

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

PRINTED: 03/15/2013  
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 03/01/2013
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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  A standard survey for recertification and an abbreviated survey to investigate KY#00019818 was initiated on 02/27/13 and concluded on 03/01/13. A Life Safety Code survey was conducted 02/28/13. KY#00019818 was substantiated. The highest scope and severity was a "D"	F 000		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN  The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy it was determined the facility failed to ensure the plan of care was followed for one (1) of nineteen (19) sampled residents (Resident #6). Observations on 02/27/13 and 02/28/13 revealed the Risk for Pressure plan of care for Resident #6 was not followed related to applying heel booties while in bed and having lambs wool on the resident's wheelchair.  The findings include:  Review of the facility's policy titled, "Comprehensive Care Plan", undated, revealed it was the policy of the facility that a comprehensive care plan be developed for every Resident to	F 282	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.  F282  Resident #6 had lambs wool applied to w/c and heel booties were applied while resident was in bed by unit coordinator on 3/1/13.	

RECEIVED  
MAR 22 2013  
BY: \_\_\_\_\_

3-20-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dana Shavitt TITLE: Administrator (X6) DATE: 3-22-13

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 282 Continued From page 1

meet the resident's medical, nursing, and psychological needs. The policy continued on to state, the comprehensive care plan would be developed and maintained for each resident. The purpose of the comprehensive care plan is to identify the professional services responsible for each element of care and to prevent declines in the resident's functional status and/or functional levels.

Record review revealed Resident #6 was admitted to the facility, on 03/09/11, with diagnosis which included Heart Failure, Aortic Valve Disorder, Irritable Bowel Syndrome, Congestive Heart Failure, Hypertension, and Urinary Retention.

Review of the most recent quarterly Minimum Data Set (MDS) Assessment, dated 11/29/12, for Resident #6 revealed a Brief Interview for Mental Status (BIMS) score of fifteen (15) out of fifteen (15), indicating the resident was cognitively intact. Continued review of the MDS revealed the facility assessed Resident #6 as requiring extensive assistance from staff for bed mobility, transfers, locomotion, dressing, toilet use, personal hygiene, and bathing. Under Skin Conditions, the MDS identified Resident #6 as being at risk for pressure ulcer development.

Review of Resident #6's Comprehensive Plan of Care, dated December 2012, revealed he/she was at risk for pressure areas related to requiring assistance for bed mobility. The goal of the plan of care was for Resident #6 to remain free from redness and skin breakdown, with interventions which included to apply lambs wool to left leg of wheelchair, and heel booties to be worn while in

F 282

Audit of 100% of residents done by DON, MDS, and Unit Coordinators to determine if interventions listed on the comprehensive care plan and SRNA care plan were actually in place. These items included but were not limited too heel booties, lambs wool, w/c cushions, and gerl sleeves. Missing items were obtained and applied immediately. This was completed on 3/19/13.

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F 282 : Continued From page 2  
bed.

Observation of Resident #6, on 02/27/13 at 12:03 PM, revealed Resident #6 did not have lambs wool applied to the left leg of his/her wheelchair as stated in the plan of care. Additional observations, on 02/28/13 at 9:25 AM and 1:00 PM, revealed the lambs wool continued to not be in place on the left leg of Resident #6's wheelchair.

Observation of Resident #6, on 02/27/13 at 2:37 PM and 4:10 PM, revealed heel booties were not in place while Resident #6 was in bed. Further observation, on 02/28/13 at 2:35 PM, revealed Resident #6 was in bed, and did not have heel booties in place as instructed in the plan of care.

Interview with State Registered Nursing Assistant (SRNA) #1 who was caring for Resident #6, on 02/28/13 at 2:30 PM, revealed plans of care should be followed. She indicated she was not aware Resident #6 had interventions to have lambs wool on the wheelchair and to have heel booties applied while in bed, even though it was written on the SRNA care plan.

Interview with SRNA #2 who was responsible for Resident #6, on 02/28/13 at 2:40 PM, revealed she normally provided care for Resident #6 two (2) or three (3) days per week. SRNA #2 stated the Nurse Aide Care Plans are a guide to help meet the Resident's needs and should be followed for each resident. She indicated she was not aware Resident #6 had interventions to have lambs wool on the wheelchair and to have heel booties applied while in bed, even though it was written on the SRNA care plan.

F 282

An in service for nurses and SRNAs was completed by the DON beginning on 3/8/13 and ending on 3/18/13 on following care plans daily and the procedure for what to do if an item is not available. This in service will be repeated monthly for three (3) additional months by the DON and then at least every six (6) months thereafter. This information will also be included in the orientation for new nursing staff by the staff development nurse.

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F 282	<p>Continued From page 3</p> <p>Interview, on 02/28/13 at 2:45 PM, with Licensed Practical Nurse (LPN) #1 who provided care to Resident #6 revealed the Nurses updated the comprehensive plans of care as new orders were taken. LPN #1 stated the Nurse Aide Care Plans included interventions that the SRNAs were to implement from the Comprehensive Care Plan. She stated the Nurse Aide Care plans were kept at the Nurse's station for the SRNAs to review. LPN #1 stated it was the responsibility of the Unit Coordinator as well as the Nurses on the units to ensure plans of care were being followed. LPN #1 stated she was unsure if Resident #6 had lambs wool on her wheelchair, but stated it should be in place based on the plan of care. LPN #1 stated she believed Resident #6 had heel booties, but was not sure where they were located. She stated when Resident #6 was in bed, the heel booties should have been applied as stated in the plan of care.</p> <p>Interview with the Pink Unit Coordinator, on 03/01/13 at 1:20 PM, revealed SRNAs were to obtain a copy of the Nurse Aide Care Plan each morning from the nurses's station. The Unit Coordinator stated the SRNAs were to follow the Nurse Aide Care Plan which was based off of the Comprehensive Care Plan, in order to provide appropriate care to resident. She stated rounds were conducted by the Nurses and Unit Coordinators to ensure care plans were followed. However, she was unsure how Resident #6's not following of the care plan had been missed and should have been followed for Resident #6.</p> <p>Interview with the Acting Director of Nursing, on 02/28/13 at 4:00 PM, revealed the Unit</p>	F 282	<p>An audit of 100% of residents will be done weekly for four (4) weeks by the DON, ADON, MDS nurse or Unit Coordinator to determine if interventions listed on the comprehensive care plan and SRNA care plan are actually in place. These items include but are not limited too heel booties, lambs wool, w/c cushtons, and geri sleeves. The audit will then continue biweekly for one month and then monthly as an ongoing practice. Any non compliance will be addressed immediately and reported to the DON. The DON will report audit findings to the committee no less than quarterly for one year.</p>	3-20-13
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F 282 Continued From page 4  
Coordinators and Nurses on each hall were responsible to ensure the care plans were followed. Although, there was no formal auditing tool in place. The Acting Director of Nursing was also unaware how often the audits were conducted to ensure plans of care were followed. The Acting Director of Nursing concluded by stating the heel bootles and lambs wool to wheelchair should have been in place as stated in Resident #6's plan of care.

F 282

F 431 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS

F 431

F431

The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

Unit Coordinators removed all expired items from the medical supply rooms and refrigerators on 3/1/2013.

Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

Unit Coordinators, medical records director and treatment nurse went through all inventory in medical supply rooms, refrigerators, medication and treatment carts. Any expired inventory was disposed of immediately. This was completed by 3/18/2013.

In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the

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F 431	<p>Continued From page 5</p> <p>Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure biologicals used in the facility were labeled in accordance with currently accepted professional principles and expired medical supplies were disposed per manufacturers' specifications.</p> <p>The findings include:</p> <p>Observation of Medial Supply Room D, on 02/27/13 at 10:00 AM, revealed 9 (nine) red top blood draw tubes with expiration date of 01/2013, 1 (one) blue top blood draw tube with expiration date of 09/2011, and 3 (three) purple top blood draw tubes with expiration date of 12/2012. Additional observation of Para Pak Culture &amp; Sensitivity (C &amp; S) Stool transport with the name of a former resident, date obtained of 11/12/11, and expiration date of 12/2011, in same cabinet with current transports. Continued observation revealed 2 (two) red top blood culture bottles with expiration date of 02/02/13 and 2 (two) blue top blood culture bottles with expiration date of 02/05/13. Further observation revealed in a black refrigerator, biological vial used for screening of residents and staff for tuberculosis, opened without a date on the label or box, an influenza</p>	F 431	<p>An in service was done for nursing staff and medical records by the DON beginning on 3/8/13 and completed on 3/18/2013 on checking expiration dates on all inventory, including but not limited too medications, IV fluids, lab supplies, syringes and treatment products This In service will be repeated monthly for three (3) additional months and then at least every six (6) months thereafter. It will also be included in orientation for new nursing staff by the staff development nurse.</p>	3-20-13
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F 431	<p>Continued From page 6</p> <p>vaccine vial dated as being opened on 01/14/13, and Pneumococcal vaccine vial dated as being opened on 11/11/12, with warning label on box not to use 30 (thirty) days after opening. Further observation revealed 3 (three) Sterile Foley Catheter Insertion Trays which were opened.</p> <p>Observation of Medical Supply Room B, on 02/27/13 at 10:40 AM, revealed stock Sodium Chloride IV fluid with expiration date of 05/2012, 3 (three) Specimen Traps with expiration date of 11/2012, 2 (two) green Para Pak Eco Fix with expiration date of 12/2012, and an orange Para Pak C &amp; S with expiration date of 10/2011.</p> <p>Interview with LPN #3, on 02/27/13 at 10:30 AM, revealed expired biological items in Medical Supply Room D should have been discarded. LPN #3 also stated biological vials should be dated when opened and usually discarded after 30 (thirty) days. She further stated the Insertion Trays were no longer sterile since they were opened and should have been discarded.</p> <p>Interview with Blue Unit Coordinator, on 02/28/13 at 12:40 PM, revealed the facility did not draw their own labs and every nurse was aware of dating items and expiration dates and should have discarded expired items and reorder items if necessary. She further stated sterile items which were opened should be discarded if not being used.</p> <p>Interview with Pink Unit Coordinator, on 02/28/13 at 1:00 PM, revealed there was not a set routine to monitor for expired items but she performed perodical checks and expired items must have been overlooked. She further stated all nurses</p>	F 431	<p>Unit Coordinators will audit medical supply rooms, medication and treatment carts weekly for four (4) weeks, then bi weekly for one month and then monthly on an ongoing basis. Findings will be reported to the DON who will report to the committee no less than quarterly for one year.</p>	3/20/13
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F 431	Continued From page 7 should also be looking for expired items and discarding as needed.  Interview with Director of Nursing (DON), on 02/28/13 at 1:20 PM, revealed nursing staff should be monitoring the Medical Supply Rooms for expired items and discarding as necessary. Further, she stated biological vials should be dated when opened and usually expired 30 (thirty) days after opening.	F 431			
F 514 SS=D	483.76(l)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE  The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.  The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.  This REQUIREMENT is not met as evidenced by: Based on record review, interview and review of the facility policy, it was determined the facility failed to ensure clinical records on each Resident were in accordance with accepted professional standards and practices, for one (1) of nineteen (19) sampled Residents. Resident #13's change in code status was not accurately reflected in the medical record.	F 514	F514  Medical Records director removed EMS DNR form from Resident #13's chart on 3/1/2013.  Medical Records director did an audit of 100% of residents' charts to ensure Designation of Resuscitation paper work was complete and accurate and that only residents designated as a DNR had an EMS DNR form in the chart. This audit was completed on 3/4/2013.		3-20-13

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F 514	<p>Continued From page 8</p> <p>The findings include:</p> <p>Interview with the Administrator, on 03/01/13 at 3:35 PM, revealed there was no policies or procedures in place related to ensuring accuracy of Medical Records.</p> <p>Review of the facility policy titled, "Designation of Resuscitation Status" dated 06/01/09, revealed the resuscitation status of all Residents should be documented in his/her medical record on a Designation of Resuscitation Status Form. This form should be completed and placed in the Resident's medical chart. The policy stated the attending physician should be notified of the Resident's designation and acknowledgement of this would be documented in the medical chart. In addition, the policy stated if a Resident was a Do Not Resuscitate (DNR) per the Resuscitation Designation Form, then a Kentucky Emergency Medical Services DNR would be completed and placed in the Resident's chart.</p> <p>Review of the facility policy titled, "Writing A Telephone Order", no date, revealed telephone orders should be documented and noted on the chart. Then, the new order should be faxed to pharmacy.</p> <p>Review of the medical record revealed Resident #13 was admitted to the facility, on 12/07/12, with diagnosis which included Altered Mental Status, Hypothyroidism, Hypertension, Sinus Node Dysfunction, Hyperpolarsemia, Osteoarthritis, and Anxiety.</p>	F 514	<p>An in service was done by the DON beginning on 3/8/2013 and completed by 3/18/2013 for Medical Records director, Admissions Director and nurses on the policy and procedure for the Designation of Resuscitation. This will be repeated monthly for an additional three (3) months and then at least every six (6) months. It will also be included in orientation for new nurses by the staff development nurse.</p>	3-20-13
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F 514	<p>Continued From page 9</p> <p>Review of Resident #13's Monthly Physician's Orders dated 12/07/12-12/31/12, 01/01/13-01/31/13, 02/01/13-02/28/13, and 03/01/13-03/31/13, revealed Resident #13's code status was a Do Not Resuscitate (DNR). At the top of each Monthly Physician's Order form under Advanced Directives, the code status indicated Resident #13 was a DNR. There was no telephone orders or other written Physician's Order indicating a change in code status.</p> <p>Record review under the Advanced Directives section tab revealed, Resident #13's medical chart contained a Kentucky Emergency Medical Services Do Not Resuscitate Order signed 12/07/12 by Resident #13's Power of Attorney (POA). Also, in this section was a Resuscitation Designation Form signed 12/12/12 by Resident #13's POA, indicating Resident #13 was a full code.</p> <p>Record Review of the plan of care for Resident #13, Initiated 12/31/12, revealed he/she was noted to be a full code.</p> <p>Interview, on 03/01/13 at 12:10 PM, with the Unit Manager for the Blue Unit, revealed after looking through the chart she was unable to determine Resident #13's code status. The Unit Manager stated she would have to check with Medical Records and see what Resident #13's code status should be.</p> <p>Interview with Resident #13's POA, on 03/01/13 at 12:20 PM, revealed Resident #13's code status should currently be a full code. The POA reported that she had changed Resident #13's code status from DNR to full code a week after admission.</p>	F 514	<p>Medical Records director will audit 100% of residents' charts weekly for four (4) weeks, bi weekly for a month and then monthly as an on going practice. The DON will audit 100% of resident charts monthly for three (3) months then quarterly and report to the committee no less than quarterly for one year.</p>	3-2013

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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 03/01/2013
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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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(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 514	<p>Continued From page 10</p> <p>Furthermore, she reported this change had occurred after she signed papers with the Admission Director present.</p> <p>Interview with the Admission Director, on 03/01/13 at 12:35 PM, revealed Resident #13's POA had changed Resident #13's code status from a DNR to a full code on 12/12/12. The Admission Director stated the change in code status intlated in her office, when the POA signed a full code status form. After the form was signed, the Admission Director stated she took the Resuscitation Designation form to medical records. Also, she reported a Kentucky Emergency Medical Services Do Not Resuscitate Order is placed in the chart only if the Resident is a DNR.</p> <p>Interview with the Medical Records Director, on 03/01/13 at 12:42 PM, revealed once a code status had been changed, the Admission Director notifies her of this change by delivering a copy of the new Resuscitation Designation form to the Medical Records office. Once Medical Records received a copy of the change, they place a copy of the new Resuscitation Designation form in the active medical chart for the Resident involved. The Medical Records Director was unsure who was responsible for removing the previous code status Resuscitation Designation as well as the Kentucky Emergency Medical Services Do Not Resuscitate Order from the active medical chart. She stated Resident #13's POA changed Resident #13's code status on 12/12/12, the Medical Records Director reported she notified the Unit Coordinator or Nurse caring for Resident #13 of the change in code status. She stated it was the responsibility of the Nurse notified to call</p>	F 514		3-2013
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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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 03/01/2013
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)	(X5) COMPLETION DATE	
F 514	Continued From page 11 the Physician and obtain a telephone order.  Interview with Resident #13's Physician, on 03/01/13 at 12:45 PM, revealed when a code status was changed he was contacted and a telephone order was obtained. Then, when he visited the facility he would signed the new Resuscitation Designation form as well as the telephone order. However, he could not recall whether or not he was called for a telephone order when Resident #13's code status changed. Resident #13's Physician agreed the Monthly Physician's Orders did not accurately reflect the current code status.  Further Interview with the Unit Manager for the Blue Unit, on 03/01/13 at 1:30 PM, revealed when a code status was changed the Admissions office gave the signed form to Medical Records. Then Medical Records informed the Unit Manager or the Nurse caring for the Resident of the change in code status. A copy of the Resuscitation Designation form was placed in the Physician's box to sign. Per the Blue Unit Manager, the Nurse or Unit Coordinator that was notified by Medical Records was responsible for calling the Physician to obtain a telephone order. Then the telephone order was faxed to pharmacy, so the change could be made on the Monthly Physician's Orders by the pharmacy. Also, the Nurse or Unit Coordinator notified of the change by Medical Records was responsible for removing the previous Resuscitation Designation form as well as the Kentucky Emergency Medical Services Do Not Resuscitate Order from the active medical chart. The Unit Manager reported she was working on 12/12/12 when Resident #13's code status changed, but could not recall being notified	F 514		3-2013	

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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		
(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 514	Continued From page 12 of the change.  Interview with Licensed Practical Nurse (LPN) #2, on 03/01/13 at 4:22 PM, who was responsible for Resident #13 on 12/12/12, revealed she could not recall being notified of the change in code status. LPN #2 stated when a code status was changed, the Nurse responsible for the Resident should call the Physician and obtain a telephone order. Then, the telephone order is faxed to pharmacy, so the Monthly Physician's Orders would reflect the change. However, she reported it was the responsibility of Medical Records personnel to remove the previous Resuscitation Designation form from the active medical chart.  Interview with the Acting Director of Nursing and the Administrator, on 03/01/13 at 4:35 PM, revealed the Nurse or Unit Manager notified by Medical Records of a code status change, should obtain a telephone order and fax this order to pharmacy. Further interview revealed the pre-printed Monthly Physician's Orders from pharmacy would reflect this change in code status. The Administrator stated per policy, a Physician's Order was not necessary to change a code status; however, both the Acting Director of Nursing and the Administrator agreed the Monthly Physician's Orders should not have continued to state Resident #13 was a DNR after the change in code status to a full code on 12/12/12. In addition, they stated the Kentucky Emergency Medical Services Do Not Resuscitate Order as well as the previous DNR Resuscitation Designation Form should have been removed from the active medical chart.	F 514		3/20/13	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185277	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  02/28/2013
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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 1985 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 conducted 02/28/2013. The facility was found to be in 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		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dana Shavitt TITLE: Administrator (X6) DATE: 3-22-13

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.