

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

PRINTED: 11/28/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  165399	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 11/09/2012
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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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS  An abbreviated survey (KY #19324) was conducted on 11/07/12 through 11/09/12 to determine the facility's compliance with Federal requirements. KY #19324 was substantiated with deficiencies cited.	F 000	"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."	
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES  The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.  This REQUIREMENT is not met as evidenced by: Based on interview, closed record review, facility policy/procedure review, and review of the facility's investigation, it was determined the facility failed to ensure written policies and procedures were implemented that prohibit neglect of residents for one resident (#1), in the selected sample of four (4) residents. The facility failed to implement the Abuse and Neglect policy/procedure as evidenced by the failure to identify an allegation of neglect according to their policy's definition of neglect. This failure prevented the facility from notifying the State Agencies about the allegation. On 11/02/12, Resident #1 reported an allegation of neglect to the Business Office, alleging that the facility failed to provide timely care and services for Resident #1 related to the failure of staff to respond timely to the resident when he/she was having chest pain.	F 226	Resident #1 was discharged from the center on 12/1/12.  An audit of the facility grievance log and Resident Council Minutes for the past 90 days were reviewed by the Administrator 11/9/12, with no concerns identified.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Paula Sledge* TITLE Administrator (X6) DATE 12/7/12

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

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F 226	Continued From page 1  Findings include:  A review of the facility's "Prohibition of Abuse, Neglect, Mistreatment, and Misappropriation of Resident Property" policy/procedure, dated 01/08, revealed the definition of neglect as the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. The Administrator or his/her designee reports alleged violations and substantiated incidents to the State agency and to all other agencies required.  A closed record review revealed Resident #1 was admitted to the facility on 10/12/12 with diagnoses to include Hypertension, Diabetes, and recent Myocardial Infarction. The resident was sent to the hospital on 11/01/12.  An interview with the Business Office Manager (BOM), on 11/09/12 at 11:20 AM, revealed she spoke to Resident #1 at the hospital on 11/02/12. She stated Resident #1 stated he/she had concerns related to the night he/she was sent to the hospital. Resident #1 informed the BOM that he/she told the nurse he/she was having chest pain and the nurse went to get someone else, but never came back. The resident stated he/she pushed the call light, but no one ever came. Resident #1 told her that his/her chest was hurting bad, so he/she yelled out, and still no one came. The resident told the BOM that he/she finally yelled for someone that was walking down the hall. The BOM stated she made the Administrative staff aware of Resident #1's concerns in the morning meeting, which was taking place at that time.	F 226	The Resident Council met and the Administrator reviewed the minutes on 11/27/12 and reported no allegations of neglect. The Director of Clinical Operations educated the Administrator, Director of Nursing Services and Staff Development Coordinator on identifying and reporting allegations of abuse and neglect, per the company Abuse Prohibition Policy on 11/09/12 and again on 12/6/12 to include timely reporting and employee suspension while investigating. Facility staff were re-educated on identifying and reported allegations of abuse and neglect as of 11/14/12 by the staff development coordinator.  The Administrator and /or Director of Social Services will audit the grievance log weekly for thirty days and then monthly for one year. Resident Council Minutes will be reviewed by the Administrator and/or Social Services Director monthly. Concerns identified will be addressed as indicated. A summary of these findings will be submitted to the Performance	

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F 226	Continued From page 2  A review of the facility's investigation into the incident revealed that the facility reviewed the record and interviewed the staff involved; however, the incident was not reported to the appropriate State Agencies.  An interview with the Administrator and Director of Nursing (DON), on 11/08/12 at 3:00 PM, revealed after Resident #1 was admitted to the hospital, the resident told the BOM that there was a long time between the complaint of chest pain and being sent out to the hospital. They revealed they looked at the complaint as a grievance, not as an allegation of neglect. They stated they reviewed the record and interviewed the staff involved, but found no evidence the staff did not respond appropriately and timely to Resident #1.	F 226	Improvement Committee monthly for one year for further review and recommendations.	12-7-12	