

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

PRINTED: 02/11/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185277	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 01/29/2015
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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 000 INITIAL COMMENTS

F 241 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY

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.

This REQUIREMENT is not met as evidenced by:  
Based on interview and record review, it was determined the facility failed to promote care for residents in a manner to maintain or enhance each resident's dignity and respect for one (1) of four (4) sampled residents (Resident #2). Resident #2 experienced bowel incontinence on 01/08/15 and 01/09/15 after waiting approximately thirty (30) to forty (40) minutes after a State Registered Nursing Assistant (SRNA) told him/her they would assist after completing rounds.

The findings include:  
Review of Resident #2's medical record revealed the facility admitted the resident on 02/17/11, with diagnoses which included Insomnia, Anxiety Disorder and Depression. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 12/16/14, revealed the facility assessed Resident #2 as being cognitively intact. Further review revealed the facility assessed Resident #2

F 000

F 241

The preparation and execution of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiency. This Plan of Correction is prepared and executed solely because it is required by Federal and State Law.

F 241

Resident #2 was interviewed by the Administrator on 2-14-15 to assure that the resident's call light is being answered timely and that she had no further incident of being told to wait until rounds were completed before her needs could be met. No further incident has occurred and there was no distress expressed by the resident and no harm was

2/17/2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Dana Shaw* TITLE Administrator (X6) DATE 2-18-15

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 241	<p>Continued From page 1</p> <p>as having an indwelling catheter, and as being occasionally incontinent of bowel, and requiring an assist of two (2) with toileting.</p> <p>Interview with Resident #2 on 01/28/15 at 1:15 PM, revealed he/she had to wait thirty (30) to forty (40) minutes for staff to respond to his/her call light on third shift. Resident #2 revealed he/she kept track of time by a clock on his/her wall. Per interview, he/she had diarrhea "once in a while", had to go to the bathroom two (2) to three (3) times per night, and could not "hold" his/her bowels "that long". Resident #2 stated on the nights of 01/08/15 and 01/09/15, he/she had been experiencing diarrhea and rang the call light to go to the bathroom. According to Resident #2, a SRNA responded to the call light, and told the resident she would assist him/her after completion of her rounds. Resident #2 stated the SRNAs had told him/her that "a lot" on night shift. Continued interview revealed when the SRNA finally finished her rounds thirty (30) to forty (40) minutes later, Resident #2 had already had a bowel movement accident. Resident #2 revealed he/she just felt "bad" when staff didn't get to him/her in time and he/she had an accident. Further interview revealed Resident #2 felt "like the nurses or someone should tell them (SRNAs) to come in here".</p> <p>Interview, on 01/29/15 at 9:00 AM, with SRNA #6, who worked the third shift on 01/09/15, revealed she has let Resident #2 know before, she has to do her rounds first if she is the only SRNA on the hall and the staff on the other halls are busy also doing their rounds. Per interview, rounds usually took twenty (20) to thirty (30) minutes depending on the number of residents and their needs. She stated the nurse was usually busy and could not</p>	F 241	<p>F 241</p> <p>Social Service Director will interview all residents with a BIM score of greater than 13 to evaluate if any resident has concerns regarding their call light not being answered timely. Interviews will be completed by 2-26-15. Results of interviews will be shared with the Director of Nursing. The Social Services Director will discuss answering of call lights with the Residents during the next Resident Council Meeting. For the next quarter the Social Service Director will include a question regarding call light response with her quarterly MDS Assessment. Those questions will include; Is your call light answered in a timely manner?; and Are your care needs met in a timely manner?</p>	
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F 241

Continued From page 2

assist with rounds, and Resident #2 required the use of a lift for transfers, therefore she had to wait until someone was available to assist with the transfer. Further interview regarding the facility's expectations on answering call lights, revealed SRNA #6 stated the expectation was to help residents, with the goal to answer the call lights as soon as possible. SRNA #6 stated, however, it was hard to choose who to go to first when multiple residents needed help.

Interview with Registered Nurse (RN) #2 on 01/29/15 at 11:46 AM revealed she worked the night of 01/09/15. RN #2 stated no resident had ever complained to her about call lights not being answered. Per interview, when she was working if the aides were busy she would respond to call lights. RN #2 stated she was instructed to answer call lights as soon as possible, and went on to reveal she had never heard of an aide telling a resident they would have to wait until rounds were completed. Further interview revealed toileting needs would take priority over doing rounds, and if she heard of an aide telling a resident they would have to wait until rounds were done, she would ask that aide to explain themselves.

Interview with Licensed Practical Nurse (LPN) #5 on 01/29/15 at 2:30 PM, revealed she worked the night of 01/08/15. LPN #5 revealed her expectation if an aide was doing rounds and a call light went off, the aide should respond to the call light. Per interview, she had not heard of any situation in which an aide had told a resident they would have to wait until rounds were done before they could answer the call light.

Interview with the Director of Nursing (DON) on

F 241

Charge Nurse and Treatment Nurse will review all skin assessments completed between January 1 and January 30, 2015 to determine if there were any skin issues noted that may be related to residents not being toileted or changed in a timely manner. This review will take place by 2-20-15. Skin assessments will then continue to be completed on a weekly basis by the Treatment Nurse or the Charge Nurse.

SRNA #6 was immediately re-educated by the Director of Nursing regarding the importance of answering call lights and meeting the needs of the residents timely. An in-service will be conducted by the Director of Nursing and the Assistant Director of Nursing on 2-26-15 to re-educate on the importance

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F 241	<p>Continued From page 3</p> <p>01/29/15 at 10:37 AM and at 3:16 PM, revealed she had never heard of a staff member telling a resident they would have to finish rounds before responding to his/her call light. She revealed her expectation would be for the aides to answer call lights unless they were in the middle of providing care to another resident. Per interview, when staff answered call lights they were to ensure the resident's needs were met, and to recognize residents' "urgent needs". She stated going to the bathroom was an "urgent need" for a resident, as they could "only hold it so long". Further interview revealed ensuring a resident who needed to go to the bathroom was taken was a "quality of life, dignity" issue; however, some residents "abused" the call bell at times. The DON stated residents need to maintain as much continence as they could, and it was not acceptable for a resident to wait thirty (30) minutes.</p> <p>Interview with the Administrator on 01/29/15 at 3:41 PM, revealed her expectation was for all staff to respond to call lights as soon as possible, and if they were unable to assist, to get help. The Administrator stated if staff were in the process of doing rounds, she would expect them to stop and attend to the needs of a resident. Further interview revealed she would think a resident would be "angry and disappointed" if they were told they had to wait to have their needs met. Per interview, if staff were making rounds and a call light rang they should attend to the resident who had an "immediate need".</p>	F 241	<p>F 241 Continued</p> <p>of answering call lights timely. New employees will be educated regarding the importance of answering call lights timely upon hire.</p> <p>Call light audits will be conducted by the Unit Coordinators and Quality Assurance Nurse weekly for 3 weeks. Call bell audits are a part of the facility Quality Assurance program and will be audited by the Director of Nursing, Assistant Director of Nursing and Quality Assurance Nurse the first and third quarter of each year. Results of the audits will be reported to the Quality Assurance Committee each quarter they occur by the Director of Nursing.</p>	