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

PRINTED: 02/05/2015  
FORM APPROVED  
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>185277 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br>01/22/2015 |
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| NAME OF PROVIDER OR SUPPLIER<br><br>HERITAGE HALL HEALTH & REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE<br>331 SOUTH MAIN STREET<br>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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| <p>F 000 INITIAL COMMENTS</p> <p>A Recertification Survey was initiated on 01/19/15 and concluded on 01/22/15, with deficiencies cited at the highest Scope and Severity of an "E".</p> <p>F 323 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>SS=D</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Based on observation, interview and review of the facility's Material Safety Data Sheets (MSDS), it was determined the facility failed to ensure the resident environment remained free of accident hazards, as evidenced by potentially harmful personal care products left unattended and unsecured in residents rooms.</p> <p>The findings include:<br/>Review of the facility's "Wander Resident/Elopement Risk" revealed there were eight (8) residents at risk of wandering and entering other residents' rooms.</p> <p>1. Review of Resident #4's medical record revealed the facility admitted the resident on 02/11/11, with diagnoses which included Depressive Disorder and Senile Dementia with</p> | <p>F 000</p> <p>F 323</p> <p>RECEIVED<br/>1/22/2015</p> <p>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.</p> <p>F 323</p> <p>The materials identified in Resident #4's room, Resident #10's room, and Unsampled Resident A's room were removed or securely stored by staff on 1-22-15.</p> <p>On 1-23-15 all potentially hazardous items such as skin cream or deodorant were removed or securely stored in each resident room by nursing staff members and</p> | <p>F 000</p> <p>F 323</p> | <p>22/15</p> |
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dana Hawitt TITLE: Administrator DATE: 3-20-15

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 323  | Continued From page 1<br>Disturbance of Mood/Behavior. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 12/07/17 revealed the facility assessed Resident #4, as being severely cognitively impaired.<br><br>Observation on 01/19/15 at 12:16 PM, revealed a four (4) ounce (oz) bottle of McKesson Anti-Persian Deodorant Spray on the bedside table.<br><br>Review of the MSDS for the McKesson Anti-Persian Deodorant Spray revealed the product to be an ingestion hazard, requiring medical help or contact with a Poison Control Center immediately if ingested. Per the MSDS, as a precaution the product should be kept out of reach of children.<br><br>Interview with Registered Nurse (RN) #1 on 01/22/15 at 9:15 AM, revealed the McKesson Anti-Persian Deodorant Spray should have been kept in a drawer. Per interview, the danger with the deodorant spray being left out in view was a confused resident could potentially access it and ingest it.<br><br>2. Review of the medical record revealed the facility admitted Resident #10 on 08/15/13, with diagnosis which included Alzheimer's Dementia, Anxiety, Depression and Hearing Loss. Review of the Quarterly MDS Assessment dated 12/20/14, revealed the facility assessed the resident as being severely impaired cognitively.<br><br>Observation on 01/19/15 at 11:00 AM, revealed a container of Magic Butt Cream (a skin protectant cream) on Resident #10's bed side table with a label stating to apply to the Stage II Pressure | F 323  | F 323 Continued<br><br>the Housekeeping Supervisor.<br><br>In-services were initiated on 1-30-15 and were concluded on 2-6-15 by the Director of Nursing and the Assistant Director of Nursing for all nursing staff. The education included proper storage and/or disposal of potentially hazardous items to include but not limited to skin cream and deodorant. This education for nursing staff will be included in new employee orientation and will be repeated quarterly for 1 year and then no less than annually.<br><br>The Housekeeping Supervisor met with each of her staff members 1 on 1 to educate them regarding identifying and proper | 2-27-15              |  |

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| F 323 | <p>Continued From page 2</p> <p>Ulcer on the resident's left buttock and cover with dry dressing BID (twice daily).</p> <p>Review of the MSDS for the Magic Butt Cream revealed the product to be an ingestion hazard, requiring Physician notification immediately. Per the MSDS, the product was also an eye hazard requiring eyes to be flushed with large amounts of water for at least fifteen (15) minutes if contact was made. Continued review of the MSDS revealed if redness or irritation continued to the eyes after coming into contact with the product the Physician should be contacted.</p> <p>Interview with State Registered Nursing Assistant (SRNA) #7 on 01/22/15 at 1:55 PM, revealed she did not apply the Magic Butt Cream on the resident, and did not know why the cream was on the resident's bedside table. Per interview, SRNA #7 was sure if a confused resident opened the cream and ate the cream it would make the resident sick.</p> <p>Interview with Licensed Practical Nurse (LPN) #2 on 01/22/15 at 1:58 PM, revealed the Magic Butt Cream should not be sitting on the bed side table. Continued interview revealed she did not do the resident's treatment, the Treatment Nurse did. She further stated a confused resident might pick the Magic Butt Cream up and eat it, as it looked like cake icing. Per interview, if this happened it could make the resident sick.</p> <p>Interview with the LPN #6/Treatment Nurse, on 01/22/14 at 2:00 PM, revealed she had not completed Resident #10's treatment for the day, but she had completed the treatment on 01/21/14, in the evening. She stated there was not an order for the Magic Butt Cream to be kept</p> | F 323 | <p>F 323 Continued</p> <p>storage of potentially hazardous items. This education concluded on 2-12-15. The Housekeeping staff will assure all items are properly stored and/or disposed of while completing their daily cleaning of each room. The Housekeeping Supervisor will in-service her staff on identifying and storage of hazardous items monthly and upon hire for new employees.</p> <p>To ensure sustained compliance the Charge Nurse will make rounds 2 times per day for 2 weeks and the Unit Coordinators will make rounds once per day for 2 weeks to audit the environment to assure all potentially hazardous items are disposed of /or stored properly and that all items</p> | 2-27-15 |
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| F 323 | <p>Continued From page 3</p> <p>at bedside. Per interview, a confused resident could pick the Magic Butt Cream up and get it in their eyes or eat it. The LPN #6/Treatment Nurse stated she was not sure what the hazards were; however, was sure it would make a resident ingesting the product very sick.</p> <p>3. Review of Unsampld Resident A's medical record revealed the facility admitted the resident on 05/30/13, with diagnosis which included Senille Dementia, Anxiety, Depression and Cerebral Vascular Accident (CVA).</p> <p>Observation on initial tour of the facility on 01/19/15 at 10:15 AM, revealed a container of Magic Butt Cream sitting on Unsampld Resident A's bed side table which had a label stating the cream might be kept at bedside.</p> <p>Interview with LPN #4 on 01/19/15 at 10:15 AM, revealed the Magic Butt Cream should not be sitting out on the table however, and should be kept in the resident's bedside table drawer.</p> <p>Interview with the Director of Nursing (DON) on 01/22/15 at 4:30 PM, revealed all medications, including the Magic Butt Cream, should be kept in a locked cart unless the order stated to apply after each incontinent episode and the medication might be kept at bedside. Per interview, if the medication could be kept at bedside, then it should be kept in the bedside table drawer. The DON stated the expectation was for staff to keep all hazardous materials stored in the proper manner. Further interview revealed if a confused resident accessed the Magic Bull Cream and ate it or got it in their eyes the product would be harmful to the resident.</p> | F 323 | <p>F 323 Continued</p> <p>are labeled with each resident name and stored appropriately. Any noncompliance will be corrected immediately and the Director of Nursing will be notified. After the 2 weeks, rounds will be made weekly by the Charge Nurse or Unit Coordinator. The Housekeeping Supervisor will do an audit each month to assure that potentially hazardous items are <i>2-27-15</i> disposed of or properly stored and that personal items are labeled with each resident name and stored properly.</p> <p>The Director of Nursing will report the findings of the daily, weekly, and monthly rounds/audits to the Safety Committee each month and</p> |  |
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F 323 Continued

to the Quality Assurance  
Committee each quarter.  
These audits will be an  
ongoing practice until the  
Quality Assurance  
Committee deems  
otherwise.

2-27-15

Completion Date 2-26-15

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| <p>F 371</p> <p>F 371</p> <p>SS=D</p> | <p>Continued From page 4</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>The facility must -</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, review of the facility's policy and the Food and Drug Administration's (FDA's) Food Code 2013, it was determined the facility failed to store and distribute food under sanitary conditions for two (2) facility units, as evidenced by observations of the nourishment refrigerators on the Pink and Blue Unit contained unlabeled, undated and expired foods food items.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Food and Non-Food Storage/Refrigerated and Frozen Storage", copywrited 2006, revealed all foods removed from their original containers were to be clearly marked with the contents and dated.</p> <p>Review of the FDA Food Code 2013, revealed food was to be "clearly marked" to indicate the date or day by which the food was to be consumed if prepared on-site. The Food Code noted for commercially processed food the food</p> | <p>F 371</p> <p>F 371</p> | <p>F 371</p> <p>The refrigerator on the Pink Unit was cleaned out by the Housekeeping Supervisor on 1-19-15. The refrigerator on the Blue Unit was cleaned out by the Housekeeping Supervisor on 1-21-15. All undated, unlabeled and expired items were discarded.</p> <p>The refrigerators were checked on 2-13-15 by the Housekeeping Supervisor to ensure that all undated, unlabeled, and expired items were removed.</p> <p>All Dietary personnel were in-serviced on the importance of labeling and dating all food items on 1-26-15 and again on 2-11-15 by the Dietary Manager. This education will be provided to new dietary staff during orientation.</p> | <p>2-27-15</p> |
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| F 371 | <p>Continued From page 5</p> <p>should be "clearly marked" at the time the original container was opened to indicate the date or day by which the food should be consumed or discarded. Continued review revealed the day the original container was opened was to be counted as "day 1" and this date was not to exceed the manufacturer's "use-by date".</p> <p>1. Observation, on 01/19/15 at 11:08 AM, of the nutrition refrigerator on the Pink Unit revealed thirteen (13) Styrofoam cups containing an applesauce-like appearance which were not labeled or dated.</p> <p>Interview, on 01/19/15 at 11:11 AM, with Kentucky Medication Aide (KMA) #2 revealed the Styrofoam cups contained applesauce and were sent to the unit by the kitchen and were usually dated. KMA #2 revealed the cups were not dated and the KMA thought the cups were sent to the unit over the weekend. KMA #2 further revealed it was important to include a date on food items to ensure they were not expired.</p> <p>Interview, on 01/22/15 at 4:15 PM, with Licensed Practical Nurse (LPN) #1/Unit Manager (UM) #1 of the Pink Unit, revealed all items in the nutrition refrigerator were supposed to be labeled and dated. LPN #1/UM revealed she had been made aware the applesauce was not dated and stated the kitchen was responsible to put on the date on the containers. However, she stated if nurses had observed the undated applesauce they should have removed the items from the refrigerator and possible resident use because of safety.</p> <p>2. Observation, on 01/21/15 at 2:10 PM, of the nutrition refrigerator on the Blue Unit revealed:</p> | F 371 | <p>F 371 Continued</p> <p>Compliance regarding labeling and dating food items will be monitored by the Dietary Manager and the Assistant Dietary Manager on a daily basis and on a weekly basis by the Dietician.</p> <p>The Director of Nursing and the Assistant Director of Nursing initiated in-services on 1-30-15 and they were concluded on 2-6-15 for all nursing staff. The education included the importance of labeling and dating any food item. This education will be provided to newly hired nursing staff during orientation.</p> <p>7P to 7A Charge Nurse will inspect refrigerators on each unit daily for 2 weeks. Unit Managers will inspect/audit refrigerators 3 times per week for 2 weeks.</p> | 2-27-15 |
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| F 371 | <p>Continued From page 6</p> <p>two (2) cups of pudding dated 01/13/15; a box of fried chicken and a half-filled container of "Wendy's" chili with no dates or names on them. Further observation revealed a mason jar containing a white milky-like substance.</p> <p>Interview, on 01/21/15 at 2:10 PM with LPN #2/Unit Manager (UM) of the Blue Unit revealed the night shift nurses were responsible for cleaning out the unit refrigerator and removing all expired food items. LPN #2/UM revealed the food items dated 01/13/15 were expired and should have been removed and discarded. LPN #2/UM stated the box with chicken, the chili container, and the mason jar with the white milky-like substance were probably brought in by a resident's family member, however, all the containers should have been labeled with a resident's name and the date.</p> <p>Interview, on 01/22/15 at 1:28 PM, with Registered Nurse (RN) #2 revealed night shift was supposed to monitor food in the nutrition refrigerators. Per interview, food items were supposed to be labeled and dated when fixed and nurses were to make sure food items were not expired. RN #2 revealed if the food items were not labeled/dated staff were unable to determine what the food was, who it belonged to and how long it had been in the refrigerator.</p> <p>Interview, on 01/22/15 at 1:58 PM, with the Assistant Dietary Manager (ADM) revealed nursing monitored the nutrition refrigerators on the units, and informed the kitchen when applesauce was needed. The ADM revealed when the kitchen dipped the applesauce into the cups, they were supposed to date the cups before they sent them out to the units. Per</p> | F 371 | <p>F 371 Continued</p> <p>Thereafter the 7A -7P Charge Nurse will be responsible to check the refrigerators weekly and will remove any undated, unlabeled or expired food.</p> <p>The refrigerators will be audited monthly by the Safety Committee to ensure on going compliance. Results of the audit will be reported to the facility Quality Assurance Committee no less than quarterly.</p> | 2-27-15 |
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F 371 Continued From page 7  
interview, the pudding dated 01/13/15 was expired and was supposed to have been removed; the fried chicken and mason jar should have been labeled/dated; and the half container of chili was not supposed to be stored in the refrigerator.

Interview, on 01/22/15 at 3:38 PM, with the Director of Nursing (DON) revealed night shift nurses and the UMs were responsible for monitoring the nutrition refrigerators and undated food items were supposed to be removed, and replaced as needed. The DON revealed the other food items, the chili, fried chicken, and substance in the mason jar, were supposed to have been labeled with the resident's name and what the food item was, and dated. Per interview, if staff had observed the food items, they were supposed to have removed them due to concerns related to freshness and possible food borne illness.

Interview, on 01/22/14 at 4:04 PM, with the Administrator revealed the food items in the nutrition refrigerators were supposed to be labeled and dated. The Administrator revealed the UMs were responsible for checking the refrigerators and making sure food items were stored correctly. Per interview, the UMs should remove any foods not labeled and/or dated stored in the refrigerators, as there was a potential risk for expired foods served to the residents.

F 411 483.55(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS

The facility must assist residents in obtaining routine and 24-hour emergency dental care.

F 371

F 411

Resident #3 was seen by the OnHealth Care Dentist on 1-15-14 and had her bottom teeth extracted by an oral surgeon per the recommendation of the Dentist. Dental Services have been refused by POA due to no dental concerns. Dental Services will continue to be offered no less than annually.

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F 411 Continued From page 8

A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist.

This REQUIREMENT is not met as evidenced by:

Based on interview and record review, it was determined the facility failed to provide or obtain from an outside resource routine dental services or annual inspection of residents' oral cavities for signs of disease or diagnosis of dental disease for five (5) of nineteen (19) sampled residents (Residents #3, #10, #13, #14, and #16). Record review revealed there was no documented evidence these residents had been seen by a dentist for routine annual dental services.

The findings include:

1. Review of the medical record revealed the facility admitted Resident #3 on 04/14/11, with diagnosis which included Altered Mental Status, Oropharyngeal Dysphagia and Organic Brain Syndrome. Review of the Quarterly MDS Assessment dated 12/11/14, revealed the facility assessed the resident as having severely impaired cognition. Further review of the MDS Assessment revealed the facility assessed Resident #3 to have no oral concerns or mouth or facial pain, or discomfort or difficulty with

F 411

Resident #10 is no longer a resident of this facility.

Resident #13 was seen by the OnHealth Care Dentist on 2-5-15.

Resident #14 has not been seen previously due to POA refusing service. POA has now agreed for resident to be seen by dentist on the next routine visit.

Resident #16 has not been seen previously due to POA refusing service. POA has now agreed for the resident to be seen by dentist on the next routine visit.

Director of Nursing, Assistant Director of Nursing, and Social Services Director, reviewed each resident record by 2-20-15 to ensure past documentation of

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F 411

Continued From page 9  
chewing.

Further review of the medical record, revealed no documented evidence a Resident #13 had been seen by a dentist for routine dental care and services since, and no documented evidence of refusal of dental services in the past year.

2. Review of the medical record revealed the facility admitted Resident #10 on 08/15/13, with diagnosis which include Alzheimer's Dementia, Hypertension (HTN) and Atrial Fibrillation (A-Fib). Review of the Quarterly Minimum Data Set (MDS) Assessment dated 12/20/14, revealed the facility assessed the resident to have severe cognitive impairment. Further review of the MDS Assessment revealed the facility assessed Resident #10 to have no oral concerns or mouth or facial pain, or discomfort or difficulty with chewing.

Further review of the medical record, revealed no documented evidence Resident #10 had been seen by a dentist for routine dental care and services since admission to the facility.

3. Review of the medical record revealed the facility admitted Resident #13 on 09/13/13, with diagnoses which included Diabetes Type II, Depression, Morbid Obesity, Hypertension and Anxiety. Review of the Quarterly MDS Assessment dated 11/19/14, revealed the facility assessed Resident #13 to have no oral health/dental concerns.

Further review of the medical record, revealed no documented evidence a Resident #13 had been seen by a dentist for routine dental care and services since, and no documented evidence of

F 411

F 411 Continued

dental exam in the past year or proof of refusal by resident or family.

Our facility has a dental agreement for dental services and referrals will be made as needed and at least once per year.

MDS Nurses will continue to complete Section L on the MDS, including an annual oral exam, and if appropriate make referrals for dental services to the facility Social Services Director. Social Services Director will follow up with the dental provider to ensure dental consults occur if needed and not less than annually to meet the needs of each resident.

Social Services will audit resident records of all residents referred for dental

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F 411 Continued From page 10 refusal of dental services.

Interview on 01/22/15 at 2:00 PM, with the SSD revealed she had mailed the consent to Resident #13's family to sign, but the resident's family did not return the consent.

Interview on 01/22/15 at 2:20 PM, with the Director of Nursing (DON) revealed she was not sure why Resident #13 had not received dental service. However, it was the SSD responsibility to obtain consent for or denial of dental services.

4. Review of Resident #14's medical record revealed the facility admitted the resident on 01/18/13, with diagnoses which included Osteoarthritis, Alzheimer's Disease, Hypertension, Chronic Facial Neuropathy, Chronic Anxiety State, Gastroesophageal Reflux Disease and Chronic Liver Disorder.

Further review of the medical record, revealed no documented evidence a Resident #14 had been seen by a dentist for routine dental care and services and no documented evidence of refusal of dental services since admission to the facility on 01/18/13.

Interview, on 01/22/15 at 2:20 PM, with the DON revealed there was no record of a dental consultation for Resident #14 since admission.

5. Review of the medical record revealed the facility admitted Resident #16 on 05/07/13, with diagnosis which include Cerebral Vascular Accident (CVA), Hypertension and Dementia. Review of the Quarterly MDS Assessment dated 12/12/14, revealed the facility assessed to be severely cognitively impaired. Continued review

F 411

F 411 Continued

services to ensure the referral was made, family was notified, the visit was completed and the plan was followed up on. Assistant Director of Nursing will audit dental services for all residents once per quarter with the Social Services Director to assure all residents dental needs have been met.

*2/27/15*

The Social Services Director will report the findings of the dental visit audit each quarter to the Quality Assurance Committee. The audits will continue each quarter to ensure sustained compliance.

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| F 411  | <p>Continued From page 11</p> <p>of the MDS revealed the facility assessed Resident #16 to have no oral health/dental concerns.</p> <p>Further review of the medical record, revealed no documented evidence a Resident #16 had been seen by a dentist for routine dental care and services since admission to the facility.</p> <p>Interview with Licensed Practical Nurse (LPN) #3, on 01/22/15 at 9:50 AM, revealed Resident #16 apparently had not been seen by a dentist for annual routine screening as there was no documentation in the medical record to indicate he/she had been seen.</p> <p>Interview with the DON, on 01/21/15 at 9:30 AM and at 2:31 PM and on 01/22/15 at 2:20 PM, revealed residents were given the choice on admission to the facility of whether to have the facility contracted dentist or their own dentist see them for dental care. Per interview, not all residents were seen annually, however, if they needed to see a dentist the facility would arrange for that. Further interview revealed it was the responsibility of the SSD to provide documentation of a consent or of a resident or their family declining dental service.</p> <p>Interview on 01/22/15 at 2:00 PM, with the SSD revealed she was responsible for mailing consents for dental care to residents' families or responsible party for their signature.</p> <p>Interview with the Administrator, on 01/22/15 at 5:00 PM, revealed she wasn't aware of the regulation stating residents were to receive annual oral assessments. Continued interview revealed the facility contracted with "OnHealth</p> | F 411  | <p style="text-align: right;">2-27-15</p>  |

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F 411 Continued From page 12  
Care" for residents dental care needs and services. Further interview revealed the facility did not have a tracking process in place to assure all residents received an annual oral assessment by a dentist.

F 411

F 441

1.

F 441 483.85 INFECTION CONTROL, PREVENT SS=D SPREAD, LINENS

F 441

SRNA #1 was re-educated on hand washing protocols on 1-23-15 by the Director of Nursing.

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.

The Director of Nursing reviewed the 24 hour report and MD orders for the 2 weeks prior to and 2 weeks after the survey to identify any potential negative outcomes related to not washing hands during meal service. None were noted. This was completed on 2-6-15.

(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.

(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.

Nursing staff were in-serviced beginning 1-30-15 through 2-6-15 on hand washing techniques, and protocols including during meal service. This education was presented by the Director of Nursing and the

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| F 441  | Continued From page 13<br>(c) Linens<br>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, record review and review of the facility's policies, it was determined the facility failed to maintain an Infection Control Program designed to provide a sanitary environment and help prevent potential transmission of infection and disease for two (2) of nineteen sampled residents (Resident #2 and Resident #12).<br><br>Observation during a meal service revealed staff failed to wash their hands prior to assisting Resident #2 with his/her meal. Additionally, observation of Resident #12's room revealed personal items, such as, a toothbrush, two (2) bath basins, two (2) bed pans and an emesis basin which were bagged but unlabeled, and the resident had a roommate who shared the bathroom.<br><br>The findings include:<br><br>Review of the facility's policy titled, "Hand Hygiene", revised 11/01/12, revealed the facility used good hand hygiene practices as a means to prevent the spread of infections.<br><br>1. Review of Resident #2's medical record revealed the resident was admitted by the facility on 09/08/10, with diagnoses which included Senile Dementia, Right Sided Hemiparesis and | F 441  | F 441 Continued<br><br>Assistant Director of Nursing.<br>This education will be provided to all newly hired nursing staff during orientation.<br><br>Unit Managers and Charge Nurses will monitor each meal in each dining room daily for 2 weeks then weekly for 2 weeks to observe hand washing technique and frequency. Thereafter the Infection Control Nurse will monitor meal service at least weekly to observe for compliance.<br><br>The Infection Control Nurse will complete a competency review on all SRNA's within the next quarter and annually thereafter to ensure that each SRNA demonstrates competency with hand washing. | 2-27-15              |  |

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F 441 Continued From page 14

Diabetes. Review Resident #2's Comprehensive Care Plan revealed a care plan for the resident to be at risk for nutritional problems, dated 06/21/04, which revealed an intervention of staff assistance as needed to complete meals.

Observation, on 01/20/15 from 8:07 AM to 8:41 AM, of the dining service in the Anderson dining room revealed one (1) State Registered Nursing Assistant (SRNA) present. Continued observation revealed at 8:21 AM and again at 8:36 AM SRNA #1, after placing some residents' meal trays onto a cart, then assisted a resident with consuming part of his/her meal. Further observation revealed SRNA #1 then went to Resident #2 and provided meal assistance without washing her hands between all the tasks.

Interview, on 01/22/15 at 1:22 PM, with SRNA #1 revealed they usually had only one (1) staff person supervise dining in the Anderson dining room after the residents' meal trays were passed. SRNA #1 stated the residents who ate in Anderson were normally able to eat independently, but there were a couple of residents who needed some help at times. Per interview, when there were multiple residents in the dining room, and if she was the only staff present, she was unable to sit down and assist residents. Continued interview revealed as she was the only staff person in the dining room she was only able to offer the two (2) residents observed a few bites at a time. SRNA #1 revealed she had not washed her hands prior to assisting the residents with their meals; however, was supposed to do that because she would not want to spread germs.

Interview, on 01/22/15 at 2:30 PM, with SRNA #3

F 441

F 441 Continued

All newly hired SRNA's will complete this competency within 30 days of hire and annually thereafter.

Results of all meal audits will be provided to the Director of Nursing for review.

Infection Control Nurse will report on SRNA competencies monthly until all are completed. Audits and competencies will be reported to the Quality Assurance Committee by the Director of Nursing no less than quarterly.

2.

Resident #12's toothbrush was labeled on 2-6-15 by the Housekeeping Supervisor. All bed pans, emesis basin and bath basins in Resident #12's room were removed,

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| F 441  | Continued From page 15<br>revealed she worked in the Anderson dining room at times, and they usually had only one (1) aide in there during meals to pick up trays, assist residents who want to leave the table, and assist some residents with meals if needed at times. Per interview, she was not always able to wash her hands after completing other tasks and coming back to assist a resident with his/her meal. SRNA #3 further revealed not washing hands was a potential risk to spread germs and cause illness.<br><br>Interview, on 01/22/15 at 1:28 PM, with Registered Nurse (RN) #2 revealed residents in the Anderson dining room were supposed to eat independently and just needed tray set up, but sometimes a resident had a bad day and might need some meal assistance. Per interview, aides were to wash their hands to make sure they were clean prior to assisting residents with their meal.<br><br>Interview, on 01/22/15 at 4:15 PM, with Licensed Practical Nurse (LPN) #1/Unit Manager (UM) revealed all residents in the Anderson dining room were able to eat independently; however, a couple of residents needed some meal assistance at times. LPN #1/UM revealed because of the potential to spread germs staff were supposed to wash their hands prior to assisting residents with meals.<br><br>Interview, on 01/22/15 at 2:50 PM, with the Infection Control Nurse (ICN) revealed staff were to ensure their hands were washed prior to assisting residents in the dining rooms. The ICN revealed by not washing hands there was the risk of germ transmission and cross contamination and the potential for illness for residents. | F 441  | F 441 Continued<br><br>checked, labeled, and bagged on 2-13-15 by the Housekeeping Supervisor.<br><br>All personal items or supplies belonging to the residents such as toothbrushes, bed pans, emesis basins, and bath basins were clearly marked with their name and properly stored by 2-13-15. This was completed by the Housekeeping Supervisor.<br><br>In-services were initiated 1-30-15 and concluded 2-6-15 to cover infection control procedures and the importance of labeling and storing resident supplies/items appropriately. This education was presented by the Director of Nursing and the Assistant Director of Nursing. All newly hired nursing staff will | 2-27-15              |  |

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| F 441  | <p>Continued From page 16</p> <p>Interview, on 01/22/15 at 3:38 PM, with the Director of Nursing (DON) revealed staff were to wash their hands prior to assisting residents with meals. Per interview, it was an infection control issue because of potential for the spread of germs and infections.</p> <p>Interview, on 01/22/15 at 4:04 PM, with the Administrator revealed if a resident needed meal assistance the aide was supposed to wash their hands prior to assisting the resident. The Administrator further revealed not washing one's hands prior to assisting a resident with his/her meal was an infection control problem.</p> <p>2. Review of Resident #12's medical record revealed the resident was admitted by the facility on 02/12/13, with diagnoses which included Depression and Chronic Heart Disease. Record review revealed Resident #12 resided in room C7 bed one (1).</p> <p>Observation, on 01/21/15 at 10:08 AM revealed Resident #12 was in his/her bathroom brushing his/her teeth with staff's supervision. Further observation of the bathroom in room C7, Resident #12's room, on 01/22/15 at 1:45 PM, with SRNA #6 present revealed there was: an unlabeled toothbrush lying on the bathroom shelf; two (2) unlabeled bed pans; one (1) emesis basin; and (2) unlabeled bath basins in the bathroom.</p> <p>Interview, on 01/22/15 at 1:45 PM, with SRNA #6 revealed Resident #12's toothbrush was on the shelf and was supposed to be labeled. However, she stated staff knew it was Resident #12's toothbrush as he/she always placed it on the shelf. Per interview, the bath pans and bed pans</p> | F 441  | <p>F441 Continued</p> <p>be educated during orientation.</p> <p>To ensure sustained compliance the Charge Nurse will make rounds 2 times per day for 2 weeks and the Unit Coordinator will make rounds once per day for 2 weeks to audit the environment to assure all potentially hazardous items are disposed of or stored properly and that all items are labeled with each resident name and stored appropriately. Any noncompliance will be corrected immediately and the Director of Nursing will be notified. After the 2 weeks, rounds will be made weekly by the Charge Nurse or Unit Coordinator. The Housekeeping Supervisor will do an audit each month to</p> | 2-27-15                                      |

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| NAME OF PROVIDER OR SUPPLIER<br><br>HERITAGE HALL HEALTH & REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE<br>331 SOUTH MAIN STREET<br>LAWRENCEBURG, KY 40342 |
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F 441 Continued From page 17  
were to be labeled with each resident's name, but staff knew which ones belonged to Resident #12.

Interview, on 01/22/15 at 1:50 PM, with LPN #5 revealed all resident supplies were supposed to be labeled and bagged. Per interview, she was unsure why Resident #12's supplies were not labeled and it was an infection control issue for them not to be. LPN #5 revealed she told SRNA #6 all the supplies were to be thrown away and new ones provided for each resident labeled with their name and stored off the floor, as this was an infection control issue.

Interview, on 01/22/15 at 4:30 PM, with the DON revealed resident supplies were to be kept off the floor, bagged and labeled with the resident's name.

F 514 483.75(l)(1) RES  
SS=E 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.

F 441

F 441 Continued  
  
assure that potentially hazardous items are disposed of or are properly stored and that personal items are labeled with each resident name and stored properly.

The Director of Nursing will report the findings of the daily, weekly, and monthly rounds/audits to the Safety Committee each month and to the Quality Assurance Committee each quarter.

These audits will be an ongoing practice until the Quality Assurance Committee deems otherwise.

2-27-15

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:<br><br>185277 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br>01/22/2015 |
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| F 514 | <p>Continued From page 18</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interviews and record review it was determined the facility failed to ensure staff accurately documented residents' bowel movements (BMs) in the medical records for four (4) of nineteen (19) sampled residents (Residents #2, #8, #12 and #13).</p> <p>The findings include:</p> <p>Interview, on 01/22/15 at 4:26 PM, with the Administrator revealed the facility did not have a policy on medical record documentation; however, her expectation was for all residents' medical records to be complete and accurately documented.</p> <p>1. Review of Resident #2's medical record revealed the resident was admitted by the facility on 09/08/10, with diagnoses which included Senile Dementia, Diabetes, Seizure Disorder and Constipation. Review of the Quarterly MDS, dated 10/29/14, revealed the facility assessed Resident #2 as being incontinent of bowel.</p> <p>Review of Resident #2's Monthly Physician orders, for November 2014 and December 2014 revealed the resident was ordered the following routine medications to treat constipation: Bisacodyl (a laxative medication) two (2) 5 mg tablets at bedtime; Colace (a stool softener) 250 mg capsule once daily; Senokot (a laxative medication) two (2) 8.6 mg tablets at bed time; and Bisacodyl two (2) 5 mg tablets PRN for constipation.</p> <p>Review of the November 2014 and December 2014 MARS for Resident #2 revealed the routine</p> | F 514 | <p>F 514</p> <p>Documentation related to resident bowel movements for Resident #2, #8, #12 and #13 was reviewed from 1-1-15 through 1-23-15. Any period of time greater than 3 days was investigated by interviewing nursing assistants, the identified residents, and families of identified residents to determine if the documentation was accurate. Physical assessments were completed on the resident if there was no documented BM for three days prior to 1-23-15. MARS and nurses notes were reviewed for appropriate documentation. No noted negative outcomes were noted related to missing documentation. This was completed by the Director of Nursing on 2-6-15.</p> | 2-27-15 |
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F 514 Continued From page 19

constipation medications Bisacodyl, Colace, and Senokot were given as ordered.

Review of Resident #2's Resident Bowel and Bladder by Shift charting for November 2014 and December 2014 revealed the resident had no documented evidence of BMs from: 11/25/14 through 12/06/14, an eleven (11) day period; and from 12/13/14 through 12/20/14, an eight (8) day period. However, further review of the November 2014 and December 2014 MARs revealed Resident #2 only received one (1) PRN dose of the Bisacodyl two (2) 5 mg tablets ordered for constipation on 12/19/14 at 10:30 AM.

Interview, on 01/22/15 at 4:15 PM, with LPN #1/Unit Manager (UM) revealed she had reviewed Resident #2's BM records and Nurse's Notes for November 2014 and December 2014 and revealed the resident had intervals where no BMs were recorded. Per interview, the Nurse's Notes had no nursing assessments noted of Resident #2's BMs during the periods reviewed, 11/25/14 through 12/06/14, and 12/13/14 through 12/20/14. LPN #1/UM revealed Resident #2 had no negative outcomes related to not having a BM during those timeframe's, and she felt it was really a documentation issue.

Interview, on 01/22/15 at 3:38 PM, with the Director of Nursing (DON) revealed Resident #2 had no negative outcome related to no documented BMs over the periods of time identified. Per interview, she felt like it was a matter of staff not documenting BMs or related assessments accurately.

2. Review of the medical record revealed the facility admitted Resident #8 on 12/02/11, with

F 514

F 514 Continued

Assistant Director of Nursing reviewed documentation related to bowel movements for all residents on 2-11-15 for the past 10 days. Any noted periods of time over 3 days between documented bowel movements were investigated by interviewing nursing assistants, residents, and if necessary resident families. Physical assessments were completed on any resident noted to not have a BM for 3 days prior to 2-11-15.

Licensed Nurses will be re-educated on the facility program for monitoring a resident bowel movements and managing residents with constipation on 2-17-15 and 2-26-15.

*2-27-15*

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| F 514 | <p>Continued From page 20</p> <p>with diagnoses which included Dementia, history of Cerebrovascular Accident (CVA) with Left-Sided Hemiplegia (paralysis of one side of the body), Anxiety, Depression, Bipolar and Diabetes Type II. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 11/30/14, revealed the facility assessed Resident #8 to have a Brief Interview for Mental Status (BIMS) score of fifteen (15) which indicated the resident was cognitively intact.</p> <p>Review of the January 2015 monthly Physician's Orders revealed Resident #8 had Docusate Sodium (a stool softener) 100 milligrams (mgs) one (1) every other day; Bisacodyl suppositories (a laxative medication) 10 mgs one (1) suppository once daily as needed (PRN) for constipation; and Miralax 17 grams (gms) in four (4) to eight (8) ounces (oz) of liquid once daily PRN constipation.</p> <p>Review of Resident #8's Bowel and Bladder by Shift charting revealed no documented evidence the resident had a BM from the dates of 01/10/15, first shift through 01/14/15, first shift, a four (4) day period.</p> <p>However, review of Resident #8's January 2015, Medication Administration Record (MAR) revealed no documented evidence Resident #8 received the PRN bowel medications as ordered for constipation.</p> <p>3. Review of Resident #12's medical record revealed the facility admitted the resident on 02/12/13, with diagnoses which included Hypertension, Depression, Chronic Heart Disease, and a History of Constipation. Review of the Annual MDS, dated 11/10/14, revealed the</p> | F 514 | <p>F 514 Continued</p> <p>This education will include the procedure to check the resident bowel movement by shift report, the use of appropriate laxatives, and the physical assessment of the abdomen. This education was provided by the Director of Nursing and the Assistant Director of Nursing. Newly hired nurses will receive this education during orientation.</p> <p>Nursing Assistants were re-educated on the importance of documenting resident bowel movements in Care Tracker and a reminder to document bowel movements for residents that are continent also. This will be completed on 2-17-15 and 2-26-15 by the Director of Nursing and the Assistant Director of Nursing.</p> | 2-27-15 |
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| F 514 | <p>Continued From page 21</p> <p>resident was assessed as being occasionally incontinent of bowel.</p> <p>Review of Resident #12's October 2014 and December 2014 Monthly Physician Orders revealed the resident had PRN medications ordered to treat constipation: Milk of Magnesia 30 milliliters (ml) once daily, and Bisacodyl 10 mg suppository once daily.</p> <p>Review of Resident #12's Resident Bowel and Bladder by Shift charting for October 2014 and December 2014 revealed Resident #12 had no BMs recorded from: 10/26/14 through 10/30/14, a four (4) day period; and from 12/26/14 through 12/29/14, a three (3) day period.</p> <p>Review of the October 2014 and December 2014 MAR and Nurse's Notes no documented evidence the PRN Milk of Magnesia or Bisacodyl was administered in those months. Review of the Nurse's Notes revealed no documented evidence of assessment of Resident #12's bowels or BMs noted.</p> <p>Continued interview, on 01/22/15 at 2:15 PM and at 3:38 PM, with the DON revealed Resident #12's BMs or related assessments were not accurately documented over the periods of no BM identified on the reports. Per interview, Resident #12 had no negative outcome related to the lack of documented BMs over the periods identified, and she again felt it was a matter of staff not documenting BMs and related assessments accurately.</p> <p>4. Review of the medical record revealed the facility admitted Resident #13 on 09/13/13, with diagnoses which included Diabetes Type II,</p> | F 514 | <p>F 514 Continued</p> <p>Newly hired nursing assistants will be educated on Caretracker documentation during orientation.</p> <p>The Assistant Director of Nursing will be responsible to check that staff nurses are running and following up on the bowel movement report daily for 2 weeks then will check 3 times per week for one month then will check the documentation for <u>2-27-15</u> follow up weekly. The Assistant Director of Nursing will complete a program audit monthly for 3 months then quarterly.</p> <p>The Director of Nursing will report the findings of the audits to the Quality</p> |  |
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F 514 Continued From page 22  
Depression, Morbid Obesity, Hypertension and Anxiety. During an observation of Resident #13 and interview with the resident on 01/22/15, at 11:00 AM, revealed the resident was alert and oriented to person, place, time, and able to answer questions.

Review of the monthly Physician's Orders dated November 2014 and December 2014, revealed Resident #13 had an order for Milk of Magnesia (a laxative medication) 400 mgs once daily PRN for constipation.

Review of Resident #13's Bowel and Bladder by Shift charting revealed no documented evidence the resident had a BM from the dates of 11/26/14, third shift through 12/04/14, third shift, a seven (7) day period.

The Surveyor requested the November 2014 and December 2014 MARs for Resident #13; however staff was unable to provide the MARs for Resident #13.

Interview, on 01/20/15 at 10:00 AM, with State Registered Nursing Assistant (SRNA) #3, revealed SRNA's recorded residents' bowel and bladder results on their report sheet daily, then entered the data in the facility's electronic computer system. Continued interview revealed the nurses pulled the record off the computer system daily and reported if a resident did not have a BM greater than three (3) days.

Interview, on 01/22/15 at 1:25 PM, with Licensed Practical Nurse (LPN) #3, revealed if a resident did not have BMs after six (6) shifts, nurses would complete a bowel assessment, check on the resident in regards to whether he/she needed a

F 514

F 514 Continued  
Assurance Committee no less than quarterly. Quarterly audits by the Assistant Director of Nursing will continue until the Committee deems them to not be necessary. 2-27-15  
Completion Date 2-27-15

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| F 514  | <p>Continued From page 23</p> <p>PRN bowel medication. Continued interview revealed after three (3) days the nurses treated the resident with a PRN bowel medication. Per interview, Resident #13 should have received PRN treatment. She stated not having a BM could have caused the resident to have mental status changes, nausea, vomiting and potential for a bowel obstruction.</p> <p>Interview, on 01/22/15 at 1:28 PM, with Registered Nurse (RN) #2 revealed nurses monitored residents' bowel movements via a report which listed residents who had not had a BM for a three (3) day period or more. Per interview, nurses investigated to determine if a resident had not had a BM, assessed the resident's stomach and bowel sounds to determine if a laxative was needed and documented their findings in the Nurse Notes. The RN further revealed they were unable to go back into the BM report so it was important to document the findings in the Nurse Notes to communicate to other staff.</p> <p>Continued interview, on 01/22/15 at 2:15 PM and at 3:38 PM, with the DON revealed she expected the nurses to document in their notes all potential problems regarding residents. Further interview revealed the nurses were responsible for checking the bowel list and treating all residents who had not had a BM greater than three (3) days. In addition, the DON revealed the worst-case scenario if not treated would be for a resident to be at risk for a bowel obstruction.</p> <p>Interview, on 01/22/15 at 2:30 PM, with the Administrator revealed she expected the nurses to accurately document on the appropriate records. She stated without documented</p> | F 514  |   | 2-21-15                                      |

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| F 514 | Continued From page 24<br>evidence the resident was at risk for a potential bowel obstruction. | F 514 |  | 2-27-15 |
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K 000

INITIAL COMMENTS

CFR: 42 CFR §483.70 (a)

BUILDING: 01

PLAN APPROVAL: 1973 Original Construction Date, 1985 Additlon

SURVEY UNDER: 2000 Existing

FACILITY TYPE: SNF/NF

TYPE OF STRUCTURE: One (1) Story, Type III (000) Unprotected

SMOKE COMPARTMENTS: Five (5) smoke compartments.

COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM

FULLY SPRINKLED, SUPERVISED (Dry SYSTEM)

EMERGENCY POWER: Type II LP Generator.

A Life Safety Code Survey was initiated and concluded on 01/21/15. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility was found not in substantial compliance with the Requirements for Participation for Medicare and Medicaid. The facility is licensed for ninety-four (94) beds and the census was one hundred and three (103) the day of the survey.

K 000:

FEB 14 2015

K 018

The doors identified B8, B9, B11, and E23 will be repaired by 2-24-15.

The Maintenance Director and Maintenance Assistant conducted an inspection of all doors in the building on 2-12-15. Any door that was identified as having a greater than 1/2 an inch gap will be repaired by 2-24-15.

2-26-15

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

TITLE

(X6) DATE

*Dana Gravitt*

Administrator

2-14-15

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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K 000 Continued From page 1  
Deficiencies were cited with the highest deficiency identified at a "D" level.

K 018 NFPA 101 LIFE SAFETY CODE STANDARD  
SS=D  
Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3  
Roller latches are prohibited by CMS regulations in all health care facilities.

This STANDARD is not met as evidenced by:  
Based on observation and interview, it was determined the facility failed to ensure corridor doors were maintained according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect two (2) of six (6) smoke compartments, eight (8) residents, staff and visitors.

The findings include:

K 000  
K 018  
K 018 Continued  
The Regional Maintenance Director visited the facility on 1-28-15 to assist with determining the appropriate measures to resolve the door gap issues. Supplies have been ordered to repair and resolve the gap which is greater than ½ an inch for resident room doors. Door gap issue will be resolved by 2-24-15.  
The Maintenance Director and Maintenance Assistant will continue to inspect all doors each month to assure all doors are in compliance. The inspections of the doors will be monitored monthly by the Regional Maintenance Director as documented in the facility TELS program. 2-26-15

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

PRINTED: 02/05/2015  
FORM APPROVED  
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>185277 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 01 - MAIN BUILDING 01<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br>01/21/2015 |
|--|--|--|--|

|  |  |
|--|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>HERITAGE HALL HEALTH & REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE<br>331 SOUTH MAIN STREET<br>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 |
|--------------------|--|---------------|---|----------------------|
|--------------------|--|---------------|---|----------------------|

K 018: Continued From page 2

Observation, on 01/21/15 at 2:08 PM, with the Maintenance Director, revealed resident room doors B8, B9, and B11 had a gap greater than 1/2 an inch between the top of the resident room door face and the door stop.

Observation on 01/21/2015 at 2:11 PM, with the Maintenance Director, revealed resident room door E23 had a gap greater than 1/2 an inch between the top of the resident room door face and resident room door stop. Interview, with the Maintenance Director, at the time of the observation, revealed maintenance staff checked doors on a monthly basis to ensure resident room doors did not have a gap greater than 1/2 an inch between resident room doors and resident room door stops. Further interview revealed the Maintenance Director, failed to identify the resident room doors having a gap greater than 1/2 an inch due to the Maintenance Director inspecting the top of the resident room doors and door stop areas, and not the resident room door face and resident room door stop.

Reference:

Centers for Medicare and Medicaid Survey and Certification (S&C) Letter 07-18.

K 018:

K 018 Continued

The Maintenance director will report the findings of the door inspections and any repairs completed each month to the Safety Committee and quarterly to the Quality Assurance Committee.

Completion Date 2-26-15

2-26-15