

PRINTED: 01/04/2012  
FORM APPROVED  
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(K1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186277	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 12/15/2011
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NAME OF PROVIDER OR SUPPLIER  HERITAGE HALL HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 391 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
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F 000  F 241 SS-E	<p><b>INITIAL COMMENTS</b></p> <p>A Recertification Survey was initiated on 12/12/11 and concluded on 12/15/11. Deficiencies were cited with the highest Scope &amp; Severity being an "E". In addition, an Abbreviated Survey Investigating ARO #KY00017478 was investigated. The complaint was substantiated with no delinquent practice identified.</p> <p><b>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</b></p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Observations of the evening meal service, on 12/12/11, revealed staff stood over two (2) unsampled residents to feed them. In addition the facility failed to ensure trays were served table by table in the main dining room. Two residents waited ten (10) minutes while other residents at the same table were eating.</p> <p>The findings include:</p> <p>1. Observation of the supper meal, on 12/12/11 at 6:15 PM, revealed Unsampled Resident A</p>	F 000  F 241	<p>F 241:</p> <p>Unsampled Residents A,B,C, and D were assessed by the Director of Nursing on 12-15-11 to ensure there was no negative outcome from being fed while employee stood and not receiving a tray with others at the table. No resident voiced any distress over the noted practice.</p> <p>No other residents were noted to be affected by the specific actions noted, but all alert and oriented residents were interviewed one on one by the Director of Nursing, Assistant Director of Nursing and Unit Coordinators beginning 12-15-11 and continuing through 1-6-12 to determine if there were any concerns related to dignity and making sure the resident's choices are respected.</p>	1-7-12
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JAN 10 2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  Dana Gravett	TITLE Administrator	(X6) DATE 1-10-12
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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 required to continued program participation.

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F 241	<p>Continued From page 1</p> <p>waluted on his/her meal tray for eleven (11) minutes after other residents at same table eating. In addition, Unsampled Resident B waluted fourteen (14) minutes for his/her meal tray while other residents were eating at same table.</p> <p>Interview with Licensed Practical Nurse (LPN) #3, on 12/12/11 at 6:46 PM, revealed each table should be served one at a time with all residents receiving a tray prior to moving to the next table.</p> <p>Interview with LPN #4, on 12/12/11 at 6:50 PM, revealed trays should come on the food cart in order of table but did not always come out that way. She revealed staff should complete meal service at one table before moving on to the next table.</p> <p>Interview with the Dietary Manager, on 12/13/11 at 9:50 AM, revealed all residents at a table should be served before servers moved to the next table.</p> <p>2. Observation of the evening meal in the main dining room, on 12/12/11 at 6:30 PM, revealed Unsampled Resident C and Unsampled Resident D were fed by staff who were standing over the residents. Continued observation revealed one of the staff members was standing between two (2) residents with her hips at face level to the resident behind her.</p> <p>Interview with Certified Nursing Assistant (CNA) #10, on 12/12/11 at 7:20 PM, revealed she had not been trained regarding standing and feeding the residents. She stated she did not realize how close she was standing to the resident behind her, or that her hips were at face level to the</p>	F 241	<p>F 241 Continued</p> <p>All residents with cognitive impairment were assessed through record review and family interviews by the Director of Nursing, Assistant Director of Nursing and the Unit Coordinators beginning on 12-15-11 and continuing through 1-6-12 to ensure resident dignity and choices are respected. No other issues were identified.</p> <p>In-servicing for nursing and dietary staff was initiated on 12-15-11 and concluded on 12-27-11 by the Director of Nursing, Assistant Director of Nursing and Dietary Manager on tray pass procedures and meal service with emphasis on maintaining the residents dignity and treating all residents with respect. This education will be repeated monthly for</p>	

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AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA  
IDENTIFICATION NUMBER:

185277

(X2) MULTIPLE CONSTRUCTION

A. BUILDING \_\_\_\_\_

B. WING \_\_\_\_\_

(X3) DATE SURVEY  
COMPLETED

C

12/16/2011

NAME OF PROVIDER OR SUPPLIER

HERITAGE HALL HEALTH & REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

331 SOUTH MAIN STREET  
LAWRENCEBURG, KY 40342

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F 241	<p>Continued From page 2.</p> <p>resident. She acknowledged it was not appropriate to stand in such a manner during a meal.</p> <p>Interview with Registered Nurse (RN) #1, on 12/12/11 at 6:45 PM, revealed she did not know she was not to stand while feeding the residents.</p> <p>Interview with Registered Nurse (RN) #1, on 12/12/11 at 6:55 PM, revealed she had not been told or inserviced on order of serving meal trays in the dining room. Further, RN #1 stated she had not been trained on the process of serving or not standing over resident when the resident was being feed.</p>	F 241	F 241 Continued	
F 280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>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.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the 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>	F 280	<p>three(3) months then repeated no less than twice a year. All newly hired employees will be educated during orientation. The kitchen staff will place trays in the carts according to residents preferred seating arrangements. The Dietary Manager/Cook will monitor each cart daily for 30 days then weekly to ensure trays are placed appropriately. The nurse assigned to monitor the dining room during meal service will ensure that staff are seated while assisting a resident with meals. The staff will serve all residents at a table before serving another table.</p>	

**F 241 Continued**

The nurse assigned to monitor the dining room during meal service will observe to ensure that all trays are served at a table before serving another table.

Social Services will interview each interviewable resident and if possible the family of those non-interviewable residents quarterly regarding resident choices, resident dignity and staff treatment.

The Assistant Director of Nursing will monitor meal service three(3) times per week for 30 days then daily for 14 days, then weekly to ensure trays are delivered by table and that staff are seated while assisting residents with meals. Non-compliance will be addressed immediately and reported to the Director of Nursing.

The Director of Nursing will report on compliance no less than quarterly to the Quality Assurance Committee.

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F 280	<p>Continued From page 3</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to revise the care plan for one (1) of nineteen (19) sampled residents, (Resident #9). Resident #9 had three (3) different infections in October 2011: Clostridium Difficile, treated with the antibiotic Flagyl, a Urinary Tract Infection treated with the antibiotic Keflex, and Shingles, treated with the antiviral Acyclovir. The facility failed to follow their process and revise the care plan with appropriate interventions for staff to follow related to the Clostridium Difficile and Shingles infections.</p> <p>The findings include:</p> <p>Review of the clinical record revealed Resident #9 re-entered the facility, on 10/10/11, after a hospital stay with diagnoses which included Clostridium Difficile and a Urinary Tract Infection (UTI). Record review revealed the resident was being treated with Flagyl for the Clostridium Difficile infection and treated with Keflex for the UTI. Review of the care plan revealed an acute care plan with interventions created on 10/10/11 for the UTI; however, there was no acute care plan related to the Clostridium Infection. Further record review revealed on 10/17/11, the resident was assessed to have a rash from the right side of the abdomen to the back, with scattered blisters which was diagnosed as Shingles. The resident was placed on the antibiotic Acyclovir for treatment. Further review of the care plan revealed documented evidence an acute care plan was created for this infection.</p>	F 280	<p>F 280</p> <p>Resident #9's acute care plan was revised on 12-15-11 by the Unit Coordinator to include Clostridium Difficile and Shingles. There was no negative outcome to Resident #9 from the cited deficiency.</p> <p>A review of all residents with infections was completed by the Director of Nursing on 12-17-11 to ensure acute care plans had been completed and revised for all residents with infections.</p> <p>An audit of all care plans/acute care plans was conducted on 12-15-11 and concluded on 12-22-11 by the Unit Coordinators to ensure all residents had care plans and</p>	12/28/11
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F 280	<p>Continued From page 4</p> <p>Interview, on 12/15/11 at 4:45 PM, with Licensed Practical Nurse (LPN) #3, Unit Coordinator for the D and E Halls, revealed when a resident was admitted with or prescribed antibiotics for infections the facility's process was to create an acute care plan. She stated there should have been an acute care plan created for the Clostridium Difficile and Shingles infections since antibiotics were ordered for both the infections. Continued interview revealed the care plan lets staff know what kind of infection the resident has and what kind of precautions may be appropriate to prevent transmission of the infection.</p> <p>Interview, on 12/15/11 at 5:25 PM, with the Director of Nursing (DON) revealed the facility was supposed to create acute care plans when antibiotics were ordered. The DON confirmed the care plan was not revised on 10/10/11 for the Clostridium Difficile infection, treated with the antibiotic Flagyl, and on 10/17/11 for the Shingles infection, treated with the antiviral Acyclovir. She stated the care plan alerts staff of the infections. Continued interview revealed it was the Unit Coordinators' responsibility to revise the care plans for infections.</p> <p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy and procedure, it</p>	F 280	<p>revisions in place with appropriate interventions for staff to follow.</p> <p>In-services for all nurses was initiated on 12-15-11 and concluded on 12-27-11 by the Director of Nursing and the Assistant Director of Nursing related to acute care plans and revisions of care plans with appropriate interventions. This in-service will be held monthly for three(3) months and all newly hired employees will receive this in-service during orientation. The in-service will be repeated no less than twice a year.</p> <p>Nurses assigned to each unit/hall will initiate The resident's acute care plan when a Physician's order has been received for an</p>	

**F 280 Continued**

antibiotic. The nurse will include the appropriate intervention on the acute care plan.

The Unit Coordinators will review the Physician's orders daily to ensure the acute care plans have been revised with appropriate interventions. This is an ongoing practice.

The Assistant Director of Nursing will review the acute care plans each week for three(3) months then weekly for one(1) month then once monthly to ensure care plans have been initiated/revised with appropriate interventions for staff to follow. Non-compliance will be addressed immediately and reported to the Director of Nursing.

The Director of Nursing will report on compliance no less than quarterly to the Quality Assurance Committee to ensure sustained compliance.

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F 281	<p>Continued From page 5</p> <p>was determined the facility failed to provide professional standards of care for two (2) of nineteen (19) sampled residents (Resident #9 and #6). The facility failed to ensure Physician's orders were followed for Resident #9 related to the administration of sliding scale Insulin. Also, the facility failed to ensure Physician's orders related to the administration of oxygen were followed as ordered for Residents # 6 and #9.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Review of the facility's Policy and Procedure titled Administration of Drugs, undated, revealed the person who administered the drugs must chart medications immediately following the administration. The date, time administered, dosage, etc., must be entered in the medical record and signed by the person entering the data.</li> </ol> <p>Record review revealed Resident #9 was re-admitted by the facility, on 11/26/11, with diagnoses which included Diabetes Mellitus, Acute Cerebrovascular Accident, and Systemic Inflammatory Response Syndrome. Review of Resident #9's Physician's Orders for 11/11 revealed orders for Finger Stick Blood Sugar (FSBS ) before meals and at bedtime. Continued review revealed the resident was to receive Humalog (Insulin), 100 Unit / Milliliter (ML) Via, Subcutaneous (SQ) before meals and at bedtime per sliding scale (SS), based on the resident's blood sugar level: 162-200=1 unit, 201-250=3 units, 251-300=5 units, notify Medical Doctor (MD) if greater than 300.</p> <p>Review of Resident #9's December 2011</p>	F 281	<p>F 281</p> <p>Resident #6 and #9 were assessed by the Director of Nursing on 12-15-11. Oxygen settings were appropriate, and residents in no distress. Resident #9's blood sugar was checked and insulin has been administered per MD order. Physician for Resident #6 and #9 were notified of the inaccurate Oxygen settings between 12-13-11 and 12-15-11, no new orders were received. Physician for Resident #9 was notified of the medication error related to sliding scale insulin and no new orders were received.</p> <p>Education was provided immediately to nurse responsible by the Director of Nursing.</p> <p>An audit of all physician orders was initiated on 12-15-11 and concluded on 1-5-12 by the</p>	1-6-12

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F 281	<p>Continued From page 6 . .</p> <p>Medication Administration Record (MAR) revealed the following: on 12/01/11 at 6:00 AM the resident's FSBS was 180 with no documentation Humalog was given at that time; on 12/02/11 at 6:00 AM the resident's FSBS was 200 with no documentation Humalog was given; on 12/03/11 at 6:00 AM the resident's FSBS was 164 with no documentation Humalog was given; and on 12/05/11 at 6:00 AM the resident's FSBS was 162 with no documentation Humalog was given.</p> <p>Interview, on 12/15/11 at 4:25 PM, with Licensed Practical Nurse (LPN) #3, Unit Coordinator for Hall D and E, revealed based on review of Resident #9's December 2011 MAR records of FSBS recorded on 12/01/11, 12/02/11, 12/03/11 and 12/05/11 at 6:00 AM and Humalog sliding scale insulin given on those dates revealed the resident should have gotten one (1) unit of Humalog per Physician's orders at 6:00 AM on those dates for those FSBS levels. LPN #3 stated the process was to document on the MAR when a medication was given and if it was not documented it was not given. She further stated it was the Unit Coordinator's job to periodically audit the current month's MAR to ensure medications were consistently given as ordered.</p> <p>Interview, on 12/15/11 at 5:25 PM, with the Director of Nursing (DON) revealed the insulin should have been given as ordered on those dates and times. She stated the medication just got missed. Continued interview revealed the Unit Coordinators were responsible for checking the MARs daily to ensure medications were being administered as ordered.</p>	F 281	<p>F 281 Continued</p> <p>Unit Coordinators to ensure all orders were appropriately and accurately transcribed to the Medication and Treatment Administration Records. All Medication and Treatment Administration Records were reviewed to ensure all orders were documented as administered as ordered. Education was initiated on 12-15-11 and concluded on 12-27-11 for all nurses and was conducted by the Director of Nursing and Assistant Director of Nursing related to following Physician orders, documentation of such and included emphasis on sliding scale insulin orders and oxygen orders. This education will be repeated monthly for three(3) months then repeated twice a</p>	

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F 281	<p>Continued From page 7</p> <p>Further review of the Medication Record for Resident #9 revealed the resident also had a Physician's order for oxygen at two (2) liters per minute via nasal cannula.</p> <p>Observations of Resident #9, on 12/12/11 at 5:36 PM, 12/13/11 at: 9:30 AM, 1:10 PM, and 6:10 PM, 12/14 at 9:56 AM, and 12/15/11 at 4:25 PM revealed the resident did not have supplemental oxygen via nasal cannula. Further observation of Resident #9 on 12/14/11 at: 11:15 AM and at 2:00 PM revealed the resident's oxygen concentrator was set at one (1) liter per minute. On 12/15/11 at 4:25 PM the oxygen concentrator was set between one (1) and two (2) liters.</p> <p>Interview, on 12/15/11 at 4:26 PM, with LPN #3 revealed the Physician's order stated the resident was to have oxygen via nasal cannula at 2 liters per minute at all times. LPN #3 stated she was not aware the resident was not wearing the nasal cannula and it was staff's responsibility to make sure the resident had the oxygen as ordered by the Physician.</p> <p>2. Review of the clinical record revealed Resident #6 was admitted by the facility on 06/03/06 with diagnoses which included Congestive Heart Failure and Chronic Obstructive Pulmonary Disease. Review of the current active Physician's orders revealed the resident was to have supplemental oxygen (O2) at two (2) liters per minute (LPM).</p> <p>Observations on 12/13/11 at 10:17 AM, 11:15 AM, 12:16 PM, 3:05 PM, and 4:30 PM revealed Resident #6 was receiving supplemental oxygen by nasal cannula at four (4) LPM. Observations</p>	F 281	<p>F 281 Continued</p> <p>year. All newly hired employees will be educated during orientation.</p> <p>Oxygen orders are now on the resident treatment record and a nurse will check liter flow each shift and document the check.</p> <p>The Unit Coordinators will check Medication and Treatment Administration Records daily to ensure insulin is administered per the sliding scale order, that the Oxygen checks are being completed and that all physician orders are followed. This is an on-going practice. The Unit Coordinators will conduct walking rounds three(3) times per day for 30 days then twice a day for 14 days then daily to ensure residents receiving oxygen have</p>	
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F 281	<p>Continued From page 8</p> <p>on 12/14/11 at 9:30 AM, 10:30 AM, 12:15 PM, and 2:45 PM revealed the oxygen was being delivered at four (4) LPM. Observation with the Unit Manager, on 12/15/11 at 11:10 AM, revealed Resident #6 was receiving supplemental oxygen at three (3) LPM.</p> <p>During interview, on 12/15/11 at 11:15 AM, the Unit Manager confirmed the Physician's orders directed the resident receive oxygen therapy at two (2) LPM. She stated the nurse assigned to the resident was responsible for dialing in the correct oxygen flow on the concentrator. She further stated the nurse should check for the correct flow every shift.</p> <p>Interview with LPN #1, on 12/15/11 at 11:20 AM, revealed she was assigned to Resident #6. She stated the nurse was supposed to check for the proper setting on the concentrator every shift but she had not yet checked the setting for Resident #6. She further stated she had also been assigned to Resident #6 on 12/13/11 and she was sure the oxygen was set at two (2) LPM as ordered; however, she could not recall what time of day she had checked it. Continued interview revealed LPN #1 had no idea how the setting had gotten changed as only the nurse was authorized to adjust the oxygen flow.</p> <p>Interview with the DON, on 12/15/11 at 5:25 PM, revealed for any resident with an order for oxygen therapy, the staff was responsible for making sure the resident was wearing the nasal cannula and the oxygen concentrator was set at the correct flow, according to the Physician's order.</p>	F 281	<p>F 281 Continued</p> <p>The oxygen on and the liter flow is accurate. Non-compliance will be addressed immediately.</p> <p>The Assistant Director of Nursing will audit residents with sliding scale insulin orders weekly for three(3) months then monthly thereafter to ensure compliance. The Assistant Director of Nursing will make walking rounds daily for 2 weeks then weekly to ensure oxygen orders are being followed. Non-compliance will be addressed immediately and reported to the Director of Nursing.</p> <p>The Director of Nursing will report on compliance no less than quarterly to the Quality Assurance Committee for three(3) quarters to ensure compliance.</p>	
F 323 SS-E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		

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

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 12/15/2011
NAME OF PROVIDER OR SUPPLIER  HERITAGE HALL HEALTH & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 331 SOUTH MAIN STREET LAWRENCEBURG, KY 40342	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
F 323	<p>Continued From page 8</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure the resident environment remained as free of accident hazards as is possible. A Potassium capsule was left on an unsampled resident's bedside table overnight. In addition, razors were accessible to residents when they were observed in an open trash can in the shower room. Further, a treatment cart was observed to be unlocked and unattended for ten (10) minutes.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>Review of the facility's "Containers for Reusable Sharps" policy, undated, revealed contaminated sharps that are reusable are to be placed immediately, or as soon as possible after use, into appropriate sharps containers.</li> </ol> <p>During tour of the facility's Whirl Pool Bathing Room, on 12/12/11 at 6:25 PM, observation revealed five (5) disposable razors, which appeared to be used, in a trash can accessible to residents.</p>	F 323	<p>F 323</p> <p>An audit of all resident rooms and resident care areas was conducted on 12-15-11 by the Director of Nursing and Assistant Director of Nursing to ensure all sharps items and/or potential sharps items were secured in appropriate sharps containers and not accessible to residents and that the environment was free from potential risks and hazards. No other environmental hazards were identified during the audit.</p> <p>Education was provided to SRNA #9 regarding sharps and appropriate sharps containers.</p>	12-25-11

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STATEMENT OF DEFICIENCIES  
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA  
IDENTIFICATION NUMBER:

186277

(X2) MULTIPLE CONSTRUCTION

A. BUILDING \_\_\_\_\_

B. WING \_\_\_\_\_

(X3) DATE SURVEY  
COMPLETED

C

12/16/2011

NAME OF PROVIDER OR SUPPLIER

HERITAGE HALL HEALTH & REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

331 SOUTH MAIN STREET  
LAWRENCEBURG, KY 40342

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F 323	<p>Continued From page 10.</p> <p>Interview, on 12/12/11 at 6:26 PM, with State Registered Nurse Asistant (SRNA) #9 regarding the razors observed in the trash can were used razors and should not have been in the trash can. She stated the razors could cut someone and it was a safety and infection control issue. She further stated the razors should have been disposed of in a sharps container.</p> <p>Interview, on 12/12/11 at 6:30 PM, with Licensed Practical Nurse (LPN) #3, Unit Manager for D and E Halls, revealed razors should not be disposed of in the trash can. She stated it was a safety issue for the residents and razors should be disposed of in the sharps containers.</p> <p>Interview, on 12/16/11 at 5:25 PM, with the Director of Nursing (DON), revealed razors were considered sharps and were to be disposed of in the sharps containers, not in the trash. She stated staff was responsible for disposing of them properly.</p> <p>2. Observation, on 12/13/11 at 9:35 AM, revealed a Potassium capsule was lying on Unsampled Resident E's bedside table. Review of the resident's Medication Administration Record revealed the resident was scheduled to receive Potassium 10 meq, two (2) times per day but had not received the morning dose.</p> <p>Interview with LPN #2, on 12/13/11 at 9:35 AM, revealed the Potassium capsule was from the medication pass of the night before. She stated the nurses were to observe residents take all medications and not leave the room until complete.</p>	F 323	<p>An In-service for all facility staff was initiated on 12-15-11 and concluded on 12-27-11 by the Director of Nursing and the Assistant Director of Nursing related to sharp objects and maintaining an environment free from hazards. This in-service will be repeated monthly for three(3) months. All newly hired employees will be in-serviced during the orientation process. The in-service will be repeated no less than twice a year.</p> <p>During walking rounds three(3) times a day the Unit Coordinators will observe all resident care areas to ensure the sharps objects and/or potential sharps objects are secured in the appropriate sharps container. This will</p>	

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F 323	<p>Continued From page 11</p> <p>Interview with LPN #5, on 12/14/11 at 2:00 PM, revealed during medication administration the nurse was to stay with the resident until all medications were given. She stated the facility currently had no residents with orders to take their medications independently.</p> <p>Interview with the Assistant Director of Nursing, on 12/13/11 at 9:50 AM, revealed the procedure for giving medications was to stay with the resident until medications were completely taken. She stated if a resident refused a medication, it should be removed from the room and discarded appropriately.</p> <p>3) Observation revealed that on 12/14/11 between 2:00 PM and 2:10 PM the treatment cart was unlocked and unattended by staff. Observed within the treatment cart were prescribed lotions and creams, lancets, and sanitary wipes carrying a poison-control precautionary warning.</p> <p>Observation, on 12/14/11 between 2:00 PM and 2:10 PM revealed an unsampled resident in a wheelchair holding a doll sitting beside the treatment cart.</p> <p>Interview with Unit Manager #4, on 12/14/11 at 2:10 PM, revealed the cart was unlocked and unattended. The nurse assigned to the treatment cart was on break and off the unit.</p> <p>Interview with the DON, on 12/15/11 at 5:25 PM, revealed the facility process was to ensure resident safety and the treatment carts should remain locked when unattended by staff.</p> <p>483.35(i)(3) DISPOSE GARBAGE &amp; REFUSE PROPERLY</p>	F 323	<p>be an ongoing practice. All environmental hazards identified will be addressed immediately and reported to the Director of Nursing.</p> <p>A Nurse and a Certified Nursing Assistant will be randomly selected monthly to attend the safety meeting to identify potential safety hazards and environmental risks. This will be an ongoing practice.</p> <p>The Assistant Director of Nursing will complete walking rounds daily for 30 days then daily for 14 days then once weekly to ensure the environment is free from hazards and potential risks. All non-compliance will be addressed immediately and reported to the Director of Nursing.</p>	
F 372 SS=D		F 372		

**F 323 Continued**

On weekends the nurse assigned to each hallway will complete walking rounds twice daily for three(3) months to ensure the sharp objects are secured and will observe for any potential and environmental risks. All environmental hazards will be reported to the Director of Nursing/or designee immediately.

The Director of Nursing will report on compliance related to environmental safety no less than quarterly to the facility Quality Assurance Committee for three(3) quarters then as directed by the Quality Assurance Committee to ensure sustained compliance.

Unsampled Resident E was assessed by LPN # 2 and Director of Nursing on 12-13-11. MD notified on 12-13-11 that resident appears to

**F 323 Continued**

have missed a dose of Potasslum on 12-12-11. No new orders were given.

The Licensed Practical Nurse responsible for administering the Unsampeld Resident E medication the night before, was provided education by the Director of Nursing on 12-14-11 on staying with the resident until the medication was administered.

An audit of all resident rooms and resident care areas was conducted on 12-13-11 and 12-14-11 by the Director of Nursing and the Assistant Director of Nursing to ensure residents medications were secured. No other deficiencies were identified.

An in-service for all nursing staff was initiated on 12-15-11 and concluded on 12-27-11 by the Director of Nursing and the Assistant Director of Nursing related to medication administration and maintaining an environment free from hazards. This in-service will be repeated monthly for three(3) months. All newly hired employees will be in-serviced during the orientation process. The in-service will be repeated no less than twice a year.

**F 323 Continued**

During walking rounds three(3) times a day the Unit Coordinators will observe all resident rooms and resident care areas to ensure the medications are secured. This will be an ongoing practice. The Unit Coordinator will observe for any additional environmental hazards during walking rounds.

On weekends the nurses assigned to each halfway will complete a daily walking round at the beginning of their shift for three(3) months to ensure the residents medications are secured and will observe for any potential environmental risk. Any environmental hazards or unsecured medications will be reported to the Director of Nursing/or designee immediately.

The Assistant Director of Nursing will observe the nurses during medication administration twice weekly until all nurses have been observed. Any non-compliance will be addressed immediately and reported to the Director of Nursing.

The Director of Nursing will report on compliance related to medication administration

**F 323 Continued**

and environmental safety no less than quarterly to the facility Quality Assurance Committee for three(3) quarters then as directed by the Quality Assurance Committee to ensure sustained compliance.

An audit of all facility treatment and medication carts was conducted on 12-14-11 by the Director of Nursing and the Assistant Director of Nursing to ensure all medications, treatments, sharps, objects or hazards were secured and out of reach of all residents. No other deficiencies were identified.

Education was provided to the Nurse responsible for the unlocked and unattended treatment cart.

An in-service for all nursing staff was initiated on 12-15-11 and concluded on 12-27-11 by the Director of Nursing and the Assistant Director of Nursing related to unattended medication and treatment carts and maintaining an environment free from hazards. This in-service will be repeated monthly for three(3) months. All newly hired employees

**F 323 Continued**

will be in-serviced during the orientation process. The in-service will be repeated no less than twice a year.

The Unit Coordinators will do walking rounds three(3) times a day to ensure all medication and treatment carts are secured when not in use. This will be an ongoing practice. In addition, the Unit Coordinators will observe for any environmental hazards or potential risks. Any hazards or risks or unlocked treatment carts or medication carts will be addressed immediately and reported to the Director of Nursing.

The Assistant Director of Nursing will do walking rounds daily for 30 days then daily for 14 days then once daily to ensure treatment carts and medication carts are secured when not in use. Any non-compliance will be addressed immediately and reported to the Director of Nursing.

The Director of Nursing will report on compliance related to medication administration and environmental safety no less than quarterly to the facility Quality Assurance

**F 323 Continued**

**Committee for three(3) quarters then as  
directed by the Quality Assurance Com-  
mittee to ensure sustained compliance.**

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER  HERITAGE HALL HEALTH & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 331 SOUTH MAIN STREET LAWRENCEBURG, KY 40342	

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F 372	<p>Continued From page 12</p> <p>The facility must dispose of garbage and refuse properly.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and policy review, it was determined the facility failed to store garbage and refuse properly to prevent the harborage of insects, rodents, roaches, and other insects. Observation of the facility's three (3) dumpster containers on 12/15/11, revealed the dumpster closest to the facility contained multiple bags of trash and both a side door and lid were open.</p> <p>The findings include: Review of the facility's policy titled Environmental Sanitation / Infection Control revealed dumpster lids are to be closed after trash is deposited. Observation, on 12/15/11 at 1:30 PM, revealed the lid to one (1) of three (3) dumpster containers on the facility grounds was open, the dumpster closest to the facility door. A second observation, on 12/15/11 at 2:30 PM, of the same dumpster revealed the lid and the side door were open. Numerous bags of trash were observed in the dumpster. Interview, on 12/15/11 at 2:30 PM, with Maintenance Worker #1, revealed the dumpster lid was supposed to be kept closed at all times. Interview, on 12/15/11 at 6:25 PM, with the Director of Nursing revealed the facility's garbage</p>	F 372	<p>F 372</p> <p>The lid and side door of the dumpster were immediately closed.</p> <p>In-servicing for all employees was initiated by each department supervisor on 12-16-11 and concluded on 12-27-11 to ensure all employees were aware of the policy to keep dumpster lid and door securely closed to prevent the harborage of insects, rodents, roaches and other insects. Employees will be in-serviced on this policy upon hire in new employee orientation and each month for the next 3 months and as deemed necessary by the Quality Assurance Committee thereafter but at least bi-annually.</p> <p>Maintenance Director and Maintenance</p>	12-28-11

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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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F 372	Continued From page 13 lids were supposed to be closed. It was important for infection control purposes to keep them closed.	F 372	F 372 Continued  Assistant will monitor the dumpsters each day during environmental rounds.  Dietary Supervisor will also monitor the dumpster area each day during his shift to assure that garbage is disposed of properly and that the doors and the lid to the dumpster are closed after each use.  Any non-compliance will be immediately addressed and resolved and will be reported to the Administrator. Any non-compliance will be monitored by the Quality Assurance Committee.	

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NAME OF PROVIDER OR SUPPLIER  HERITAGE HALL HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 331 SOUTH MAIN STREET LAWRENCEBURG, KY 40342
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR §483.70 (a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1973 Original Construction Date 1986 Addition</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) Story, Type III (000) Unprotected</p> <p>SMOKE COMPARTMENTS: Five (5) smoke compartments.</p> <p>COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM</p> <p>FULLY SPRINKLED, SUPERVISED (Dry SYSTEM)</p> <p>EMERGENCY POWER: Type II LP Generator.</p> <p>A life safety code survey was initiated and concluded on 12/14/11. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility was found not in substantial compliance with the Requirements for Participation for Medicare and Medicaid. The facility is licensed for one hundred twelve (112) beds and the census was one hundred eight (108) the day of the survey.</p>	K 000	<p>No Residents were affected by the cited Life Safety Code Deficiencies.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Dana Grant* TITLE: *Administrator* (X6) DATE: *1-10-12*

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 60 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PROVIDER OR SUPPLIER  HERITAGE HALL HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 331 SOUTH MAIN STREET LAWRENCEBURG, KY 40342
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<p>K 000</p> <p>K 029 SS=D</p>	<p>Continued From page 1</p> <p>Deficiencies were cited with the highest deficiency identified at "D" level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>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</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure hazardous areas were protected according to National Fire Protection Association (NFPA) standards.</p> <p>The findings include:</p> <p>Observation, on 12/14/11 at 10:41 AM, with the Maintenance Director revealed the door leading into the food storage in the kitchen area did not have a self closing device installed per NFPA Life Safety Code.</p> <p>Interview, on 12/14/11 at 10:41 AM, with the Maintenance Director revealed he was unaware of this requirement. This was also confirmed with the Administrator during the exit interview.</p>	<p>K 000</p> <p>K 029</p>	<p>On 12-17-11 a self closing device for the food storage area door in the kitchen was purchased. On 12-22-11 the self closing device was installed. Thorough rounds were made on 12-20-11 by the Maintenance Assistant and no other door was identified as being in need of a self closing device. The facility utilizes a computerized program (TELS) to assist us in maintaining a preventative maintenance program. We have added checking the self-closing door devices to the program to be checked quarterly.</p>	<p>12-23-11</p>
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K 029	<p>Continued From page 2</p> <p>Reference: NFPA 101 (2000 edition) 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:</p> <ul style="list-style-type: none"> <li>(1) Boiler and fuel-fired heater rooms</li> <li>(2) Central/bulk laundries larger than 100 ft<sup>2</sup> (9.3 m<sup>2</sup>)</li> <li>(3) Paint shops</li> <li>(4) Repair shops</li> <li>(5) Soiled linen rooms</li> <li>(6) Trash collection rooms</li> <li>(7) Rooms or spaces larger than 50 ft<sup>2</sup> (4.6 m<sup>2</sup>), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction</li> <li>(8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered</li> </ul>	K 029		
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K 062	<p>Continued From page 4 shall be located a minimum of 4 in. (102 mm) from a wall.</p> <p>NFPA 25 (1998 edition) 2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation. Exception No. 1:* Sprinklers installed in concealed spaces such as above suspended ceilings shall not require inspection. Exception No. 2: Sprinklers installed in areas that are inaccessible for safety considerations due to process operations shall be inspected during each scheduled shutdown.</p>	K 082		