

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

PRINTED: 07/12/2012
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 06/28/2012
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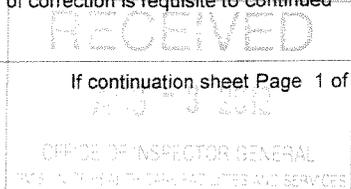
NAME OF PROVIDER OR SUPPLIER HEARTLAND VILLA CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8005 US HWY 60 WEST LEWISPORT, KY 42351
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<p>F 000 INITIAL COMMENTS</p> <p>F 203 SS=D</p>	<p>A standard health survey was conducted 06/26/12-06/28/12. A Life Safety Code Survey was conducted on 06/26/12. Deficiencies were cited with the highest scope and severity of an "F" with the facility having the opportunity to correct before remedies would be imposed. KY#18609 was investigated during the standard survey and was determined to be unsubstantiated with no regulatory findings.</p> <p>483.12(a)(4)-(6) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE</p> <p>Before a facility transfers or discharges a resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; record the reasons in the resident's clinical record; and include in the notice the items described in paragraph (a)(6) of this section.</p> <p>Except when specified in paragraph (a)(5)(ii) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged.</p> <p>Notice may be made as soon as practicable before transfer or discharge when the health of individuals in the facility would be endangered under (a)(2)(iv) of this section; the resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(i) of this section; an immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(ii) of this</p>	<p>F 000</p> <p>F 203</p>	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Heartland Villa Care & Rehabilitation 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> <p><input type="checkbox"/></p> <p>F203 Notice Requirements Before Transfer</p> <p>Residents #2, #4 & #10 were provided copies of the facility's Transfer notices on 07/06/12 by the Director of Social Services.</p> <p><input type="checkbox"/></p> <p>7/2/12 Transfer Agreements were prepared by the Social Services Director and presented to residents with a scheduled</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>x Paulie Sewlfer</i>	TITLE <i>x Administrator</i>	(X6) DATE <i>x 8/7/12</i>
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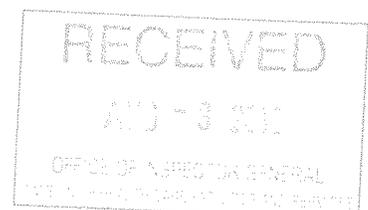
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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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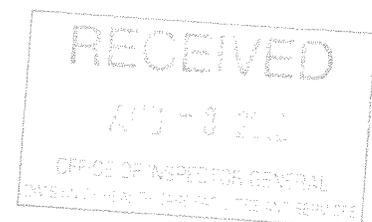
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F 203	<p>Continued From page 1</p> <p>section; or a resident has not resided in the facility for 30 days.</p> <p>The written notice specified in paragraph (a)(4) of this section must include the reason for transfer or discharge; the effective date of transfer or discharge; the location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone number of the State long term care ombudsman; for nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy, it was determined the facility failed to provide a Notice of Transfer, including the right to appeal, for three (3) of twelve (12) sampled residents (Residents #2, #4 and #10) prior to their transfer to an acute care hospital. The facility sent Resident #4 out to a doctor's appointment. During the appointment, the resident had a seizure and required hospitalization. Resident #2 and #10 were sent out to the hospital. The facility failed to provide</p>	F 203	<p>medical or social appointment for the next 30 days.</p> <p>Transfer Agreements include the reason of transfer, effective date, location transferred, a statement that the resident has the right to appeal the action to the state, the contact information for the state ombudsman, agency for protection and advocacy of developmentally disabled, and agency for protection and advocacy of mentally ill as indicated.</p> <p>Transfer Agreements will be prepared 30 days in advance and presented to any resident with a scheduled social or medical appointment and transfer agreements have been made available to the licensed staff to provide to any resident with an unscheduled transfer.</p> <p>■ The Social Services Director was re-educated on 07/05/12, by the Administrator and licensed nurses were re-educated on 7/24/12 by the Clinical Case Manager and the director of Nursing Services on F203</p>



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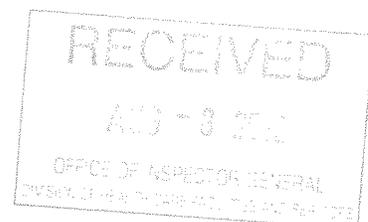
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F 203	<p>Continued From page 2 these residents with Notices of Transfer prior to transfer.</p> <p>The findings include:</p> <p>Review of the facility's Admission policies, revealed residents would be provided a Notice of Transfer, including information to appeal the transfer, prior to transfer or discharge.</p> <p>Review of the clinical record for Resident #4, revealed the facility admitted the resident on 02/08/12 with diagnoses of Congestive Heart Failure and Seizures. The facility sent the resident to a physician's office on 06/15/12. The resident had a seizure while at the physician's office and was admitted to the hospital. The facility could not provide documentation showing the resident received a Notice of Transfer, including appeal rights, prior to the physician's office visit.</p> <p>The facility did not provide a record of the notice before discharge for Resident #2 and Resident #10.</p> <p>Review of the clinical record for Resident #2 revealed the resident was transferred to the hospital on 06/12/12. The resident also received dialysis services away from the facility on Mondays, Wednesdays, and Fridays since admission on 11/23/10.</p> <p>The clinical record for Resident #10 revealed the resident was transferred to the hospital on 05/08/12. Interview with the Licensed Practical Nurse (LPN) #3 revealed she had never given a resident or</p>	F 203	<p>Notice Requirements Before Transfer Discharge. Social Service Director provided education on the Transfer Agreements during a Resident Council meeting on 7/16/12.</p> <p>■ The facility Administrator will audit all scheduled and unscheduled discharges weekly for four weeks and five per month for two months and then at least quarterly to ensure the appropriate transfer agreement was presented timely with contact information prior to transfer. The Administrator will report the results to the Performance Improvement Committee Meeting, for three months and at least quarterly attended by the Medical Director, Administrator, Director of Nursing Services and the Social Services Director for further recommendations.</p> <p style="text-align: right;">07/25/12</p>



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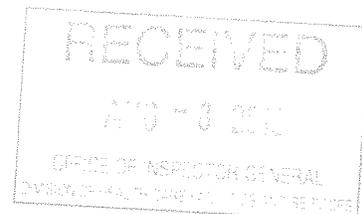
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F 203	Continued From page 3 guardian a notice before discharge form and did not know where to obtain it. The LPN stated the Social Worker was responsible to give the paperwork to the resident or guardian. She stated anything could happen while the resident was out of the facility which could result in the resident not returning to the facility. Interview with Licensed Practical Nurse (LPN) #4, on 06/27/12 at 3:30 PM, revealed she was not familiar with a form containing information on how the resident could appeal a discharge or transfer. She stated the facility did not give residents a form of this type. Interview with Registered Nurse (RN) #1, on 06/28/12 at 1:30 PM, revealed the facility did not provide residents with a form listing appeal rights for transfers and discharges. She stated a transfer form with medical information was sent, however, she was not familiar with a Notice of Transfer.	F 203			
F 205 SS=D	483.12(b)(1)&(2) NOTICE OF BED-HOLD POLICY BEFORE/UPON TRANSFR Before a nursing facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the nursing facility must provide written information to the resident and a family member or legal representative that specifies the duration of the bed-hold policy under the State plan, if any, during which the resident is permitted to return and resume residence in the nursing facility, and the nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (b)(3) of this section, permitting a resident to return.	F 205	F205 Notice of Bed Hold Policy Before/Upon Transfer Residents #2, #4 & #10 were provided copies of the facility's Bed Hold Policy on 07/06/12 by the Director of Social Services. Bed Hold policies were prepared by the Social Services Director and presented to residents with a scheduled		



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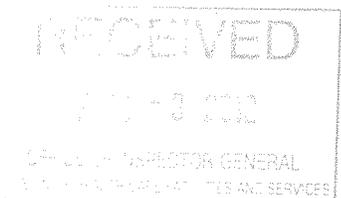
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F 205	<p>Continued From page 4</p> <p>At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and a family member or legal representative written notice which specifies the duration of the bed-hold policy described in paragraph (b)(1) of this section.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy, it was determined the facility failed to provide three (3) of twelve (12) sampled residents (Resident #2, 4 and 10) with a notice of their bedhold policy prior to being transferred or discharged from the facility. Resident #4 was sent to a physician's office where the resident had a seizure. The resident was admitted to the hospital. Residents #2 and #10 were transferred to the hospital and the facility failed to provide them with a bedhold policy.</p> <p>The findings include:</p> <p>Review of the facility's Admission policy, revealed residents would be notified of the bedhold policy, if applicable.</p> <p>Review of the clinical record for Resident #4, revealed the facility admitted the resident on 02/08/12 with diagnoses of Congestive Heart Failure and Seizures. The facility sent the resident to a physician's office on 06/15/12. The resident had a seizure while at the physician's office and was admitted to the hospital. The facility did not provide record of the bed hold policy for Resident #2 and Resident #10.</p>	F 205	<p>medical or social appointment within the next 30 days on 7/2/12.</p> <p>Bed Hold Policies were made available to the licensed staff to provide to any resident with a scheduled or unscheduled transfer, appointment, or therapeutic leave of absence on 7/2/12.</p> <p>■</p> <p>The Social Services Director was re-educated on 7/5/12 by the Administrator and licensed nurses were re-educated on 7/24/12 by the Clinical Case Manager and Director of Nursing Services on F205 Notice of Bed Hold Policy Before/Upon Transfer. The Social Service Director provided education on the Bed Hold Policy during a Resident Council meeting on 7/16/12.</p> <p>■</p> <p>The facility Administrator will audit all scheduled and unscheduled discharges weekly for four weeks and five per month for two months and at least quarterly to ensure the appropriate Bed Hold Policy was presented timely prior to transfer.</p>



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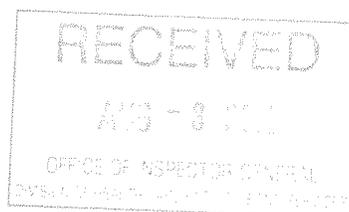
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F 205	Continued From page 5 Review of the clinical record for Resident #2 revealed the resident was transferred to the hospital on 06/12/12. The resident also received dialysis services away from the facility on Mondays, Wednesdays, and Fridays since admission 11/23/10. The clinical record for Resident #10 revealed the resident was transferred to the hospital on 05/08/12. Interview with the Licensed Practical Nurse (LPN) #4 and Registered Nurse (RN) #1, on 06/28/12 at 1:30 PM, revealed they were not familiar with the bedhold policy and did not provide residents with the bedhold policy prior to transfer or discharge. Interview with the Licensed Practical Nurse (LPN) #3 revealed she had never given a resident or guardian a notice of bed hold policy and readmission form and did not know where to obtain it. The LPN stated the Social Worker was responsible to give the paperwork to the resident or guardian. She stated while a resident was away from the facility, anything could happen which would result in the resident not returning to the facility.	F 205	The Administrator will report the results to the Performance Improvement Committee Meeting monthly for three months, and at least quarterly, attended by the Medical Director, Administrator, Director of Nursing Services and the Social Services Director for further recommendations.	07/25/12	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the	F 280			



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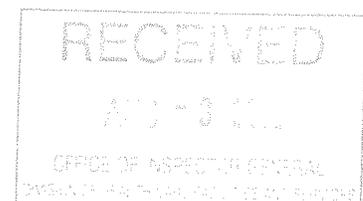
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F 280	<p>Continued From page 6</p> <p>comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy, it was determined the facility failed to revise the comprehensive care plan for one (1) of twelve (12) sampled residents (Resident #8) with repeated urinary tract infections. The facility had identified urinary tract infections as a resident problem; however, the resident's care plan had not been revised since 09/13/11.</p> <p>The findings include:</p> <p>The facility did not provide a policy for prevention of urinary tract infections.</p> <p>Review of the clinical record for Resident #8, revealed the facility admitted the resident with diagnoses of Cancer of the Lung and Chronic Obstructive Pulmonary Disease. The</p>	F 280	<p>F280 Right to Participate, Planning, Revise Care Plan</p> <ul style="list-style-type: none"> ■ Resident # 8 care plan was reviewed and updated by the Director of Nursing on 7/2/12 to reflect current needs and recurrent UTI's. ■ Current residents charts were reviewed on 07/20/12 to identify those residents receiving an Antibiotic or having a UTI or current change of condition by the Director of Nursing Services. Care plans for the identified residents were updated and revised to reflect current needs. ■ The MDS Coordinator and Licensed Nurses were re-educated by the Director of Nursing on revision of care plans with resident changes of condition including UTI's. on July 24, 2012. ■ The Director of Nursing and/or Assistant Director of Nursing



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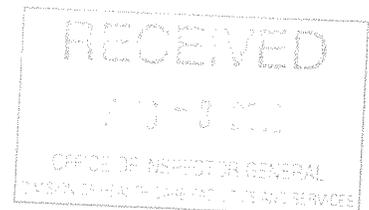
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F 280	<p>Continued From page 7</p> <p>comprehensive care plan, dated 09/13/11, revealed the resident had chronic urinary tract infections. Interventions included: good personal hygiene and the resident toileted independently.</p> <p>Review of the laboratory test findings revealed Resident #8 received antibiotics for urinary tract infections on 12/07/11 for Proteus Mirabilis, on 03/16/12 for E Coli, on 04/25/12 for E Coli, on 05/11/12 for Proteus Mirabilis and on 05/24/12 for E Coli.</p> <p>Interview with Resident #8, on 06/27/12 at 4:00 PM, revealed the resident toileted independently. The resident stated toilet paper was used to wipe after bowel movements and urination. The resident indicated no memory of training on the correct way to perform hygiene after using the toilet. The resident was not willing to demonstrate toileting and was not able to identify how incorrect toileting affected the urinary tract infections.</p> <p>Interview with Certified Nurse Aide (CNA) #4, on 06/27/12 at 3:00 PM, revealed Resident #8 was independent with toileting and no assistance from staff was provided. She stated she was not aware of any interventions to prevent urinary tract infections.</p> <p>Interview with the Director of Nursing, on 06/28/12 at 10:30 AM, revealed the resident preferred no assistance with toileting. She stated she was not aware of any interventions</p>	F 280	<p>will complete a review of resident charts for changes in condition and the accompanying revision of the care plan, any concerns will be addressed at that time. This review will be completed on five charts per week for four weeks; then three charts per month for two months, then at least quarterly. The Director of Nursing will report findings from these chart reviews to the Performance Improvement Committee monthly for three months and then at least quarterly, attended by the Medical Director, Administrator, Director of Nursing Services and the Social Services Director for further recommendations.</p> <p>Completion Date: 07/25/12</p>



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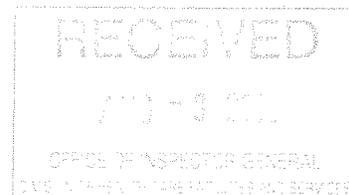
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F 280	Continued From page 8 implemented since the last care plan revision to decrease the resident's risk for urinary tract infections.	F 280		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from 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, it was determined the facility failed to ensure food was served in a sanitary manner for all residents at lunch on 6/27/12. Dietary employees were noted to handle food with bare hands and to cross contaminant hands during the meal service. In addition, a nursing employee entered the kitchen during the meal service. The findings include: Review of the facility's Nutrition Services Policies, dated 07/08, revealed dietary employees were to wash their hands between dirty and clean tasks. Continued review revealed Dietary staff members must monitor that the entrance to the food	F 371	F371 Food Procure, Store, Prepare, Serve- Sanitary ■ Dietary staff and Nursing Assistant #4 were re-educated regarding F371 glove use, hand washing and/or traffic in the kitchen on 6/27/12, by the Regional Director of Nutrition Services. ■ Nutrition Services Director conducted a tray line audit of glove use, hand hygiene and traffic in the kitchen, for five days 7/1/12 through 7/5/12. No further problems identified. ■ Dietary Staff re-educated on F371, hand hygiene, glove use and traffic in the kitchen on 6/27/12 by the Regional Director of Nutrition Services. Facility staff were re-educated on traffic in the kitchen on 7/13/12 by the Administrator.	



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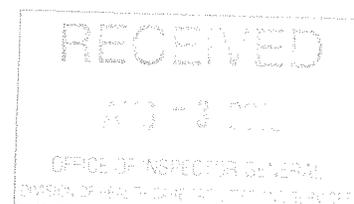
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185399	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/28/2012
NAME OF PROVIDER OR SUPPLIER HEARTLAND VILLA CARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, 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
F 371	<p>Continued From page 9</p> <p>preparation and service areas were limited to scheduled employees in proper uniforms.</p> <p>Observation of the kitchen, on 06/27/12 at 11:40 AM, revealed a nurse aide was observed entering the kitchen, proceeding to the coffee pot area where she took a plastic coffee cup lid and returned to the dining room. No dietary employee stopped the nurse aide or spoke to her about entering the kitchen.</p> <p>Interview with Certified Nurse Aide (CNA) #4, on 06/27/12 at 12:40 PM, revealed she knew she was not allowed to enter the kitchen and had entered in the past. She stated she did not expect to see a surveyor present. She indicated her uniform was not clean due to a morning of resident care and knew germs should not be taken into the kitchen where food was being prepared.</p> <p>Interview with the Dietary Manager, on 06/27/12 at 12:05 PM, revealed employees, not working in the dietary department, were allowed to put on a hair net and come inside the dietary department door and no farther. She stated the nurse aide was not allowed in the kitchen to prevent cross contamination of food.</p> <p>Continued observation of the kitchen, on 06/27/12 at 11:54 AM, revealed a dietary employee picked up a bun and made a fish sandwich, and served to a resident with her bare hands. At 11:59 AM, the server left the tray line and placed an oven</p>	F 371	<p>■</p> <p>The Nutrition Services Director will audit the tray line for glove use, hand hygiene and for kitchen traffic for five days for one week, three days for two weeks, two days for two weeks and weekly for one month and then at least quarterly. The Nutrition Service Director will report the results to the Performance Improvement Committee monthly for three months and then at least quarterly, attended by the Medical Director, Administrator, Director of Nursing Services and the Nutrition Services Director for further recommendations.</p> <p>Completion Date:</p>	07/25/12



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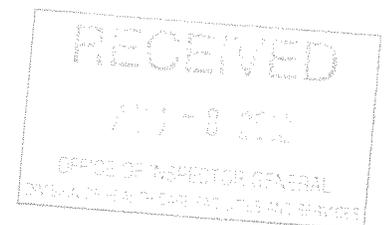
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F 371	Continued From page 10 mitt over her gloves. She then retrieved a pan from the oven and returned to the tray line without changing gloves or washing her hands. The server was noted to leave the line several times to open the microwave and neither washed their hands or changed their gloves. Interview with the Dietary Server, on 06/27/12 at 12:15 PM, revealed not changing gloves and washing hands during the lunch service could spread germs and make residents sick. Interview with the Dietary Manager, on 06/27/12 at 12:05 PM, revealed the server did not wash her hands and the actions could contaminate the food being served, causing residents to become sick.	F 371	
F 500 SS=C	483.75(h) OUTSIDE PROFESSIONAL RESOURCES-ARRANGE/AGRMNT If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the facility under an arrangement described in section 1861(w) of the Act or an agreement described in paragraph (h) (2) of this section. Arrangements as described in section 1861(w) of the Act or agreements pertaining to services furnished by outside resources must specify in writing that the facility assumes responsibility for obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and the timeliness of the services.	F 500	F500 Outside Professional Resources -arrange/agreement <input type="checkbox"/> The Dialysis Agreement was signed and received at the facility on 7/5/12. <input type="checkbox"/> Current contracts for outside providers were reviewed by the Administrator on 7/5/12. No other problems were identified. <input type="checkbox"/> The Administrator was re-educated by the Regional Director of



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F 500	<p>Continued From page 11</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, and record review, it was determined the facility failed to have a signed, written agreement with a dialysis provider. One (1) of twelve (12) sampled residents had been receiving the service since admission. Resident #2.</p> <p>The findings include:</p> <p>There was no policy for Dialysis Agreements.</p> <p>Review of the clinical record for resident #2 revealed an admission date of 11/23/10, and physician orders to receive dialysis. Review of the record revealed the resident had been receiving dialysis services since the admission date in 2010.</p> <p>Review of the nursing home dialysis transfer agreement provided by the facility, on 06/27/12, revealed blank areas for the signature and date of the agreement.</p> <p>Interview with the Administrator, on 06/27/12 at 3:00 PM, revealed there was no signed contract with the Dialysis Center, and stated they had been trying to get an agreement signed. The Administrator also stated that the Corporate and Dialysis Corporate VP had to sign off on all agreements, and was delayed in that area. The Administrator stated the contract was e-mailed today for signature, however, at the time of the exit conference, on 06/28/12 the contract had not been signed or dated.</p>	F 500	<p>Operations on 7/4/12 regarding F500 Outside Professional Resources Arrangements/Agreements.</p> <p>■</p> <p>The Administrator will review the Outside contracts quarterly for six months for signed written agreements. The Administrator will report the results to the Performance Improvement Committee for six months, attended by the Medical Director, Administrator, Director of Nursing Services and the Nutrition Services Director for further recommendations.</p> <p>Completion Date: 7/25/12</p>



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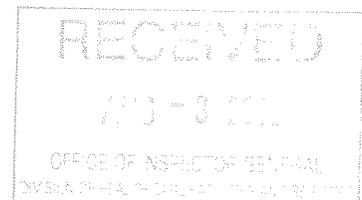
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K 000	<p>INITIAL COMMENTS</p> <p>AMENDED SOD 07/18/12 Tag K62 deleted from SOD</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1995</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type II (111)</p> <p>SMOKE COMPARTMENTS: Three (3) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with smoke detectors</p> <p>SPRINKLER SYSTEM: Complete automatic wet sprinkler system.</p> <p>GENERATOR: Type II generator. Fuel source is diesel.</p> <p>A standard Life Safety Code survey was conducted on 06/26/12. Heartland Villa Care and Rehab Center was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for forty five (45) beds with a census of forty four (44) on the day of the survey.</p> <p>The findings that follow demonstrate</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Paula Sandpiper</i>	TITLE <i>Administrator</i>	(X6) DATE <i>8-7-12</i>
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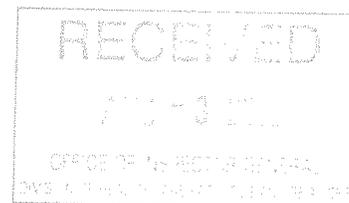
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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.

OFFICE OF INSPECTION GENERAL
U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES

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K 000	Continued From page 1 noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)	K 000	This Plan of Correction is prepared and submitted as required by law.	
K 018 SS=F	Deficiencies were cited with the highest deficiency identified at "F" level. NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure there were no impediments to the closing of corridor doors to resist the passage of smoke in accordance with NFPA standards. The deficiency had the	K 018	and submitted as required by law. By submitting this Plan of Correction, Heartland Villa Care & Rehabilitation 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." <input type="checkbox"/> K018 NFPA 101 Life Safety Code Standard UL rated door seals were ordered and will be installed on rooms 103, 109, 110, 201, 205, 206, 208, 209, 210, 301, 304, 306, and 307 on 7/24/12 by the Maintenance Director. Room 109 and 205 latch plates were replaced on 7/11/12 by the Maintenance Director.	



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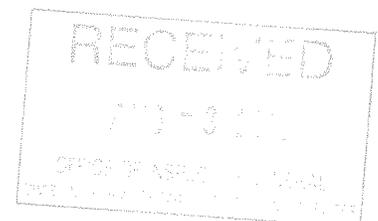
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K 018	<p>Continued From page 2</p> <p>potential to affect three (3) of three (3) smoke compartments, residents, staff and visitors. The facility is licensed for forty five (45) beds with a census of forty four (44) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 06/26/12 between 2:30 PM and 5:30 PM, with the Maintenance Director revealed the corridor doors to rooms 103, 109, 110, 201, 205, 206, 208, 209, 210, 301, 304, 306, and 307 had a gap too large around the jamb and would not resist the passage of smoke. Further observation revealed the doors to rooms 109, and 205 would not latch when closed.</p> <p>Interview, on 06/26/12 between 2:30 PM and 5:30 PM, with the Maintenance Director revealed he was not aware of the doors having a gap that would not resist the passage of smoke. Further interview revealed he was not aware the doors to rooms 109, and 205 did not latch.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor</p>	K 018	<p><input type="checkbox"/> The Maintenance Director audited all doors for impediments that would resist the passage of smoke and latch securely on 06/26/12. No additional problems were identified.</p> <p><input type="checkbox"/> The Maintenance Director was re-educated by the Administrator regarding K018 for doors resisting the passage of smoke and impediments to the closure of doors on 06/26/12.</p> <p><input type="checkbox"/> The Maintenance Director will audit ten doors each month for three months and then at least quarterly to ensure the doors resist passage of smoke and there are no impediments to the closure of doors. The Maintenance Director will report the results to the Performance Improvement Committee monthly for three months and then at least quarterly, attended by the Medical Director, Administrator, Director of Nursing Services and the Maintenance Dir. for further recommendations.</p>	7/25/12
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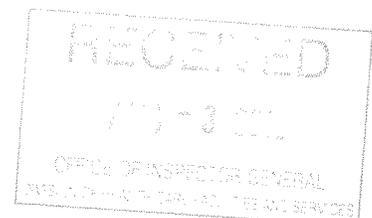


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K 018	Continued From page 3 doors. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke. 19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with NFPA standards.	K 018	K046 NFPA Life Safety Code Standard <input type="checkbox"/> The emergency light located in the Mechanical room with the generator transfer switch was repaired on 7/5/12 by the Maintenance Director. <input type="checkbox"/> The Maintenance Director audited all emergency lighting on 6/26/12. No other battery failure was identified. <input type="checkbox"/> The Director of Maintenance was re-educated by the facility Administrator regarding K046 on emergency lighting of at least 1 ½ hour duration on 6/26/12. <input type="checkbox"/> The Maintenance Director will audit all emergency lighting for functioning each month for three months and then at least quarterly. The Maintenance Director will report the results to the Performance Improvement Committee monthly for three months and then at least quarterly, attended by the Medical Director, Administrator, Director of Nursing Services and the Maintenance	
K 046 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to provide emergency lighting in accordance with NFPA standards. The deficiency had the potential to affect three (3) of three (3) smoke compartments, residents, staff and visitors. The facility is	K 046	Director for further recommendations	

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K 046

Continued From page 4
licensed for forty five (45) beds with a census of forty four (44) on the day of the survey.

The findings include:

Observation, on 06/26/12 at 3:55 PM, with the Maintenance Director revealed an emergency light located in the Mechanical Room with the generator transfer switch, did not function when tested.

Interview, on 06/26/12 at 3:55 PM, with the Maintenance Director revealed he was unaware the light was not functioning properly.

Reference: NFPA 101 (2000 edition)
7.9.2.1* Emergency illumination shall be provided for not less than 1 1/2 hours in the event of failure of normal lighting. Emergency lighting facilities shall be arranged to provide initial illumination that is not less than an average of 1 ft-candle (10 lux) and, at any point, not less than 0.1 ft-candle (1 lux), measured along the path of egress at floor level. Illumination levels shall be permitted to decline to not less than an average of 0.6 ft-candle (6 lux) and, at any point, not less than 0.06 ft-candle (0.6 lux) at the end of the 1 1/2 hours. A maximum-to-minimum illumination uniformity ratio of 40 to 1 shall not be exceeded.

K 050
SS=F

NFPA 101 LIFE SAFETY CODE STANDARD

Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine.

K 046

K0050 NFPA 101 Life Safety Code Standard

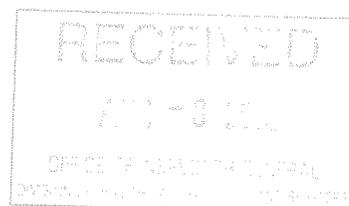
The Maintenance Director conducted a fire drill on 7/17/12 at 2:00 AM.

The Director of Maintenance and the Administrator revised the scheduled fire drills to be conducted for the remainder of the calendar year, ensuring no drill was scheduled at the same time for any shift and to be conducted at unexpected times under varying conditions on 6/28/12.

The Director of Maintenance was re-educated by the facility Administrator regarding K050 conducting fire drills at unexpected times and under varying condition on 6/26/12.

The Administrator will audit each fire drill conducted quarterly for six months to ensure fire drills are conducted at unexpected times under varying conditions in compliance with

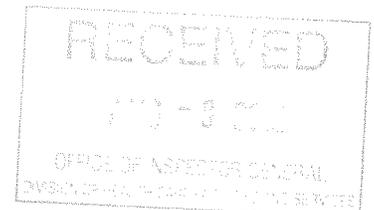
K 050



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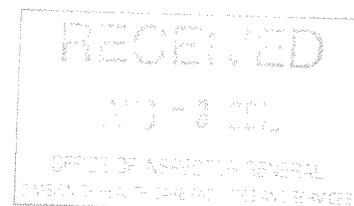
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K 050	<p>Continued From page 5</p> <p>Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure fire drills were conducted quarterly on each shift at random times, in accordance with NFPA standards. The deficiency had the potential to affect three (3) of three (3) smoke compartments, residents, staff and visitors. The facility is licensed for forty five (45) beds with a census of forty four (44) on the day of the survey.</p> <p>The findings include:</p> <p>Fire Drill review, on 06/26/12 at 2:30 PM, with the Maintenance Director revealed the fire drills were not being conducted at unexpected times under varied conditions. Third shift fire drills were being conducted predictably between 10:00 PM and 10:30 PM.</p> <p>Interview, on 06/26/12 at 2:30 PM, with the Maintenance Director revealed they were unaware the fire drills were not being conducted as required.</p> <p>Reference: NFPA 101 Life Safety Code (2000 Edition). 18.7.1.2*</p>	K 050	<p>NFPA standards.</p> <p>The Administrator will report results to the Performance Improvement Committee for six months, attended by the Medical Director, Administrator, Director of Nursing Services and the Maintenance Director for recommendations.</p>	07/25/12



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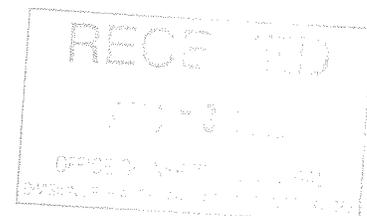
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185399	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 06/26/2012
NAME OF PROVIDER OR SUPPLIER HEARTLAND VILLA CARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 8005 US HWY 60 WEST LEWISPORT, KY 42351	
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K 072	Continued From page 7 Observation, on 06/26/12 at 3:53 PM, with the Maintenance Director revealed a table and chair sitting in the egress path, next to the exit door, located in the TV Room. Interview, on 06/26/12 at 3:53 PM, with the Maintenance Director revealed he was not aware the table and chair had been placed in the egress path to the exit door. Reference: NFPA 101 (2000 Edition) Means of Egress Reliability 7.1.10.1 Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. K 130 SS=D NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain doors within a required means of egress in accordance with NFPA standards. The deficiency had the potential to affect one (1) of three (3) smoke compartments, residents, staff and visitors. The facility is licensed for forty five (45) beds with a census of forty four (44) on the day of the survey. The findings include: Observation, on 06/26/12 at 5:16 PM, with the	K 072	Committee monthly for three months and at least quarterly, attended by the Medical Director, Administrator, Director of Nursing Services and the Maintenance Director for further recommendations. K130 NFPA 101 Life Safety Code Standard ■ The step down door holders were removed from the kitchen doors on 6/26/12 by the Maintenance Director. ■ The Maintenance Director completed a facility inspection for unapproved step down door hold open devices on 06/26/12, with no other areas identified. ■ The Director of Maintenance was re-educated by the facility Administrator regarding K130 unapproved door hold open devices on 6/26/12.
			07/25/12



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K 130	Continued From page 8 Maintenance Director revealed unapproved step down door hold open devices were installed on two (2) Kitchen doors leading to the exit corridor. Interview, on 06/26/12 at 5:16 PM, with the Maintenance Director revealed he was not aware the step down hold open devices could not be used. Reference: NFPA 101 (2000 Edition) 19.2.2.2.4 Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. NFPA 101 LIFE SAFETY CODE STANDARD	K 130	The Maintenance Director will monitor all doors within a means of egress for unauthorized door stops weekly for one month and monthly for three months and then at least quarterly. The Maintenance Director will report results to the Performance Improvement Committee monthly for three months and then at least quarterly, attended by the Medical Director, Administrator, Director of Nursing Services and the Maintenance Director for further recommendations.	
K 147 SS=E	Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect two (2) of three (3) smoke compartments, residents, staff, and visitors. The facility is licensed for forty five (45) beds with a census of forty four (44) on the day of the survey. The findings include: Observations, on 06/26/12 between 2:30 PM and	K 147	K147 NFPA 101 Life Safety Code Standard The Maintenance Director removed the power strips from the Business Office, and plugged the bed and mattress air pump, feeding machine and mattress air pump and O2 concentrator in rooms 201, 104 and 308 into appropriate outlets on 6/26/12.	07/25/12



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K 147	Continued From page 9 5:30 PM, with the Maintenance Director revealed: 1) A power strip was plugged into a power strip that was plugged into a multi plug adaptor located in the Business Office. 2) A bed and a mattress air pump were plugged into a power strip located in room #201. 3) A feeding machine and a mattress air pump were plugged into a multi plug adaptor located in room #104. 4) An oxygen concentrator was plugged into a multi plug adaptor located in room #308. Interview, on 06/26/12 between 2:30 PM and 5:30 PM, with the Maintenance Director revealed he was not aware of the misuse of power strips and multi plug adaptors. Reference: NFPA 99 (1999 edition) 3-3.2.1.2 D Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.	K 147	The Maintenance Director completed a facility inspection for electrical wiring and equipment in accordance with NFPA 70 on 6/26/12 and on other issues was identified. <input type="checkbox"/> The Director of Maintenance was re-educated by the Administrator regarding electrical wiring and equipment in accordance with NFPA 70 on 6/26/12. Staff were re-educated regarding the appropriate use of power strips and multi plug adaptors on 7/13/12 by the Administrator. <input type="checkbox"/> The Maintenance Director will monitor the use of power strips and multi plug adaptors weekly for one month and monthly for three months and then at least quarterly. The Maintenance Director will report results to the Performance Improvement committee monthly for three months and then at least quarterly, attended the Medical Director, Administrator, Director of Nursing Services and the Maintenance Director for further recommendations.	07/25/12

