

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

PRINTED: 08/09/2013
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185399	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/26/2013
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NAME OF PROVIDER OR SUPPLIER HEARTLAND VILLA CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8005 US HWY 60 WEST LEWISPORT, KY 42351
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F 000	INITIAL COMMENTS A recertification survey was conducted on 07/24/13 through 07/26/13 to determine the facility's compliance with Federal requirements. The facility failed to meet minimum requirements for recertification with the highest S/S of "E." F 323 SS=E 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 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. 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 the resident environment remained as free of accident hazards as is possible. Licensed Practical Nurse (LPN) #1 administered medication to Resident #12; however, did not observe the resident take the medication. Additionally, LPN #1 left insulin on top of the medication cart unsupervised. Findings include: Review of the General Dose Preparation and Medication Administration policy, revised 01/01/13, revealed during medication	F 000 F 323	This plan of correction is prepared and submitted as required by law. By submitting this plan of correction, Heartland Villa Center does not admit that the deficiency listed on this form exist, nor does the center admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency. 1. Resident #12 was assessed by a licensed nurse on 7/24/13 and exhibited no negative effects from the medication she received and the resident reported that she had taken it and showed the nurse the empty medication cup. 2. The Director of Nursing completed a round of all current residents to ensure that no medications were not consumed or noted at bedside and audited the medication and treatment carts to determine that no medications were left unsecured on 7/24/13. No other concerns were identified.	8/23/13
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____
Paula Sanderson NHA 8/18/13

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 323	<p>Continued From page 1</p> <p>administration, facility staff should observe the resident's consumption of the medication(s). The policy revealed facility staff should not leave medications or chemicals unattended.</p> <p>Observation, on 07/24/13 at 4:05 PM, revealed LPN #1 administered the following medications to Resident #12:</p> <ol style="list-style-type: none"> 1. Sertraline HCL 50 milligrams (mg) 2. Simvastatin 10 mg 3. AZO Cranberry tablet 4. Medizine HCL 12.5 mg <p>During the observation, LPN #1 left the room before the resident had consumed the medication.</p> <p>A record review revealed Resident #12 was admitted to the facility on 10/09/09 with a diagnosis to include Depressive Disorder. Review of the annual Minimum Data Set, dated 05/22/13, revealed the facility identified the resident as moderately cognitively intact.</p> <p>Observation, on 07/24/13 at 3:10 PM, revealed an unsupervised medication cart in the hallway with two bottles of insulin on the cart. Further observation revealed LPN #1 was in a resident's room administering medications at that time.</p> <p>Observation, on 07/24/13 at 3:15 PM, 4:05 PM, and 4:15 PM, revealed LPN #1 continued to leave the medication cart unattended with the two insulin bottles on the cart.</p> <p>Interview with LPN #1, on 07/24/13 at 4:20 PM, revealed she was "probably" supposed to watch Resident #12 consume the medications before leaving the room; however, the resident "always" takes the pills. She also verified the two insulin bottles should have been secured in the</p>	F 323	<p>3. Licensed nurses and certified medication technicians have been re-educated as of 8/23/13 on Medication Administration including not leaving medications at bedside without ensure the resident has taken them by the Staff Development Coordinator. A post test on Medication Administration was completed by licensed nurses and certified medication technicians..</p> <p>4. The Director of Nursing or Assistant Director of Nursing will observe medication administration on licensed nurses and medication technicians and complete a Clinical Competency Validation audit tool during this observation. These observations will be done three times a week X 4 weeks, two times a week X 4 weeks and then monthly x 10 months. The findings from these medication observations will be submitted to the Performance Improvement Committee monthly for one year for further review and recommendations.</p>	8/23/13
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F 323	Continued From page 2 medication cart when left unsupervised.	F 323	1) The chocolate milk, nectar thick lemon flavored water; nectar thick cranberry cocktail beverage the honey thick lemon flavored water, apple juice; orange juice, sweet tea and cranberry cocktail were discarded on 7/24/13 by a dietary aide.	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy/procedure, it was determined the facility failed to ensure milk and thickened liquids were stored appropriately in the refrigerator. The current census was forty-three (43) residents, with one (1) resident on tube feeding. Five (5) residents required thickened liquids. Findings include: Review of the Cold Food Storage policy/procedure, dated 07/08, revealed the designated Nutrition Service Director/Cook(s)	F 371	2) An audit was completed of food storage areas by the acting dietary manager on 07/24/13 to determine that food items were stored appropriately with no concerns identified. 3) The Dietary staff members were re-educated on 7/24/13 by the acting manager, to the Cold Food Storage policy which included dating all items when they are opened and write the date they are to be discarded. A posttest was completed by dietary staff on food storage. 4) The Food Service Director will audit the cooler for appropriate storage of food items including milk and thickened liquids. Audits will be conducted five times per week for two weeks, three times per week for two weeks, two times per week for four weeks and weekly for 10 months. Any concerns identified will be addressed at that time. A summary of findings from the audits will be submitted to the Performance Improvement Committee by the Food Service Director monthly for one year for further review and recommendations.	8/23/13

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F 371	<p>Continued From page 3</p> <p>ensured all food items were stored properly in covered containers, labeled and dated.</p> <p>Observation in the refrigerator, on 07/24/13 at 10:40 AM, revealed the following items were opened, but not dated:</p> <ul style="list-style-type: none"> (1) nectar thickened lemon flavored water (1) honey thickened lemon flavored water (1) nectar thickened cranberry cocktail (1) honey thickened apple juice (1) honey thickened orange juice (1) honey thickened sweet tea (2) honey thickened cranberry cocktail <p>Review of the labels for each of the above thickened liquids revealed to refrigerate up to five days, once opened.</p> <p>Additional observation, on 07/24/13 at 10:40 AM, revealed (1) container of chocolate 1% lowfat milk with a "best by" date of 07/23/13.</p> <p>Interview with Dietary Aide #1, on 07/24/13 at 11:35 AM, revealed he was supposed to date the thickened liquids upon opening them; however, he "forgot". He revealed the chocolate milk was expired and should have been removed from the refrigerator. He revealed it was "overlooked."</p> <p>Interview with the Administrator, on 07/26/13 at 10:20 AM, revealed she expected staff to follow manufacturer's guidelines related to food storage in the refrigerator.</p>	F 371		
F 431 SS=D	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of</p>	F 431		

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F 431	<p>Continued From page 4</p> <p>a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy/procedure, it was determined the facility failed to ensure drugs and biologicals used in the facility were stored appropriately.</p>	F 431	<p>1. The expired 2 boxes of Duonebs solution vials, that included 8 vials in one box and 22 vials in the second box, was discarded on 7/24/13 by a licensed nurse.</p>	

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F 431	Continued From page 5 Findings include: Review of the "Storage and Expiration of Medications, Biologicals, Syringes, and Needles" policy/procedure, revised 01/01/13, revealed the facility should ensure medications and biologicals have not been retained longer than recommended by the manufacturer or supplier guidelines. Observation, on 07/24/13 at 3:20 PM, revealed the following items in the medication room, available for resident use: (2) boxes of Duoneb 0.5 milligrams (mg)-3 mg/3 milliliters (ml) solution: eight (8) vials available in one box, with twenty-two (22) vials available in the other box. Both boxes expired May 2013. Interview with Registered Nurse (RN) #1, on 07/24/13 at 3:25 PM, revealed the nurses were responsible to ensure expired nebulizer medications were removed from the cabinet. Interview with the Director of Nursing (DON), on 07/26/13 at 10:15 AM, revealed the facility checks for expired medications on a weekly basis; however, the nurse was responsible for checking the expiration date prior to administering the medication.	F 431	2. The medication room was audited by the Assistant Director of Nursing on 7/24/13 to determine that no expired medications or biologicals were maintained. No other concerns were identified. 3. Licensed nurses and certified medication technicians were re-educated as of 8/23/13 by the Assistant Director of Nursing of the Storage and Expiration of Medications, Biologicals, Syringes and Needles policy which included the expectation that all medications must be discarded upon the expiration date. A post test on the Storage and Expiration of Medications, Biologicals, Syringes and Needles policy was completed by licensed nurses and medication technicians. 4. Medication room, medication and treatment cart audits will be completed by either the Director of Nursing or Assistant Director of Nursing to determine that there are no expired medications present. Any issues identified will be addressed at that time. These audits will be completed two times weekly X 4 weeks, then one time weekly X 4 weeks then monthly x10 months. A summary of findings from these medication room audits will be submitted to the Performance Improvement Committee by the Director of Nursing monthly for one year for further review and recommendations.	8/23/13	

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100679	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/26/2013
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N 219	<p>Continued From page 1</p> <ol style="list-style-type: none"> 1. Sertraline HCL 50 milligrams (mg) 2. Simvastatin 10 mg 3. AZO Cranberry tablet 4. Medizine HCL 12.5 mg <p>During the observation, LPN #1 left the room before the resident had consumed the medication.</p> <p>A record review revealed Resident #12 was admitted to the facility on 10/09/09 with a diagnosis to include Depressive Disorder. Review of the annual Minimum Data Set, dated 05/22/13, revealed the facility identified the resident as moderately cognitively intact.</p> <p>Observation, on 07/24/13 at 3:10 PM, revealed an unsupervised medication cart in the hallway with two bottles of insulin on the cart. Further observation revealed LPN #1 was in a resident's room administering medications at that time.</p> <p>Observation, on 07/24/13 at 3:15 PM, 4:05 PM, and 4:15 PM, revealed LPN #1 continued to leave the medication cart unattended with the two insulin bottles on the cart.</p> <p>Interview with LPN #1, on 07/24/13 at 4:20 PM, revealed she was "probably" supposed to watch Resident #12 consume the medications before leaving the room; however, the resident "always" takes the pills. She also verified the two insulin bottles should have been secured in the medication cart when left unsupervised.</p> <p>Interview with the Director of Nursing (DON), on 07/26/13 at 10:15 AM, revealed she expected staff to stay within visual site, to ensure consumption of medications. She revealed insulin should not be left on top of the medication cart unattended.</p>	N 219	<p>post test on Medication Administration was completed by licensed nurses and certified medication technicians..</p> <p>4) The Director of Nursing or Assistant Director of Nursing will observe medication administration on licensed nurses and medication technicians and complete a Clinical Competency Validation audit tool during this observation. These observations will be done three times a week X 4 weeks, two times a week X 4 weeks and then monthly for 10 months. The findings from these medication observations will be submitted to the Performance Improvement Committee monthly for one year for further review and recommendations.</p>	8/23/13

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N 283	Continued From page 2	N 283		
N 283	<p>902 KAR 20:300-10(8)(b) Section 10. Dietary Services</p> <p>(8) Sanitary conditions. The facility shall: (b) Store, prepare, distribute, and serve food under sanitary conditions; and</p> <p>This requirement is not met as evidenced by: Based on observation, interview, and review of the facility's policy/procedure, it was determined the facility failed to ensure milk and thickened liquids were stored appropriately in the refrigerator. The current census was forty-three (43) residents, with one (1) resident on tube feeding. Five (5) residents required thickened liquids.</p> <p>Findings include:</p> <p>Review of the Cold Food Storage policy/procedure, dated 07/08, revealed the designated Nutrition Service Director/Cook(s) ensured all food items were stored properly in covered containers, labeled and dated.</p> <p>Observation in the refrigerator, on 07/24/13 at 10:40 AM, revealed the following items were opened, but not dated:</p> <p>(1) nectar thickened lemon flavored water (1) honey thickened lemon flavored water (1) nectar thickened cranberry cocktail (1) honey thickened apple juice (1) honey thickened orange juice (1) honey thickened sweet tea (2) honey thickened cranberry cocktail</p> <p>Review of the labels for each of the above</p>	N 283	<p>1) The chocolate milk, nectar thick lemon flavored water; nectar thick cranberry cocktail beverage the honey thick lemon flavored water, apple juice; orange juice, sweet tea and cranberry cocktail were discarded on 7/24/13 by a dietary aide.</p> <p>2) An audit was completed of food storage areas by the acting dietary manager on 07/24/13 to determine that food items were stored appropriately with no concerns identified.</p> <p>3) The Dietary staff members were re-educated on 7/24/13 by the acting manager, to the Cold Food Storage policy which included dating all items when they are opened and write the date they are to be discarded. A post test was completed by dietary staff on food storage.</p> <p>4) The Food Service Director will audit the cooler for appropriate storage of food items including milk and thickened liquids. Audits will be conducted five times per week for two weeks, three times per week for two weeks, two times per week for four weeks and weekly for 10 months. Any concerns identified will be addressed at that time. A summary of findings from the audits will be submitted to the Performance Improvement Committee by the Food Service Director monthly for one year for further review and recommendations.</p>	8/23/13

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N 283	<p>Continued From page 3</p> <p>thickened liquids revealed to refrigerate up to five days, once opened.</p> <p>Additional observation, on 07/24/13 at 10:40 AM, revealed (1) container of chocolate 1% lowfat milk with a "best by" date of 07/23/13.</p> <p>Interview with Dietary Aide #1, on 07/24/13 at 11:35 AM, revealed he was supposed to date the thickened liquids upon opening them; however, he "forgot". He revealed the chocolate milk was expired and should have been removed from the refrigerator. He revealed it was "overlooked."</p> <p>Interview with the Administrator, on 07/26/13 at 10:20 AM, revealed she expected staff to follow manufacturer's guidelines related to food storage in the refrigerator.</p>	N 283		
N 313	<p>902 KAR 20:300-14(4) Section 14. Pharmacy Services</p> <p>(4) Labeling of drugs and biologicals. The facility shall label drugs and biologicals in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date.</p> <p>This requirement is not met as evidenced by: Based on observation, interview, and review of the facility's policy/procedure, it was determined the facility failed to ensure drugs and biologicals used in the facility were stored appropriately.</p> <p>Findings include:</p> <p>Review of the "Storage and Expiration of Medications, Biologicals, Syringes, and Needles"</p>	N 313	<ol style="list-style-type: none"> 1. The expired 2 boxes of Duonebs solution vials, that included 8 vials in one box and 22 vials in the second box, was discarded on 7/24/13 by a licensed nurse. 2. The medication room was audited by the Assistant Director of Nursing on 7/24/13 to determine that no expired medications or biologicals were maintained. No other concerns were identified.. 3. Licensed nurses and certified medication technicians were re-educated as of 8/23/13 by the Assistant Director of Nursing of the Storage and Expiration of Medications , Biologicals, Syringes and Needles policy which included the expectation that all medications must be discarded upon the 	

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N 313	Continued From page 4 policy/procedure, revised 01/01/13, revealed the facility should ensure medications and biologicals have not been retained longer than recommended by the manufacturer or supplier guidelines. Observation, on 07/24/13 at 3:20 PM, revealed the following items in the medication room, available for resident use: (2) boxes of Duoneb 0.5 milligrams (mg)-3 mg/3 milliliters (ml) solution; eight (8) vials available in one box, with twenty-two (22) vials available in the other box. Both boxes expired May 2013. Interview with Registered Nurse (RN) #1, on 07/24/13 at 3:25 PM, revealed the nurses were responsible to ensure expired nebulizer medications were removed from the cabinet. Interview with the Director of Nursing (DON), on 07/26/13 at 10:15 AM, revealed the facility checks for expired medications on a weekly basis; however, the nurse was responsible for checking the expiration date prior to administering the medication.	N 313	expiration date. A post test on the Storage and Expiration of Medications, Biologicals, Syringes and Needles policy was completed by licensed nurses and medication technicians. 4. Medication room, medication and treatment cart audits will be completed by either the Director of Nursing or Assistant Director of Nursing to determine that there are no expired medications present. Any issues identified will be addressed at that time. These audits will be completed two times weekly X 4 weeks, then one time weekly X 4 weeks then monthly x10 months. A summary of findings from these medication room audits will be submitted to the Performance Improvement Committee by the Director of Nursing monthly for one year for further review and recommendations.	8/23/13

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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: 1995.</p> <p>SURVEY UNDER: 2000 Existing.</p> <p>FACILITY TYPE: SNF/NF.</p> <p>TYPE OF STRUCTURE: One (1) story, Type II (111).</p> <p>SMOKE COMPARTMENTS: Three (3) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system installed in 1995, with 36 smoke detectors and no heat detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic wet sprinkler system installed in 1995.</p> <p>GENERATOR: Type II generator installed in 1995. Fuel source is Diesel.</p> <p>A standard Life Safety Code survey was conducted on 07/24/13. Heartland Villa Center was found in non-compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for Forty- Five (45) beds with a census of Forty-Three (43) 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</p>	K 000	<p>This plan of correction is prepared and submitted as required by law. By submitting this plan of correction, Heartland Villa Center does not admit that the deficiency listed on this form exist, nor does the center admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiency. The center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Paula Sandifer* TITLE *NHA* (X6) DATE *8/18/13*

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

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186399	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 07/24/2013
NAME OF PROVIDER OR SUPPLIER HEARTLAND VILLA CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 8005 US HWY 60 WEST LEWISPORT, KY 42351	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 Fire).	K 000	<p>1) The Therapy Department was relocated to the rear of the facility off of the dining room on 8/16/13. This location is secured by walls and has an automatic smoke detector/sprinkler system. The room at the end of 300 hall remains open with no obstructions allowing the exit access to be readily accessible at all times.</p> <p>2) The Maintenance Director completed a round of the center on 7/24/13 to determine that corridors are separated from use areas by walls with at least a 1/2 hour fire resistance rating. No concerns were identified.</p> <p>3) The Maintenance Director and Administrator were educated regarding K017 on 8/9/13 by the Regional Property Manager and the complete Life Safety Code for K017 was reviewed to ensure the new area met criteria for a patient treatment area.</p> <p>4) The Administrator will conduct rounds to ensure that patient treatment, resident sleeping areas and hazardous storage areas are secured in rooms secured by walls, with automatic smoke detector/sprinkler system. The rounds will be conducted weekly for four weeks and then monthly for 11 months. Findings will be submitted to the Performance Improvement Committee by the Administrator monthly for one year for further review and recommendations.</p>	8/23/13
K 017 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that rooms open to the corridor would not interfere with egress requirements in accordance with NFPA standards. The deficiency had the potential to affect two (2) of three (3) smoke compartments, all residents, staff and visitors. The facility is certified for Forty- Five (45) beds with a census of Forty-Three (43) on the day of the survey. The facility failed to ensure the</p>	K 017		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185398	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 07/24/2013
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NAME OF PROVIDER OR SUPPLIER HEARTLAND VILLA CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8005 US HWY 60 WEST LEWISPORT, KY 42351
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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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K 017	<p>Continued From page 2</p> <p>therapy department was not open to the exit corridor.</p> <p>The findings include:</p> <p>Observation, on 07/24/13 at 3:16 PM with the Maintenance Supervisor, revealed the therapy department was part of the exit corridor at the end of 300 hall. The contents of this room are not permitted to be in an area open to the corridor.</p> <p>Interview, on 07/24/13 at 3:16 PM with the Maintenance Supervisor, revealed this area was originally designed as a television lounge and had been converted to the therapy department.</p> <p>Reference: NFPA 101 (2000 edition) 19.3.6.1 Corridors shall be separated from all other areas by partitions complying with 19.3.6.2 through 19.3.6.5. (See also 19.2.5.9.) Exception No. 1: Smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.3 shall be permitted to have spaces that are unlimited in size open to the corridor, provided that the following criteria are met: (a) The spaces are not used for patient sleeping rooms, treatment rooms, or hazardous areas. (b) The corridors onto which the spaces open in the same smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, or the smoke compartment in which the space is located is protected throughout by quick-response sprinklers. (c) The open space is protected by an electrically supervised automatic smoke detection system in</p>	K 017		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185399	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 07/24/2013
NAME OF PROVIDER OR SUPPLIER HEARTLAND VILLA CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 8005 US HWY 60 WEST LEWISPORT, KY 42351	
(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 017	Continued From page 3 accordance with 19.3.4, or the entire space is arranged and located to allow direct supervision by the facility staff from a nurses ' station or similar space. (d) The space does not obstruct access to required exits. 7.5.1.1 Exits shall be located and exit access shall be arranged so that exits are readily accessible at all times.	K 017		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour 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 one (1) of three (3) smoke compartments, thirty-eight residents, staff and visitors. The facility is certified for Forty- Five (45) beds with a census of	K 029	1) Door closures for the conference room, business office and administrator's office were ordered on 8/15/13 and will be installed by the maintenance director upon arrival. 2) The facility was audited by the Maintenance Director for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction on 07/24/13. No other problems were identified. 3) Administrative staff members were educated on 08/12/13 by the Administrator regarding appropriate storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction. 4) The Maintenance Director will audit areas throughout the facility monthly X 1 year to ensure storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction are stored appropriately. Any issues identified will be addressed at that time. Findings will be reported to the Performance Improvement	

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NAME OF PROVIDER OR SUPPLIER HEARTLAND VILLA CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8006 US HWY 60 WEST LEWISPORT, KY 42351
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K 029	<p>Continued From page 4</p> <p>Forty-Three (43) on the day of the survey. The facility failed to ensure 3 office doors were self-closing.</p> <p>The findings include:</p> <p>Observations, on 07/24/13 at 3:16 PM with the Maintenance Supervisor, revealed the door to the conference room, business office, and the Administrators' office did not have a door closer installed to keep the areas separate from the facility. The rooms were stacked with boxes and papers around the rooms.</p> <p>Interview, on 07/24/13 at 3:16 PM with the Maintenance Supervisor, revealed he was unaware the areas were considered hazardous storage thus requiring a door and a self-closer.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>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 ft² (9.3 m²) (3) Paint shops</p>	K 029	Committee by the Maintenance Director monthly for one year for further review and recommendations.	8/23/13
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NAME OF PROVIDER OR SUPPLIER HEARTLAND VILLA CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 8005 US HWY 60 WEST LEWISPORT, KY 42351	
(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 (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 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.	K 029		