

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

PRINTED: 10/16/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185400</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R</b> <b>10/07/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>HEARTHSTONE PLACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>506 ALLENSVILLE ROAD</b> <b>ELKTON, KY 42220</b>		
(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 000}	INITIAL COMMENTS  Based upon implementation of the acceptable PoC, the facility was deemed in compliance, 10/07/13 as alleged.	{F 000}			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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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NAME OF PROVIDER OR SUPPLIER  HEARTHSTONE PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 608 ALLENSVILLE ROAD ELKTON, KY 42220
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F 000	INITIAL COMMENTS  A recertification survey was conducted on 08/20/13 through 08/23/13 to determine the facility's compliance with Federal requirements. The facility failed to meet the minimum requirements for recertification with the highest scope and severity of an "E".	F 000	<i>Disclaimer:</i> The preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts or conclusions set forth in support of the allegations of deficiency. Further, the facility reserves its right to dispute the facts and conclusions in any forum necessary and disputes that any action or inaction on its part created any deficient practice. The facility also disputes that the circumstances constituted non-compliance to any resident. This plan of correction is prepared and executed solely because it is required by federal and state law.	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)  A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.2(a).  The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2), or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.  The facility must record and periodically update	F 157	<b>F 157</b>  483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)  The corrective action accomplished to correct the alleged deficient practice:  On 8/23/13, Resident #6's physician was notified by a Licensed Nurse on the fall that occurred on 7/6/2013. The physician did not verbalize any new orders related to the fall.  How the facility will identify other residents having the potential to be affected by the same alleged deficient practice:  On 9/17/13, the Director of Nursing completed a chart audit on all current residents for the past 30 days to determine if physician was notified of resident change in condition or status. For any resident(s) identified, the Director of Nursing completed required notification and documentation in resident's medical record.  What measures or systemic changes were made to ensure that the alleged deficient practice will not recur:  On 8/30/13, Administrator reviewed the current Change in Resident's Condition or Status Policy which included the Licensed Nurses notification	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kathi D. Evans TITLE: Administrator (X6) DATE: 9/19/13

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

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F 157	<p>Continued From page 1</p> <p>the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, interview and facility policy review it was determined the facility failed to ensure the physician was notified as required by the facility's policy for Change in Resident's Condition or Status, for one (1) resident (#6), in the selected sample of thirteen (13) residents. Resident #6 sustained a fall on 07/06/13 with no evidence of notification to the physician.</p> <p>The findings include:</p> <p>A review of the facility's policy Change in Resident's Condition or Status policy, dated 10/15/10, revealed the Nurse Supervisor/Charge Nurse will notify the resident's attending physician or on call physician when there has been an accident or incident involving the resident.</p> <p>A record review revealed the facility admitted Resident #6 on 12/19/12 with diagnosis to include Alzheimer's Disease, Muscle Weakness-General, Frequent Falls, Paget's Disease and Dementia.</p> <p>A review of the Minimum Data Set (MDS) assessment, dated 06/02/13, revealed the facility assessed Resident #6's cognition as severely impaired and he/she required supervision.</p> <p>A review of the Comprehensive Care Plan, dated 12/18/11, revealed Resident #6 was at risk for falls related to a history of falls, decreased safety awareness and weakness.</p>	F 157	<p>of the residents attending physician when a change in condition is identified. The policy was determined to be sufficient.</p> <p>On 8/30/13, Administrator reviewed the current Continuous Quality Improvement (CQI) Tool N-26 "Notification of Change in Resident Condition". The tool was determined to be a sufficient tool to monitor for physician notification following a resident change in status.</p> <p>On 9/24/13, Director of Nursing will complete an in-service for Licensed Nurses on the Change in Resident's Condition or Status Policy.</p> <p>How the facility plans to monitor its performance to ensure that solutions for the alleged deficient practice are sustained:</p> <p>CQI Tool N-26 "Notification of Change in Resident Condition" will be completed by the Director of Nursing weekly x 4, then monthly x 2, and then per CQI Calendar to monitor that physician notification is documented in the residents' medical record after resident change in condition.</p> <p>Completion Date:</p>	10/7/13
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F 157	<p>Continued From page 2</p> <p>A review of the nurses notes, dated 07/06/13 at 9:45 PM, revealed the resident was found on the floor or the mat at bedside. There was evidence the nurse notified the resident's Power of Attorney (POA) of the fall on 07/07/13 at 6:30 AM but there was no evidence the physician was notified of the fall.</p> <p>A review of the facility's Unusual Occurrence Report, dated 07/06/13, the facility provided revealed no physician notification.</p> <p>Interview with the Director of Nursing (DON), on 08/23/13 at 9:10 AM, revealed Resident #6 had a fall on 7/06/13 with no documented evidence that the physician was notified. He stated he would expect the nurse to notify the physician for a fall or any significant change.</p> <p>Interview with the Administrator, on 08/23/13 at 4:30 PM and 6:00 PM, revealed she would expect the nurse to notify the physician of a fall. The Administrator stated it was the facility's policy that the resident's physician is notified with information regarding falls and the nurse should have notified physician.</p>	F 157	
F 221 SS-D	<p>483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS</p> <p>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, interview,</p>	F 221	<p><u>F 221</u></p> <p>483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS</p> <p>The corrective action accomplished to correct the alleged deficient practice:</p> <p>On 8/23/13, Assistant Director of Nursing assessed Resident #5 and determined the Broda chair was a restraint that was used to treat the resident's medical symptoms.</p>

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F 221	<p>Continued From page 3</p> <p>and review of the facility's policy/procedure, the facility failed to ensure the resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, for one (1) resident (#5), in the selected sample of thirteen (13) residents. Observations throughout the duration of the survey revealed Resident #5 to be reclined in a Broad chair; however, the resident was not assessed in a timely manner for the use of the Broad chair.</p> <p>The findings include:</p> <p>A review of the facility's policy/procedure "Use of Restraints," undated, revealed "practices that inappropriately utilize equipment to prevent resident mobility are considered restraints and are not permitted, including placing a resident in a chair that prevents the resident from rising."</p> <p>A review of the facility's policy/procedure "Device Implementation," undated, revealed "devices will be assessed by qualified staff (Licensed Nurse, Therapy) prior to the implementation of the device. Residents receiving therapy services may have devices implemented after assessment and determination to be safe and appropriate to treat the medical condition identified. Documentation of risk versus benefits will be documented on the therapy evaluation or nursing risk versus benefit assessment."</p> <p>A record review revealed the facility admitted Resident #5 on 01/10/12 with diagnoses to include: Dementia, Alzheimer's Disease, Diabetes Mellitus Type II, Renal Insufficiency, Dysphagia, Pleural Effusion, Psychosis,</p>	F 221	<p>On 8/23/13, the attending physician was contacted and an order was obtained by the Assistant Director of Nursing. Resident #5's comprehensive care plan and nurse aide care plan were updated to reflect the new order.</p> <p>On 9/18/13, a clarification order was written regarding Resident #5's restraint.</p> <p>How the facility will identify other residents having the potential to be affected by the alleged deficient practice.</p> <p>On 9/17/13, an audit was conducted by the Director of Nursing and Assistant Director of nursing on current devices in use for current residents to identify any restraints any residents with a device. Any device identified as a restraint will have a physician order, NACP, CP Assessment for restraint.</p> <p>What measures or systemic changes were made to ensure that the alleged deficient practice will not recur:</p> <p>On 8/30/13, Administrator reviewed the current Restraint Policy. The policy was determined to be a sufficient policy of required restraint criteria and documentation.</p> <p>On 8/30/13, Administrator reviewed the current CQI Tool N-1 "Physical Restraints (Device) and Side Rail". The tool was determined to be a sufficient tool to monitor for device assessment and restraint documentation.</p> <p>On 9/13/13, Administrator completed an in-service with the Director of Nursing and Assistant Director of Nursing on the Restraint Policy.</p> <p>On 9/24/13, Director of Nursing will complete an in-service with Licensed Staff, Certified Medication Technicians, State Registered Nurses Aides on Restraint Policy.</p>	

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F 221	<p>Continued From page 4</p> <p>Depression, Hypertension, and Altered Mental Status.</p> <p>A review of the quarterly Minimum Data Set (MDS) assessment, dated 06/30/13, revealed the facility assessed Resident #5's cognition as severely impaired and a chair which prevented rising was used daily.</p> <p>A review of the Interdisciplinary Care Plan, dated 10/11/12, revealed a Broda chair was initiated for positioning and safety, effective 12/28/12.</p> <p>A review of the physician's order, dated 12/28/12, revealed: "Broda chair for positioning and safety."</p> <p>A review of the Risk/Benefit Analysis, dated 01/03/13, revealed the Broda chair was used for positioning and comfort while providing safety from fall.</p> <p>Observations, on 08/20/13 at 1:15 PM and 3:55 PM, on 8/21/13 at 9:00 AM, on 08/22/13 at 9:45 AM, and on 08/23/13 at 11:00 AM and 5:00 PM, revealed Resident #5 was sitting quietly in a reclined position in his/her Broda chair on the 200 hallway near the nurses' station.</p> <p>Observation, on 08/23/13 at 3:00 PM, revealed Resident #5 was sitting in a reclined position in his/her Broda chair with both legs thrown across the right side of the chair.</p> <p>Further review of the Risk/Benefit Analysis, dated 01/21/13, revealed a pressure alarm to the chair behind his/her knees was put into place. Additional review of the summary of findings on the Risk-Benefit Analysis related to the alarm revealed: "pressure alarm behind knees allows</p>	F 221	<p>How the facility plans to monitor its performance to ensure that solutions for the alleged deficient practice are sustained:</p> <p>The CQI Tool N-1 "Physical Restraints (Device) and Side Rail" will be completed by the Assistant Director of Nursing weekly x 4, then monthly x 2, and then per CQI Calendar to monitor residents for proper restraint assessment.</p> <p>Completion Date:</p>
			10/7/13

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F 221	<p>Contin ed From page 5</p> <p>staff to be notified when resident is raising [his/her] legs off the Broda chair." Observation, on 08/22/13 at 10:35 AM, revealed the pressure alarm in the resident's Broda chair was turned off, until surveyor questioned the staff.</p> <p>Interview with Certified Nurse Aide (CNA) #1, on 08/22/13 at 10:15 AM, revealed the resident can stand with the assistance of two staff, take short steps, and ambulate a short distance. If reclined in the geri-chair, he/she cannot get out of the chair. If not reclined, he/she could stand; however, he/she could not do so safely without staff assistance. He stated he had observed the resident throw both legs over one side of the recliner geri-chair, whether reclined or upright.</p> <p>Interview with CNA #2, on 08/22/13 at 10:50 AM, revealed the resident can stand and ambulate short distances with the assistance of two staff. He/she can swing both feet/legs around while reclined in the geri-chair. The geri-chair usually stays in the reclined position.</p> <p>Interview with Licensed Practical Nurse (LPN) #2, on 08/22/13 at 10:00 AM, revealed the definition of a restraint would be anything that would confine a resident and not allow him/her to move freely, if they chose to get up. She stated the resident can scoot himself/herself to the edge of the Broda chair if sitting in an upright position, and cannot stand up or ambulate on his/her own without staff assistance. At times, the resident has thrown both legs over to the side of the Broda chair if in a reclined position, in an attempt to get up. The resident's Broda chair was initiated on 12/28/11 by therapy; however, a Risk/Benefit Analysis (same as nursing assessment) was not completed until 01/03/13. She stated the</p>	F 221		

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F221	<p>Continued From page 6</p> <p>Risk/Benefit Analysis form should be completed at the time the device is implemented. Additionally, the resident has a pressure alarm in his/her chair, and the alarm was not turned on this morning (08/23/13). He/she can reach the alarm and turn it on/off; however, the staff is responsible to monitor the alarm. She stated the Broda chair does not prevent him/her from rising when upright; however, he/she will fall if up on his/her own.</p> <p>Interview with LPN #1, on 08/22/13 at 8:25 AM, revealed the Broda chair is usually reclined due to the resident having some edema in his/her legs; however, he/she can get both legs over either side of the chair whether reclined or not. If not reclined the resident may attempt to stand up; however, he/she cannot stand independently. She stated therapy provided the recommendation for the Broda chair, and nursing does the assessment for the Broda chair.</p> <p>Interview with the MDS Coordinator, on 08/23/13 at 3:00 PM, revealed she did not code the resident's restraint on the last MDS; however, when completing the MDS for this resident, the device for this resident would be coded under the restraint section, whether it was a restraint or not. He/she throws his/her legs over the side of the geri-chair whether reclined or upright. The resident cannot stand on his/her own without falling.</p> <p>A review of the therapy evaluation documentation revealed the Broda chair was utilized by therapy on 12/28/12, 12/31/12 through 01/04/13, and 01/07-08/13, and 01/10/13. There was no evidence of an assessment prior to use of the Broda chair on 12/28/12.</p>	F 221		
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F 221	Continued From page 7  Interview with the Physical Therapist (PT) and Occupational Therapist (OT), on 08/23/13 at 12:10 PM, revealed OT began on 12/28/12 after a referral on 12/27/12. Services extended through 01/11/13. Further interview revealed the resident had been observed to throw his/her legs over the side of the Broda chair whether in a reclined position or an upright position.  Interview with the Director of Nursing (DON), on 08/23/13 at 2:20 PM, revealed if the resident was sitting upright in the geri-chair, he/she would attempt to get out of the chair; however, he stated he did not see the danger of the geri-chair versus other options.  Interview with the Administrator, on 08/23/13 at 3:30 PM revealed the geri-chair was not assessed as a restraint. If risks outweigh the benefits then the device would not be implemented. She also stated there was a physician's order for the geri-chair, then the assessment. Safety should be assessed prior to obtaining an order.	F 221		
F 253 SS-E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES  The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the Environmental Director's job duties, the facility failed to provide housekeeping and maintenance	F 253	<u>F 253</u>  483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES  The corrective action accomplished to correct the alleged deficient practice:  On 9/17/13, bent and torn blinds on the windows in rooms #217, #224, and #226 were replaced with new blinds by the Maintenance.  On 9/24/13, cracked plaster on the ceiling and holes in the walls for rooms #230, #306, #308 and #309 were repaired and repainted by Maintenance worker.	

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F 253	<p>Continued From page 8</p> <p>service necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>Finding include:</p> <p>Review of the Environmental Director's job duties, dated 01/06/10, revealed the Director should promptly report equipment or facility damage to the Administrator, make periodic rounds to check equipment and to assure that necessary equipment is available and working properly and make weekly inspections of all maintenance functions to assure that quality control measures are continually maintained.</p> <p>1. Observation, during tour of the facility on 08/20/13 at 12:30 PM, and throughout the duration of the survey, revealed:</p> <p>A. bent and torn blinds on the windows in Rooms #217, #224, and #226.</p> <p>B. cracked plaster on the ceiling and holes in the walls in four (4) rooms: #230, #306, #308, and #309.</p> <p>C. raised brown colored cracked caulking around toilets in three (3) rooms #308, #309, #306 on the Skilled Nursing Facility/Nursing Facility.</p> <p>D. In room #305, lime deposits or white substance were noted to cover the shower head; there were malfunctioning water control knobs for the hot and cold water on the shower faucets, and a heater/vent-fan/light in the ceiling that did not function.</p> <p>2. Observations on all four days of the survey, 08/20-23/13, revealed numerous darkened spots</p>	F 253	<p>On 9/24/13, raised brown colored cracked caulking around toilets was removed and replaced for rooms #306, #308, and #309.</p> <p>On 9/24/13, lime deposits were removed, heat fan was replaced and control knobs were repaired in the bathroom of room #305.</p> <p>On 9/11/13 the Director of Environmental Services (DES) and Floor Technician extracted and bonnet cleaned the carpet on hallways.</p> <p>On 9/16/13, Maintenance removed mops, brooms, and boxes stored on the Housekeeping and Janitor Closets on the 100 and 200 Hallways.</p> <p>How the facility will identify other residents having the potential to be affected by the same alleged deficient practice:</p> <p>On 9/18/13, Director of Environmental Services conducted an audit was completed to determine if any broken or bent blinds, raised brown caulking, lime deposits on fixtures were present in resident rooms and to identify any other carpet in need of stain removal. Any allegedly deficient practices will be scheduled for cleaning and/or repair.</p> <p>What measures or systemic changes were made to ensure that the alleged deficient practice will not recur:</p> <p>On 8/30/13, Corporate Compliance Director made corrections to CQI Tool ES-1 to include: "Window blinds are in good repair to ensure resident privacy" and ES-14 "General Environment" to include: "Plaster on ceilings and walls are in good repair", "Caulking in bathroom is clean and in good repair", "Bathroom fixtures are in working order and free of stains, lime deposits, etc.", and "Carpet is clean and free of stains."</p> <p>On 9/24/13, Administrator and Director of Nursing will complete an in-service with Nursing, Dietary, Laundry, Housekeeping and Supportive</p>

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185400	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  08/23/2013
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NAME OF PROVIDER / SUPPLIER  HEARTHSTONE PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 608 ALLENSVILLE ROAD ELKTON, KY 42220
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F 253	<p>Continued From page 9</p> <p>and stairs on the carpeted entry way and all the carpeted hallways.</p> <p>3. Observations, on 08/23/13 from 2:50 PM until 3:15 PM revealed there were mops, brooms and boxes of stripping wax and sealer stored on the floor in the Housekeeping and Janitor Closets on the 100 and 200 Hallways.</p> <p>6:30 PM</p> <p>Interview, on 08/22/13 at 9:15 AM with the Director of Nursing (DON), revealed compliance rounds were done every morning by the administrative staff. The "Compliance Round Check List for Dept. Heads" revealed statements had been checked on 08/19/13 that there were leaky faucets, broken bed locks, and other items.</p> <p>Interview, on 08/23/13 at 11:45 AM with the Maintenance Supervisor and Housekeeping Supervisor, revealed environmental concerns were noted each morning on compliance rounds by the administrative staff and after rounds were completed a work order was written and the work completed. There was no evidence of a written report for the above items.</p> <p>An interview with the Administrator, on 08/23/13 at 6:30 AM, revealed she was aware the carpet needed replacing and stated the storage concern would be addressed.</p>	F 253	<p>Staff on completing work orders for any broken or bent blinds, cracked plaster on ceilings or walls, raised brown caulking, fixtures that are broken or have lime deposits on fixtures identified, and cleaning up spills regardless of time to prevent carpet/floor covering from staining.</p> <p>On 9/11/13, Administrator and Director of Environmental Services drafted and implemented weekly cleaning schedule to have carpet retracted and bonnet cleaned by the Floor Technician and/or Director of Environmental Services.</p> <p>How the facility plans to monitor its performance to ensure that solutions for the alleged deficient practice are sustained:</p> <p>The CQI form ES-1 "General Environment" and ES-14 "Housekeeping Review" will be completed by Director of Environmental Services weekly x 4, then monthly x 2, and then per CQI Calendar to monitor the facility for providing housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>Completion Date:</p>	10/7/13
F 441 SS+E	<p>483.65 INFECTION CONTROL, PREVENTION, SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p>	F 441	<p><u>F 441</u></p> <p>483.65 INFECTION CONTROL, PREVENTION SPREAD, LINENS</p> <p>The corrective action accomplished to correct the alleged deficient practice:</p> <p>On 9/18/13, the medical record of Resident #2 was reviewed by the DON to determine if there was a change in resident condition or status due to the alleged deficient practice. No change in condition or status was determined.</p>	

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NAME OF PROVIDER OR SUPPLIER  HEARTHSTONE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 506 ALLENSVILLE ROAD ELKTON, KY 42220	
(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 441	<p>Continued From page 10</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy/procedure, it was determined the facility failed to provide a safe, sanitary and comfortable environment related to not sanitizing a stethoscope and oxygen saturation monitor</p>	F 441	<p>How the facility will identify other residents having the potential to be affected by the same alleged deficient practice:</p> <p>On 9/18/13, Director of Nursing completed an audit on current residents. Current residents had the potential to be affected by this alleged deficient practice.</p> <p>What measures or systemic changes were made to ensure that the alleged deficient practice will not recur:</p> <p>On 8/30/13, Administrator reviewed Cleaning and Disinfection of Resident Care Items and Equipment Policy. The policy was determined to be a sufficient policy of when and how to clean and disinfect resident care reusable equipment.</p> <p>On 8/30/13, CQI Tool IC-2 "Infection Control General" was revised by Corporate Compliance Director to include: "Staff is observed using proper hand washing technique"; and, "Multiple use noncritical devices used on multiple residents are disinfected after each use".</p> <p>On 9/24/13, DON will complete an in-service with Licensed Nurses, Certified Medication Aides and State Registered Nurses Aides on Cleaning and Disinfection of Resident Care Items and Equipment Policy and hand washing.</p> <p>How the facility plans to monitor its performance to ensure that solutions for the alleged deficient practice are sustained:</p> <p>CQI Tool IC-2 "Infection Control General" will be completed by Director of Nursing weekly x 4, then monthly x 2, and then per CQI Calendar to monitor the facility provides a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>Completion Date:</p>	10/7/13

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NAME OF PROVIDER OR SUPPLIER  HEARTHSTONE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 608 ALLENSVILLE ROAD ELKTON, KY 42220		
(4) 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)	(5) COMPLETION DATE	
F 441	<p>Continued From page 11</p> <p>between residents and not hand washing between residents.</p> <p>The findings include:</p> <p>Review of the facility's policy and procedure for "Cleaning and Disinfection of Resident Care Items and Equipment" revealed semi-critical items consist of items that may come in contact with mucous membranes or non-intact skin (e.g. respiratory therapy equipment, Glucometer); and reusable items are cleaned and disinfected or sterilized between residents (e.g., stethoscopes, durable medical equipment (glucometer).</p> <p>Observation, on 08/20/13 at 7:15 AM, revealed Resident #2 was sitting in a recliner in his/her room clothed in a hospital gown having yellow discoloration at the neck down to mid-chest area on the gown. Licensed Practical Nurse (LPN) #3 auscultated breath sounds across Resident #2's upper chest and both sides. LPN #3 then obtained oxygen saturation (SaO2) with the oxygen saturation monitor on Resident #2's finger. LPN#3 recorded a room air SaO2 of 94 percent (%) and a heart rate (HR) of eighty-eight (88) beats per minute (bpm) in a notebook. LPN #3 then picked up the stethoscope and the SaO2 monitor in her ungloved hands and walked across and down the hall to room #312. LPN #3 entered room #312 and proceeded to auscultate breath sounds and obtain SaO2 on Residents #16 and Resident #15. LPN#3 performed these procedures without disinfecting the equipment or performing hand hygiene between Residents #2, #15 and #16. LPN #3 proceeded to pick up the SaO2 monitor in her ungloved hands and walked out of the room and down the hall.</p>	F 441			

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NAME OF PROVIDER OR SUPPLIER  HEARTHSTONE PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 606 ALLENSVILLE ROAD ELKTON, KY 42220
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F 441	Continued From page 12 Interview, on 08/20/13 at 7:28 AM with LPN #3, revealed she cleans the equipment "ever so often" with the bleach wipes on the treatment cart located in the treatment room down the hall.	F 441		
F 463 SSD	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH  The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy/procedure, it was determined the facility failed to ensure a functioning call system was available in one (1) room #304.  The findings include:  Observation, on 08/20/13 at 12:45 PM, revealed room #314 bed A with an unplugged call light which was not alarming on the call light board at the nurses' station, the light was not lit outside the resident's room, and the light cover was cracked.  Observation of Resident #7, on 08/20/13 at 12:45 PM, revealed the resident was sitting in his/her wheelchair and had left side paralysis from a previous cerebral vascular accident.  Review of the facility's Compliance Round Check List for Department Heads revealed a check box was checked for "Call lights working. Test weekly on Monday (bathroom also); which was dated Monday 08/19/13.	F 463	F 463  483.70(f) RESIDENT CALL SYSTEM- ROOMS/TOILET/BATH  The corrective action accomplished to correct the alleged deficient practice:  On 8/21/13, Maintenance worker repaired the call light in Room #304.  On 9/19/13, Maintenance replaced the call light cover at Room #304.  How the facility will identify other residents having the potential to be affected by the same alleged deficient practice:  On 8/21/13, the Director of Environmental Services completed an audit on call lights. The audit showed full compliance with remaining call lights.  What measures or systemic changes were made to ensure that the alleged deficient practice will not recur:  On 8/30/13, Corporate Compliance Director made revisions to CQI Tool ES-1 "General Environment" to include: "Nurse call system is function properly."  How the facility plans to monitor its performance to ensure that solutions for the alleged deficient practice are sustained: The CQI form ES-1 "General Environment" weekly x 4, then monthly x 2, and then per CQI Calendar to monitor the facility provides a functioning call system available in resident rooms and toilet and bathing facilities.	

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NAME OF PROVIDER OR SUPPLIER  HEARTHSTONE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 506 ALLENSVILLE ROAD ELKTON, KY 42220		
(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	
F463	Continued From page 13  Interview, on 08/22/13 at 9:15 AM with the Director of Nursing (DON), revealed she participated in compliance rounds every morning as does every administrative staff member. The DON stated if something is identified as broken or not in working order it is entered on a work order and fixed.  Interview, on 08/23/13 at 11:45 A.M. with Maintenance Supervisor and Housekeeping Supervisor, revealed maintenance repairs should be noted on the Compliance Round Check List done every morning by the administrative personnel and a work order should have been entered for a non-functioning call light.	F 463	Completion Date:	10/7/13	
F490 SS+P	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING  A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.  This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to be administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. During a Life Safety Code (LSC) survey, conducted 08/20/13 there was a deficiency cited on the previous annual survey (09/19/12) which had not been corrected. (Refer to K 0066)	F 490	<u>F 490</u>  483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING  The corrective action accomplished to correct the alleged deficient practice:  On 8/20/13, the Director of Environmental Services removed cigarette butts from the rear exit, rear smoking area, and kitchen back exit.  On 9/19/13, Director of Environmental Services was counseled to complete daily rounds of interior and entry ways as previously instructed.  On 9/19/13, Administrator was educated to monitor Housekeeping and Maintenance Department to ensure it is administered in an effective manner.  How the facility will identify other residents having the potential to be affected by the same alleged deficient practice:		

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NAME OF PROVIDER OR SUPPLIER  HEARTHSTONE PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 506 ALLENSVILLE ROAD ELKTON, KY 42220
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F 490	<p>Continued From page 14</p> <p>The findings include:</p> <p>Observation, on 08/20/13 between 2:00 PM and 3:10 PM with the Environmental Director, revealed the area at the rear exit had over 30 cigarette butts on the ground around the smoker's pole, the rear smoking area had over 40 cigarette butts on the ground, and the kitchen back exit had over 20 cigarette butts on the ground.</p> <p>Interview, on 08/20/13 between 2:00 PM and 3:10 PM with the Environmental Director, revealed she was aware of the cigarette butts and cleans them up often. She stated it is a constant issue at the facility and she does not know how to make it stop from happening.</p> <p>Interview, on 08/20/13 at 3:50 PM with the Administrator, revealed the facility does weekly cleaning of the grounds at the facility. The Environmental Supervisor and the Maintenance Personnel are in charge of monitoring the cigarette butts and ensuring they are cleaned off the grounds. The Administrator revealed she was unaware of the cigarette butts on the ground in the three areas around the facility.</p>	F 490	<p>On 9/18/13, the Administrator toured facility grounds and exits and determined that no other area was affected by this alleged deficient practice.</p> <p>What measures or systemic changes were made to ensure that the alleged deficient practice will not recur:</p> <p>On 9/13/13, Administrator conducted an in-service for Nursing, Dietary, Housekeeping/Laundry and Supportive Services on NFPA standards to include smoking requirements.</p> <p>On 8/30/13, Corporate Compliance Director made revisions to CQI Tool ES-2 "Review of Facility Exterior" to include: "Staff designated smoking area is free of debris/trash including cigarette butts;" and "Outside doorways are free of trash/debris (including cigarette butts)."</p> <p>How the facility plans to monitor its performance to ensure that solutions for the alleged deficient practice are sustained:</p> <p>The CQI form ES-2 "Review of Facility Exterior" and ES-3 "Life Safety" will be completed by Director of Environmental Services weekly x 4, then monthly x 2, and then per CQI Calendar to cigarette butts are extinguished in approved devices only.</p> <p>Administrator will monitor affective administration of the housekeeping department through monthly Quality Assurance meetings.</p> <p>Completion Date:</p>	10/7/13
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NAME OF PROVIDER OR SUPPLIER  <b>HEARTHSTONE PLACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>506 ALLENSVILLE ROAD</b> <b>ELKTON, KY 42220</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{K 000}	INITIAL COMMENTS  Based upon implementation of the acceptable PoC, the facility was deemed to be in compliance, 10/07/13 as alleged.	{K 000}			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186400	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  08/20/2013
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NAME OF PROVIDER OR SUPPLIER  HEARTHSTONE PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 608 ALLENSVILLE ROAD ELKTON, KY 42220
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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: 1965.</p> <p>SURVEY UNDER: 2000 Existing.</p> <p>FACILITY TYPE: SNF/NF.</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (111).</p> <p>SMOKE COMPARTMENTS: Four (4) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system installed in 1965, upgraded in 1994 with 43 smoke detectors and 9 heat detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system installed in 1965 and upgraded in 201 .</p> <p>GENERATOR: Type II generator installed in 1972. Fuel source is Natural Gas.</p> <p>A standard Life Safety Code survey was conducted on 08/20/13. Hearthstone Place was found in non-compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for Sixty (60) beds with a census of fifty-two (52) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from</p>	K 000	<p><b>Disclaimer:</b> The preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts or conclusions set forth in support of the allegations of deficiency. Further, the facility reserves its right to dispute the facts and conclusions in any forum necessary and disputes that any action or inaction on its part created any deficient practice. The facility also disputes that the circumstances constituted non-compliance to any resident. This plan of correction is prepared and executed solely because it is required by federal and state law.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kathleen C. Evans TITLE: Administrator (X6) DATE: 9/19/13

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

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NAME OF PROVIDER OR SUPPLIER  HEARTHSTONE PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 508 ALLENSVILLE ROAD ELKTON, KY 42220		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000  K 011 SS=E	<p>Continued From page 1 Fire).</p> <p>Deficiencies were cited with the highest deficiency identified at "F" level.</p> <p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>If the building has a common wall with a noncombusting building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the fire wall was in accordance with NFPA standards. The deficiency had the potential to affect two (2) of four (4) smoke compartments, thirty-two (32) residents, staff, and visitors. The facility is certified for sixty (60) beds with a census of fifty-two (52) the day of the survey. The facility failed to ensure the fire doors in the two hour fire walls were rated for the wall.</p> <p>The findings include:</p> <p>Observation, on 08/20/13 at 1:40 PM with Maintenance, revealed the two hour wall separating the skilled nursing facility from the personal care home had doors and frame installed that were rated for only one hour at room</p>	K 000  K 011	<p><u><b>K 011</b></u></p> <p>NFPA 101 Life Safety Code Standard</p> <p>The corrective action accomplished to correct the alleged deficient practice:</p> <p>On 9/19/13, Maintenance ordered a fire door for the fire wall separating the Skilled Nursing Facility and Personal Care Home at Room #217 that are rated properly for a two hour wall and meet NFPA Standards.</p> <p>By 10/6/13, Maintenance will install fire door and frame that are properly rated outside Room #217.</p> <p>How the facility will identify other residents having the potential to be affected by the same alleged deficient practice:</p> <p>On 9/18/13, Administrator completed an audit to determine fire doors separating the skilled nursing facility from the personal care home were properly rated to the fire wall.</p> <p>What measures or systemic changes were made to ensure that the alleged deficient practice will not recur:</p> <p>On 9/13/13, Administrator conducted an in-service for Nursing, Dietary, Housekeeping/Laundry and Supportive Services on NFPA standards to include fire door rating requirements.</p>	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185400	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING		(X3) DATE SURVEY COMPLETED  08/20/2013
NAME OF PROVIDER OR SUPPLIER  HEARTHSTONE PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 506 ALLENSVILLE ROAD ELKTON, KY 42220		
(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
K011	<p>Continued From page 2 #217.</p> <p>Interview, on 08/20/13 at 1:40 PM with Maintenance, revealed he was unaware the doors were not rated properly for a two hour wall.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>19.1.1.4 Additions, Conversions, Modernization, Renovation, and Construction Operations.                  19.1.1.4.1 Additions.                  Additions shall be separated from any existing structure not conforming to the provisions within Chapter 19 by a fire barrier having not less than a 2-hour fire resistance rating and constructed of materials as required for the addition. (See 4.6.11 and 4.3.6.)                  19.1.1.4.2                  Communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire doors. (See also Section 8.2.)                  19.1.1.4.3                  Doors in barriers required by 19.1.1.4.1 shall normally be kept closed.                  Exception: Doors shall be permitted to be held open if they meet the requirements of 19.2.2.2.6.</p> <p>8.2.3. Fire Protection-Rated Opening Protectives.                  8.2.3.1.1                  Door assemblies in fire barriers shall be of an approved type with the appropriate fire protection rating or the location in which they are installed and shall comply with the following.                  (a) Fire doors shall be installed in accordance with NFPA 80, Standard for Fire Doors and Fire</p>	K011	<p>How the facility plans to monitor its performance to ensure that solutions for the alleged deficient practice are sustained:</p> <p>CQI Tool ES-3 "Life Safety" will be completed by Director of Environmental Services monthly x 3 months and per CQI Calendar there after to monitor fire doors for the fire wall separating the Skilled Nursing Facility and Personal Care Home at Room #217 that are rated properly for a two hour wall.</p> <p>Completion Date:</p>	10/7/13



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185400	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  08/20/2013
NAME OF PROVIDER OR SUPPLIER  HEARTHSTONE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 506 ALLENSVILLE ROAD ELKTON, KY 42220	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 029	<p>Continued From page 4</p> <p>fifty-two (52) the day of the survey. The facility failed to ensure one (1) office door was self-closing</p> <p>The findings include:</p> <p>Observations, on 08/20/13 at 2:35 PM with Maintenance, revealed the door to the Nursing Office was equipped with a door closer but the door had an unrated window assembly in the door. The room had substantial combustibles and a bin over 32 gallons for shredded paper in the room</p> <p>Interview, on 08/20/13 at 2:35 PM with Maintenance, revealed he was unaware the door could not have an unrated window assembly.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>19.3.2. Protection from Hazards. 19.3.2. Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft<sup>2</sup> (9.3 m<sup>2</sup>) (3) Paint shops</p>	K 029	<p>On 9/18/13, Administrator conducted an audit to determine if other doors had unrated windows for rooms where self closing doors are indicated by NFPA Standards. For any area(s) identified, a worker order will be completed for repairs to be completed.</p> <p>What measures or systemic changes were made to ensure that the alleged deficient practice will not recur:</p> <p>On 9/13/13, Administrator conducted an in-service for Nursing, Dietary, Housekeeping/Laundry and Supportive Services on NFPA standards to include self closing door requirements.</p> <p>How the facility plans to monitor its performance to ensure that solutions for the alleged deficient practice are sustained:</p> <p>CQI Tool ES-3 "Life Safety" will be completed by Director of Environmental Services monthly x 3 and then per CQI Calendar thereafter to self closing door requirements.</p> <p>Completion Date:</p>	10/7/13

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185400	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  08/20/2013
NAME OF PROVIDER OR SUPPLIER  HEARTHSTONE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 806 ALLENSVILLE ROAD ELKTON, KY 42220	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 029	Continued From page 5 (4) Repair shops (5) Stiled linen rooms (6) Trash collection rooms (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 (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.	K 029		
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure complete	K 056	<b>K 056</b>  NFPA 101 LIFE SAFETY CODE STANDARD  The corrective action accomplished to correct the alleged deficient practice:  By 9/24/13, Armor Fire Protection will add one sprinkler head to the Maintenance Hall shower room to ensure it is properly sprinkler protected.  How the facility will identify other residents having the potential to be affected by the same alleged deficient practice:  On 9/18/13, Administrator toured the facility and determined adequate sprinkler coverage in accordance with NFPA standards.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186400	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  08/20/2013
NAME OF PROVIDER OR SUPPLIER  HEARTHSTONE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 506 ALLENSVILLE ROAD ELKTON, KY 42220	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 056	Continued From page 6 sprinkler coverage in accordance with NFPA standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, sixteen (16) residents, staff, and visitors. The facility is certified for sixty (60) beds with a census of fifty-two (52) the day of the survey. The facility failed to ensure a shower room was properly sprinkler protected.  The findings include:  Observation, on 08/20/13 at 2:49 PM with Maintenance, revealed the maintenance hall shower room did not have proper sprinkler protection to cover the stall and the hall in the shower room.  Interview, on 08/20/13 at 2:49 PM with Maintenance, revealed he was unaware the area in the shower room did not have proper sprinkler protection.  Reference: S&C 09-04 Adoption of New Fire Safety Requirements for Long Term Care Facilities, Mandatory Sprinkler Installation Requirement <a href="http://www.cms.gov/SurveyCertificationGenInfo/downdloads/SCLetter09-04.pdf">http://www.cms.gov/SurveyCertificationGenInfo/downdloads/SCLetter09-04.pdf</a>	K 056	<b>What measures or systemic changes were made to ensure that the alleged deficient practice will not recur:</b>  On 9/13/13, Administrator conducted an in-service for Nursing, Dietary, Housekeeping/Laundry and Supportive Services on NFPA standards to include sprinkler requirements.  <b>How the facility plans to monitor its performance to ensure that solutions for the alleged deficient practice are sustained:</b>  CQI Tool ES-3 "Life Safety" will be completed by Director of Environmental Services monthly x 3 and per CQI Calendar thereafter to sprinkler requirements.  <b>Completion Date:</b>	10/7/13
K 066 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD  Smoking regulations are adopted and include no less than the following provisions:  (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING	K 066	<b>K 066</b>  NFPA 101 LIFE SAFETY CODE STANDARD  <b>The corrective action accomplished to correct the alleged deficient practice:</b>  On 8/20/13, the Director of Environmental Services removed cigarette butts from the	

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NAME OF PROVIDER OR SUPPLIER  HEARTHSTONE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 506 ALLENSVILLE ROAD ELKTON, KY 42220	
(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
K 066	<p>Continued From page 7</p> <p>or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the use of approved ashtrays. In accordance with NFPA standards. The deficiency had the potential to affect three (3) of four (4) smoke compartments, twenty-four (24) residents, staff, and visitors. The facility is certified for sixty (60) beds with a census of fifty-two (52) the day of the survey. The facility failed to ensure cigarette butts were being properly placed into approved ashtrays in three areas. This deficiency was cited on the previous survey on 09-18-12.</p> <p>The findings include:</p> <p>Observation, on 08/20/13 between 2:00 PM and 3:10 PM with the Environmental Director, revealed the area at the rear exit had over 30 cigarette butts on the ground around the smoker's</p>	K 066	<p>rear exit, rear smoking area, and kitchen back exit.</p> <p>How the facility will identify other residents having the potential to be affected by the same alleged deficient practice:</p> <p>On 9/18/13, the Administrator toured facility grounds and exits and determined that no other area was affected by cigarette butts being placed in unapproved ashtrays.</p> <p>What measures or systemic changes were made to ensure that the alleged deficient practice will not recur:</p> <p>On 9/13/13, Administrator conducted an in-service for Nursing, Dietary, Housekeeping/Laundry and Supportive Services on NFPA standards to include smoking requirements.</p> <p>How the facility plans to monitor its performance to ensure that solutions for the alleged deficient practice are sustained:</p> <p>The CQI form ES-2 "Review of Facility Exterior" will be completed by Director of Environmental Services weekly x 4, monthly x 3, and then per CQI Calendar to cigarette butts are extinguished in approved devices only.</p> <p>Completion Date:</p>	10/7/13

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NAME OF PROVIDER OR SUPPLIER  HEARTHSTONE PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 506 ALLENSVILLE ROAD ELKTON, KY 42220
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 066	<p>Continued From page 8</p> <p>pole, the rear smoking area had over 40 cigarette butts on the ground, and the kitchen back exit had over 20 cigarette butts on the ground.</p> <p>Interview, on 08/20/13 between 2:00 PM and 3:10 PM with the Environmental Director, revealed she was aware of the cigarette butts and cleans them up often. She stated it is a constant issue at the facility and she does not know how to make it stop from happening.</p> <p>Interview, on 08/20/13 at 3:50 PM with the Administrator, revealed the facility does weekly cleaning of the grounds at the facility. The Environmental Supervisor and the Maintenance Personnel are in charge of monitoring the cigarette butts and ensuring they are cleaned off the grounds. The Administrator revealed she was unaware of the cigarette butts on the ground in the three areas around the facility.</p> <p>Reference: NFPA 101 (2000 edition) 19.7.4 Smoking. Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such areas shall be posted with signs that read NO SMOKING or shall be posted with the International symbol for no smoking. Exception: In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary</p>	K 066		
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NAME OF PROVIDER OR SUPPLIER  HEARTHSTONE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 508 ALLENSVILLE ROAD ELKTON, KY 42220		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 066	Continued From page 9 signs with language that prohibits smoking shall not be required. (2) Smoking by patients classified as not responsible shall be prohibited. Exception: The requirement of 19.7.4(2) shall not apply where the patient is under direct supervision. (3) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.	K 066			
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99, 3.4.4.1.  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain the emergency generator according to NFPA standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments,	K 144	<u>K 144</u>  483.70(f) RESIDENT CALL SYSTEM-ROOMS/TOILET/BATH  The corrective action accomplished to correct the alleged deficient practice:  On 9/16/13, Maintenance installed battery backup lighting at the generator transfer switch.  How the facility will identify other residents having the potential to be affected by the same alleged deficient practice:  On 9/18/13, the Administrator observed the battery backup lighting in the generator room and determined sufficient illumination of the generator transfer switch.		

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NAME OF PROVIDER / SUPPLIER  HEARTHSTONE PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 506 ALLENSVILLE ROAD ELKTON, KY 42220
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 144	<p>Contin ed From page 10 all residents, staff, and visitors. The facility is certified for sixty (60) beds with a census of fifty-two (52) the day of the survey. The facility failed to ensure there was battery backup lighting at the generator transfer switch.</p> <p>The findings include:</p> <p>Observation, on 08/20/13 at 3:29 PM with the Environmental Supervisor, revealed the facility did not have any battery-powered lighting installed in the area where the transfer switch for the emergency generator was located.</p> <p>Interview, on 08/20/13 at 3:29 PM with the Environmental Supervisor, revealed she was not aware of the requirement for the battery backup lighting at the generator transfer switch.</p> <p>Reference: NFPA 110 (1999 Edition).</p> <p>5-3.1 The Level 1 or Level 2 EPS equipment location shall be provided with battery-powered emergency lighting. The emergency lighting charging system and the normal service room lighting shall be supplied from the load side of the transfer switch.</p>	K 144	<p>What measures or systemic changes were made to ensure that the alleged deficient practice will not recur:</p> <p>On 9/13/13, Administrator conducted an in-service for Nursing, Dietary, Housekeeping/Laundry and Supportive Services on NFPA standards to include generator transfer switch lighting requirements.</p> <p>How the facility plans to monitor its performance to ensure that solutions for the alleged deficient practice are sustained:</p> <p>The CQI form ES-3 "Life Safety" will be completed monthly x 3 and then per CQI Calendar thereafter to ensure the facility provides a functioning call system available in resident rooms and toilet and bathing facilities.</p> <p>Completion Date:</p>	10/7/13
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