

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

PRINTED: 10/11/2011
FORM APPROVED
OMB NO. 0938-0391

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 C 09/15/2011
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NAME OF PROVIDER OR SUPPLIER HERITAGE HALL HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 381 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 000	<p>INITIAL COMMENTS</p> <p>Amended</p> <p>An Abbreviated Survey Investigating #KY0017052 and #KY00017055 was initiated on 09/09/11 and concluded on 09/15/11. #KY00017052 was substantiated with deficiencies cited at 42 CFR 483.20 Resident Assessment (F-282) with the scope and severity of "D", and 42 CFR 483.25 Quality of Care (F-323) with the scope and severity of a "D". #KY00017055 was unsubstantiated with unrelated deficiencies.</p> <p>F 282 SS-D 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy it was determined the facility failed to ensure services provided by the facility was in accordance with each resident's written plan of care for one (1) of five (5) sampled residents, (Resident #1). The facility failed to ensure the Care Plan was followed for Resident #1 which indicated the resident was to be transferred by mechanical lift with two (2) person assist.</p> <p>The findings include: Record review of the facility's policy as detailed in the "Comprehensive Care Plan of Policy and</p>	F 000	<p>F282</p> <p>Care Plan for Resident #1 was reviewed by the Director of Nursing on 9-17-11 to ensure it was appropriate and up to date. Transfer status was re-evaluated by the Therapy Dept on 10-4-11 to ensure appropriateness.</p> <p>F 282</p> <p>Care Plans for all residents were reviewed by the Director of Nursing, Assistant Director of Nursing, and Unit Coordinators on 9-19-11 to ensure appropriateness. Walking rounds which included one to one observations of all residents was completed on 9-19-11 by the Director of Nursing, the Assistant Director of Nursing and Unit Coordinators to observe implementation of the care plan.</p>	10-7-11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Dana Shavitt</i>	TITLE Administrator	(X8) DATE 10-11-11
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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.