

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

PRINTED: 04/21/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185142	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/17/2014
--	--	--	---

NAME OF PROVIDER OR SUPPLIER HERITAGE MANOR HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 401 INDIANA AVE MAYFIELD, KY 42066
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

{F 000}	<p>INITIAL COMMENTS</p> <p>An on-site Revisit Survey was conducted on 04/16/14 through 04/17/14 and it was determined the facility was back in compliance on 02/24/14, as alleged in the acceptable POC.</p>	{F 000}		
---------	--	---------	--	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
---	-------	-----------

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

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

PRINTED: 01/27/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185142	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2014
NAME OF PROVIDER OR SUPPLIER HERITAGE MANOR HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 401 INDIANA AVE MAYFIELD, KY 42066		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS A Recertification Survey was conducted on 01/08/14 through 01/10/14 to determine the facility's compliance with Federal requirements. The facility failed to meet the minimum requirements for recertification with the highest scope and severity of an "E".	F 000			
F 241 SS=D	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 observation, interview and review of the facility Quality of Life policy, it was determined the facility failed to promote care in a manner that maintained and enhanced a resident's dignity and respect, for three (3) unsampled residents (Resident A, Resident B and Resident C). Licensed Practical Nurse (LPN) #1, entered all three (3) residents' rooms, without knocking, requesting permission, or announcing he/she was going to enter the room. The findings include: Review of the facility's policy on "Quality of Life", dated 04/20/12, revealed staff should ensure care was provided in a manner and in an environment that maintained or enhanced each resident's respect, in full recognition of his or her individuality. Dignity was defined as activities carried out, during the staff's interaction with	F 241	All residents are at risk if the facility fails to promote care in a manner that maintains and enhances dignity and respect. LPN #1 was given a performance improvement form by the Director of Nursing on 01/10/14, and education was provided to staff members during a scheduled in service on 01/16/14 by the facility Administrator regarding facility Quality of Life policy promoting dignity and respect. The facility Angel Care program participants interviewed residents the week of 01/13 - 01/17 and asked whether staff members knock before entering the resident rooms. The Resident Council was interviewed on 01/27/14 by the Activity Assistant as well, with no noted concerns. Staff members are educated upon hiring and as needed. Administrator and / or DNS (Director of Nursing Services) will observe for adherence to Quality of Life policy during daily rounds and follow up in QA/PI monthly for 3 months, and as needed thereafter.	02/24/14	



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

TITLE

(X6) DATE

Executive Director

02/12/14

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.

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

PRINTED: 01/27/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185142	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2014
NAME OF PROVIDER OR SUPPLIER HERITAGE MANOR HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 401 INDIANA AVE MAYFIELD, KY 42066		
(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 241	Continued From page 1 residents, that assisted the resident to maintain and enhanced his/her self esteem and self worth. The resident's private space and property were to be treated with respect, per example, asking permission to move or inspect personal clothing and knocking on the door, before entering the room and requesting permission to enter. Observation of a medication pass, on 01/09/14 from 9:00 AM until 9:45 AM, revealed LPN #1 entered three (3) residents' rooms, Resident's A, Resident B and Resident C, without knocking or requesting permission to enter. Interview with LPN #1, on 01/09/14 at 9:45 AM, revealed the reason she had knocked on the door or requested permission to ensure was because of "having her hands full." Interview with the Director of Nursing (DON), on 01/10/14 at 9:45 AM, revealed the DON would have expected the LPN to knock, prior to entering the resident's room. Interview with the Administrator, on 01/10/14 at 11:40 AM, revealed she would have expected the staff to follow the facility policy to knock on the resident's door and wait for acknowledgement from the resident, prior to entering.	F 241			
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371			

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

PRINTED: 01/27/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185142	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2014
NAME OF PROVIDER OR SUPPLIER HERITAGE MANOR HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 401 INDIANA AVE MAYFIELD, KY 42066		
(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 371	<p>Continued From page 2</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the Food and Supply Storage policy, it was determined the facility failed to store food under sanitary conditions. Observations of the kitchen, revealed undated food items stored in the freezer and refrigerator.</p> <p>Review of the facility's census and condition, dated 01/08/14, revealed there were eighty-three (83) residents in the facility and five (5) of those residents were tube feeders and did not eat food from the kitchen area.</p> <p>The findings include:</p> <p>Review of the facility "Food and Supply Storage" Policy, dated 08/31/12, revealed food products that were opened and not completely used, or prepared at the facility and stored, should have been labeled as to the contents and use by dates.</p> <p>Observation of freezers and refrigerators, on 01/08/14 at 12:10 PM, revealed: six (6) undated, gallon bags of scrambled egg mix; four (4) heads of lettuce, with a use by date of 12/14/13; a large, undated and frozen turkey; a five (5) pound container of Cottage Cheese with an expiration date of 12/28/13; and a large, undated bag of sliced zucchini.</p> <p>Interview with the Dietary Manager, on 01/08/13 at 12:25 PM, revealed she was the one who</p>	F 371	<p>All residents that are on a po diet are at risk when foods are not stored under sanitary conditions. An audit was performed on 01/08/14 by the Registered Dietitian (RD), and the Food Service Manager (FSM). All items were labeled and dated. Education was provided to Dietary staff regarding facility policy for labeling and dating food items.</p> <p>The FSM will conduct rounds 5 times weekly to ensure that foods are properly dated and labeled, and will report findings to the Administrator. The Administrator will conduct weekly rounds to ensure that items are labeled and dated. The RD will conduct weekly audits for one month, and monthly audits thereafter. The QA/PI committee will review monthly for three (3) months to ensure compliance.</p>	02/24/14

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

PRINTED: 01/27/2014
FORM APPROVED
OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185142	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2014
NAME OF PROVIDER OR SUPPLIER HERITAGE MANOR HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 401 INDIANA AVE MAYFIELD, KY 42066		
(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 371	Continued From page 3 checked the freezers and refrigerators weekly for outdated items and was not aware of the undated food items were in the refrigerators and freezers. She also stated she made daily rounds every morning and checked for outdated products but did not see these items, that morning Interview with the Administrator, on 01/10/14 at 11:40 AM, revealed she would have expected the kitchen staff to have marked and monitored the product use by dates and to have thrown away all outdated food items.	F 371			
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS 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. 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. 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,	F 431			

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

PRINTED: 01/27/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185142	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2014
NAME OF PROVIDER OR SUPPLIER HERITAGE MANOR HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 401 INDIANA AVE MAYFIELD, KY 42066		
(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 431	Continued From page 4 permanently affixed compartments for storage of controlled drugs listed in Schedule II of the 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. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to properly store narcotics, ready for disposal, under double locks. The discharged residents' controlled medications were stored in a locked cabinet, in the locked Medication Room. However, the cabinet was filled with packaged narcotics, above the mail slot and narcotics were easily obtained, through the mail slot, without unlocking the cabinet. The findings include: Interview with the Director of Nurses (DON,) on 01/10/14 at 9:45 AM, revealed there there was no policy on the storage or disposal of discharged resident's medications, but the facility procedure was that once a resident expired or was discharged from the facility, the narcotic count sheet would of been placed around the packages of narcotics and rubber banded, and placed in the large, locked narcotic bin, through the mail slot. The DON stated when the locked bin "started getting full", the narcotics were to have been destroyed, by the DON and a licensed staff member, by crushing the narcotics, placing the crushed medications in the sharps container,	F 431	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i> A narcotic destruction was initiated by the Director of Nursing Services (DNS) on 01/10/14 to ensure that contents could not be reached through the open slot in the destruction box. The remaining medications in the narcotic box with the open slot were destroyed by the DNS according to procedure on 01/10/14. The narcotic box was relocated to the DNS office on 01/09/14. Discontinued narcotics will be held on the Medication Cart in a locked narcotic box until they can be removed by DNS and Charge Nurse. Education to licensed nurses was provided by the DNS on 01/13/14. Narcotics ready for destruction will be stored in the DNS office in the closed cabinet under a double lock. Narcotics will be destroyed monthly and as needed by 2 RN's and destruction logs will be maintained by DNS. QA/PI will review destruction logs monthly for 3 months, or until QA/PI determines issue corrected.	02/24/14	

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

PRINTED: 01/27/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186142	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2014
NAME OF PROVIDER OR SUPPLIER HERITAGE MANOR HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 401 INDIANA AVE MAYFIELD, KY 42066		
(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 431	Continued From page 5 adding coffee grounds or cat litter and red-bagging the container for disposal. Observation of the Medication Room, on 01/10/14 at 9:30 AM, with the DON, revealed a locked narcotic cabinet, approximately four (4) foot tall, by two (2) foot wide and two (2) foot deep, with a mail slot, for placement of the narcotics, until disposal. Narcotics were stacked in the container, until they were above the level of the opened mail slot and 22 tablets of Tramadol (pain narcotic) 50 milligrams, were easily accessible from the container, without having to unlock the cabinet. Interview with Director of Nursing (DON), on 01/10/14 at 9:45 AM, revealed the DON would have expected the licensed staff to have alerted her as to the locked narcotic bin being full, as she did not go back to the Medication Room very often and had not been made aware the bin was full.	F 431			
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS 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. (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	F 441			

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

PRINTED: 01/27/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185142	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/10/2014
NAME OF PROVIDER OR SUPPLIER HERITAGE MANOR HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 401 INDIANA AVE MAYFIELD, KY 42066	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 6 (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. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's Blood Glucose Monitoring Using a Glucometer policy/procedure, it was determined the facility failed to properly clean the glucometer which was used to take blood samples and determine the blood sugar level for four (4) out of twenty-nine (29) diabetic residents. The findings include: Review of the facility's policy for "Blood Glucose Monitoring Using a Glucometer," dated 09/12/12, revealed after the nurse performed the	F 441	<i>This Plan of Correction is the center's credible allegation of compliance</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i> LPN#2 and RN #1 were provided education on glucometer cleaning by the Director of Nursing (DNS) on 01/09/14. Residents who receive blood glucose monitoring were assessed 01/09/14 through 01/13/14 by Licensed Nurses for signs and /or symptoms of infection or an adverse reaction. None were noted. A baseline audit of licensed nurse educational records for evidence of completion of blood glucose monitor cleaning and competencies related to blood glucose monitor cleaning was completed by the DNS and Staff Development Coordinator (SDC) on 01/09/14. Education with license nursing on glucometer cleaning was completed on 01/13/14 by DNS and SDC. Any newly hired licensed nurses will receive the education during general orientation before working on the floor. Random blood glucose monitor cleaning observation of 3 licensed nurses (one per shift) will be conducted weekly for 4 weeks by the DNS/ SDC and Unit Managers, and then monthly or as recommended by the QA/PI committee until compliance is sustained.	02/24/14

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

PRINTED: 01/27/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185142	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2014
NAME OF PROVIDER OR SUPPLIER HERITAGE MANOR HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 401 INDIANA AVE MAYFIELD, KY 42066		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	<p>Continued From page 7</p> <p>glucometer testing, he/she should have removed the test strip from the glucometer and disposed of the strip, cleaned the glucometer, with a 10 percent (%) bleach solution moistened wipe, between each resident, allowing a one (1) minute contact time for the bleach wipe solution and then the nurse should have wiped away any residual bleach solution off the glucometer.</p> <p>Observation of a medication pass with Licensed Practical Nurse (LPN) #2, on 01/09/14 at 3:55 PM, revealed the nurse to administer glucometer testing to three (3) diabetic residents, without cleaning the glucometer between residents.</p> <p>Interview with LPN #2, on 01/09/14 at 4:25 PM, revealed she was unsure of the facility policy and stated the nurses were to wipe the glucometer down "but there was no set time to do this" and stated she used alcohol wipes, yet stated there was some "other stuff in the soiled utility room the could also use." She stated there were no bleach wipes on the medication cart.</p> <p>Observation of a medication pass with Registered Nurse (RN) #1, on 01/09/14 at 4:20 PM, revealed the RN to clean the glucometer with an alcohol pad in between two resident's glucometer testing.</p> <p>Interview with the RN #1, on 01/09/14 at 4:26 PM, revealed she was aware the glucometer should be wiped down in between each resident's finger stick, and stated she used alcohol but usually there were bleach wipes on the cart, but was unsure why they were not on the cart.</p> <p>Interview with RN #2, on 01/09/14 at 4:40 PM, revealed the facility policy was to use the bleach wipe and stated these were in the Medication</p>	F 441			

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

PRINTED: 01/27/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185142	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/10/2014
NAME OF PROVIDER OR SUPPLIER HERITAGE MANOR HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 401 INDIANA AVE MAYFIELD, KY 42066	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE
F 441	<p>Continued From page 8</p> <p>Room, yet were covered up by other products and the staff thought they were out of the wipes. The bleach wipes were normally kept on the Medication Carts, but the carts were recently cleaned and the wipes were not replaced. The staff were aware, if the bleach wipes were not available, they were to report this to the unit managers.</p> <p>Interview with the Director of Nursing (DON,) on 01/10/14 at 9:50 AM, revealed the licensed staff were aware of the need to clean the glucometer's between each resident with bleach wipes and they had been inserviced on this policy. The DON stated she would have expected them to follow the facility policy.</p> <p>Interview with the Administrator, on 01/10/14 at 11:40 AM, revealed the licensed staff were inserviced on the facility policy, in orientation and periodically and would have expected the staff members to have followed the policy.</p>	F 441	

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

PRINTED: 01/13/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185142	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 01/08/2014
NAME OF PROVIDER OR SUPPLIER HERITAGE MANOR HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 401 INDIANA AVE MAYFIELD, KY 42066	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1971</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (211)</p> <p>SMOKE COMPARTMENTS: Twelve (12) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system with (57) smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic wet sprinkler system.</p> <p>GENERATOR: Type II generator. Fuel source is natural gas.</p> <p>A standard Life Safety Code survey was conducted on 01/08/14. Heritage Manor Health Care Center was found to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for one hundred (100) beds and the census was eighty-three (83) on the day of the survey.</p> <p>The findings that follow demonstrate compliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)</p>	K 000		

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

TITLE

(X6) DATE

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