with skills. Further record review revealed Resident #1 was now a one (1) person assist with transfers and was to have supervision with skills due to safety deficit and functional transfers.</p> <p>Review of Nurse's Notes and the facility's investigative report, dated 05/16/12 at 6:40 PM, revealed staff had responded to Resident #1's bed alarm sounding and Resident #1 was found sitting on the floor beside his/her bed. Staff assessed Resident #1 and no injuries were identified. Further review revealed Resident #1 had slid out of the bed due to an unsteady gait and the facility had educated the resident to keep shoes on while sitting on the side of the bed.</p> <p>Review of Nurse's Notes and the facility's investigative report, dated 06/07/12, revealed Resident #1 was being assisted with undressing for a shower by Certified Nursing Assistant (CNA) #1 at approximately 4:10 PM. Resident #1 became agitated when his/her shirt sleeves were difficult to get off and the resident stood up unassisted out of the wheelchair. Resident #1 became unsteady and fell back onto the wheelchair which rolled backwards with the resident and the resident fell to the floor on his/her right side. Licensed Practical Nurse (LPN) #1 assessed the resident and noted a reddened area to the resident's right shoulder and redness on the right elbow. It was determined in the investigative report Resident #1's wheelchair was not locked while CNA #1 was undressing the resident in his/her wheelchair. Continued review</p>	F 323	<p>#4 Unit Managers/ Floor Nurses will make rounds daily to observe the use of safety measures per the resident care plan. They will observe no less than 3 residents per shift per day for 2 weeks then will continue making rounds with observations of no less than 3 residents per day for 2 weeks. These rounds will continue to be done monthly by the safety committee as an ongoing process. Any issues will be identified and corrected immediately but reported to the DON for review by the facility QA Committee to determine the need for additional review or education.</p>	7-19-12

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NAME OF PROVIDER OR SUPPLIER HERITAGE HALL HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 331 SOUTH MAIN STREET LAWRENCEBURG, KY 40342
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F 323	<p>Continued From page 9</p> <p>of Nurse's Notes revealed Resident #1 did not complain of pain related to the fall and CNA #1 assisted the resident with completing his/her shower.</p> <p>Interview with CNA #1, on 06/12/12 at 4:15 PM, revealed she was in the shower room on 06/07/12 at approximately 4:10 PM assisting Resident #1 to undress in preparation for taking a shower. CNA #1 stated Resident #1 had a long sleeved shirt on with cuffs and she and the resident were having a difficult time getting the shirt off. CNA #1 continued to reveal Resident #1 got mad and acted like a "two year old" by standing up out of his/her wheelchair, "stiffening" both his/her arms and when the resident took a step backwards the wheelchair began rolling backwards with the resident. CNA #1 indicated the wheelchair and the resident traveled backwards approximately five (5) feet. CNA #1 stated the wheelchair hit the wall and Resident #1 screamed out as he/she fell out of the wheelchair to the floor on his/her right side. Additional interview with CNA #1 revealed she had not looked Resident #1's wheelchair because she was only undressing the resident and not transferring him/her. CNA #1 indicated Resident #1 had a frequent behavior of just standing up out of his/her wheelchair and from his/her bed unassisted.</p> <p>Interview with CNA #6, on 06/13/12 at 3:00 PM, revealed she had heard a loud noise, like something or someone had fallen on the afternoon of 06/07/12 and then a scream. She entered the shower room and saw Resident #1 lying on his/her right side and CNA #1 next to Resident #1. CNA #6 indicated Resident #1 had a</p>	F 323		7-19-12
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NAME OF PROVIDER OR SUPPLIER HERITAGE HALL HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 331 SOUTH MAIN STREET LAWRENCEBURG, KY 40342
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F 323	<p>Continued From page 10</p> <p>behavior of standing up out of his/her wheelchair unassisted since the resident's admission to the facility, on 03/12/12. Further interview revealed even though the resident's wheelchair had a sensor alarm to alert staff of unassisted transfers the wheelchair should be locked while staff were assisting the resident to undress in anticipation the resident might just stand up on his/her own as well as the potential the wheelchair could roll backward.</p> <p>Interview with LPN #1, on 06/13/12 at 9:45 AM, revealed she assessed Resident #1 after the fall on 06/07/12 and had completed the the initial investigative report. Further interview revealed CNA #1 told her, and observation of the wheelchair revealed, the wheelchair had not been locked. LPN #1 stated due to Resident #1's known behavior of frequently standing up out of the wheelchair, the wheelchair should have been locked as soon as CNA #1 had taken Resident #1 to the shower room prior to assisting the resident with undressing to prevent an accident from occurring. Additional interview revealed she made periodic rounds during her shift to ensure CNAs were providing the care that is needed to residents. She indicated that even though it wasn't on Resident #1's plan of care, it was "common sense" to lock the wheelchair while providing care.</p> <p>Review of Nurse's Notes, dated 06/07/12 at 5:50 PM, revealed Resident #1 was noted to be rubbing his/her right leg and right thigh area stating "it hurts, it hurts". Further review of Nurse's Notes revealed LPN #1 notified Resident #1's Physician and the resident's family. Continued review of Nurse's Notes and</p>	F 323		7-19-12
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NAME OF PROVIDER OR SUPPLIER HERITAGE HALL HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 334 SOUTH MAIN STREET LAWRENCEBURG, KY 40842
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F 323	<p>Continued From page 11</p> <p>Physician's Orders, dated 06/07/12, revealed the Physician ordered a portable x-ray to be obtained for Resident #1's right hip, right tibia/fibula, and right femur.</p> <p>Review of the final x-ray report, dated 06/08/12, revealed Resident #1 had sustained a Right Hip Fracture. Review of Nurse's Notes, dated 06/08/12, revealed Resident #1 was sent to the hospital. Review of hospital records, dated 06/08/12, revealed Resident #1 had an Open Reduction Internal Fixation (ORIF) surgery of the right hip.</p> <p>Observation, on 06/13/12 at 12:00 PM, revealed a Veranda wheelchair manufactured by Invacare was next to Resident #1's bed. Interview with CNA #2, at that time, revealed Resident #1 was still in the hospital and the wheelchair next to the resident's bed was the wheelchair Resident #1 utilized from 03/12/12 until he/she went to the hospital.</p> <p>Review of User Manual for the Invacare Veranda Wheelchair, dated 2010, revealed safety and handling of the wheelchair required close attention of the wheelchair user as well as the assistant. Additional review of the manual revealed 'when transferring to and from the wheelchair ALWAYS engage both wheel locks'.</p> <p>Interview with CNA #5, on 06/13/12 at 3:45 PM, revealed Resident #1 had a behavior of standing up out of his/her wheelchair or bed and straightening his/her shirt and then sitting back down. CNA #5 stated although it was not on the CNA care plan to lock the wheelchair during care, "it is common sense" to lock the wheelchair while</p>	F 323		7/19/12
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NAME OF PROVIDER OR SUPPLIER HERITAGE HALL HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 331 SOUTH MAIN STREET LAWRENCEBURG, KY 40342
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F 323	<p>Continued From page 12</p> <p>providing care to a resident in the wheelchair because the wheelchair could roll back causing the resident to get hurt or even injured, like Resident #1.</p> <p>Interview with the Occupational/Physical Therapy Manager, on 06/13/12 at 1:30 PM, revealed the therapy department was responsible for educating staff on the appropriate usage of equipment, such as wheelchairs. Further interview revealed although she did not have written documentation of the training, she conducted informal periodic safety education with staff as well as orientation to new hires related to ensuring the wheelchair was locked during transfers as well as during providing care such as dressing/undressing a resident while in the wheelchair to prevent accidents. She stated locking the wheelchair would not necessarily have to be a written instruction to a GNA because it was more "common sense".</p> <p>2. Review of the Resident Census and Conditions, received from the facility on 06/12/12, revealed there were ninety-one (91) residents with sixty-two (62) listed under Section C with Dementia.</p> <p>Review of the facility's policy entitled, "Food and Non-Food Storage", undated, revealed chemical and cleaning supplies were stored in a clean, well-lit, well-ventilated storage area separated from food and service ware.</p> <p>Review of the facility's policy entitled, "Occupational Exposure to Bloodborne Pathogens - Exposure Control Plan", dated 02/02/11, revealed contaminated sharps that</p>	F 323	<p>2</p> <p>#1 Unit coordinators did rounds of all bathrooms and removed or secured all potentially hazardous material(s), including but not limited to, razors, wood manicure sticks, shaving creams, denture cleaners, body wash and shampoos. This was completed on June 14, 2012.</p> <p>#2 Unit coordinators did rounds of all bathrooms and removed or secured all potentially hazardous material(s), including but not limited to, razors, wood manicure sticks, shaving creams, denture cleaners, body wash and shampoos. This was completed on June 14, 2012.</p>	7-19-12

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F 323	<p>Continued From page 13</p> <p>were not reusable were to be placed immediately, or as soon as possible, after use into appropriate sharps containers. Policy further revealed the sharps containers were puncture-resistant, labeled with a biohazard label and were leak-proof.</p> <p>Review of the facility's policy entitled, "Storage of Medication", undated, revealed drugs were to be stored in a secure and orderly manner under proper temperatures and were to be accessible only to licensed nursing and pharmacy personnel.</p> <p>Observation during the initial tour of the facility, on 06/12/12 at 1:30 PM, of the Shower Room labeled "Mens" on Hall B, revealed disposable razors, wood manicure sticks with sharp points, Effident denture tablets, McKesson Body Wash, Barbasol Shave Cream were in an unlocked and open cabinet. In addition, two (2) gallon sized bottles of Cucumber Melon Shower Wash were on the floor in shower as well as one (1) gallon sized bottle in a broken wire bracket container attached to the wall of same shower stall.</p> <p>Observation during the initial tour of the facility, on 06/12/12 at 1:45 PM, of the Shower Room labeled "Shower Room D" on Hall D, revealed disposable razors, a red sharps box turned onto its side with open lid area exposed and two used razors hanging out of the lid, two (2) cans of Barbasol Shave Cream, McKesson Body Lotion, McKesson Antiperspirant pump bottle, McKesson Baby Lotion and Calazime prescription lotion belonging to unsampled residents were in an unlocked and open cabinet. Observation also revealed a hair dryer plugged into an electrical outlet lying in the sink. In addition, two (2) bottles</p>	F 323	<p>#3 In-service for nursing staff will be completed by DON on July 5, 2012 and completed again by July 11, 2012. This will include proper storage of and disposal of potentially hazardous items, to include but not limited to, razors, wooden manicure sticks, shaving creams, denture cleaners, body wash and shampoos. The in service will also include re education of CNA responsibility to keep shower room cabinets locked and shower rooms free from all potentially hazardous items. This will be included in all new nursing staff orientation.</p>	7-19-12
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NAME OF PROVIDER OR SUPPLIER HERITAGE HALL HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 331 SOUTH MAIN STREET LAWRENCEBURG, KY 40342
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F 323	<p>Continued From page 14</p> <p>of one (1) gallon size of body wash on floor in shower area.</p> <p>Observation during the initial tour of the facility, on 06/12/12 at 2:00 PM, of the Shower Room labeled "Women's" on Hall B, revealed disposable razors, wood manicure sticks with sharp points, Effedent denture tablets, McKesson Baby Lotion, McKesson Body Lotion, Barbasol Shave Cream were in an unlocked and opened cabinet.</p> <p>Review of the Material Safety Data Sheet (MSDS), for Cucumber Melon Conditioning Shampoo and Body Wash, revealed the product had the potential to cause mild eye irritation with prolonged exposure to the concentrate and may be harmful if swallowed.</p> <p>Review of the MSDS, for Hand and Body Lotion revealed a potential to cause eye irritation and need for possible medical attention.</p> <p>Review of the MSDS for Performance Plus Baby Lotion, revealed the product may cause eye irritation and be harmful if swallowed.</p> <p>Review of the MSDS, for Barbasol Non-Aerosol Therapeutic Shave Cream, revealed the product contained a Hazardous Ingredient of Boric Acid with a potential health hazard that included acute caustic burns, severe gastrointestinal difficulty if ingested, and inflammation of the skin or scalp. Labeling stated "Precautions to be taken in handling & storage".</p> <p>Interview, on 06/13/12 at 2:15 PM, with CNA #4 revealed the cabinets were supposed to be</p>	F 323	<p>#4 Rounds will be made three (3) times per day by floor nurse for two weeks beginning July 5, 2012 and will be completed by July 18, 2012. These rounds will be done after day shift receives report, after lunch and by 10:00pm on night shift. Any findings will be handled immediately and DON will be notified. Rounds will continue two times per day by the same staff at the beginning of day shift and by 10:00pm on night shift as an ongoing process. DON will report findings to both the Safety and QA committees for further recommendations.</p>	7-19-12

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F 323	<p>Continued From page 16</p> <p>locked after each use and the person giving the shower was responsible to do so. Interview further revealed there were confused residents that go into that shower room without assistance of staff.</p> <p>Interview, on 06/13/12 at 2:25 PM, with CNA #3 revealed the cabinets were to be locked but the cabinet in Shower Room D did not have a lock. CNA #3 revealed the staff who used the shower room was responsible for locking the cabinets. Further interview revealed CNA #3 thought the residents could get into the shower room and get hurt.</p> <p>Interview, on 06/13/12 at 2:35 PM, with LPN #3 revealed the cabinets were to be locked and it was the CNA's responsibility to lock it and the Nurse's responsibility to monitor the locks. Further interview revealed there was potential for a resident to get into the shower room unattended by staff for their safety.</p> <p>Interview, on 06/13/12 at 2:45 PM, with LPN #2 revealed the cabinets were supposed to be locked and it was the CNA's responsibility to lock the cabinet and the nurse's responsibility to monitor the locks.</p>	F 323	<p>DON or ADON will make rounds daily for one month then as an ongoing practice will make rounds weekly to ensure that the floor nurses continue the practice of making rounds as per facility practice. Any findings will be reported to the facility QA Committee for review to determine if additional reviews or education are necessary to sustain compliance.</p> <p>Completion date 7-14-12</p>	7-19-12