

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

PRINTED: 01/03/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185277</b>	{X2} MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	{X3} DATE SURVEY COMPLETED  <b>R</b> <b>01/03/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>HERITAGE HALL HEALTH &amp; REHABILITATION CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>331 SOUTH MAIN STREET LAWRENCEBURG, KY 40342</b>
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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 000}

INITIAL COMMENTS

{F 000}

An offsite revisit was conducted and based on the acceptable POC the facility was deemed to be in compliance as alleged on 12/28/13.

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: 12/19/2013  
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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  12/05/2013
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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 Recertification Survey was initiated on 12/03/13 and concluded on 12/05/13 with deficiencies cited at the highest scope and severity of "D".	F 000	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 laws.	
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE  The facility must ensure that it is free of medication error rates of five percent or greater.	F 332		
	This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to maintain an error rate of less than five (5) percent during a medication pass observation. Observation of the medication pass revealed two (2) errors out of thirty (30) opportunities observed which resulted in a 6.66% medication error rate.  The findings include:  Review of Resident #9's record revealed a Physician's Order dated 11/01/13, for Neurontin (a drug used to control seizures and to treat neuropathic pain) one hundred (100) milligram (mg) capsule, take two (2) capsules by mouth twice daily. Further review of a Physician Phone Order dated 11/29/13, revealed an order for Mucinex (a drug used for thinning mucus from the chest when you have congestion from a cold or flu) six hundred (600) mg two (2) times a day for seven (7) days.  Observation of a medication pass on 12/04/13 at	F332		Resident #9 medication errors were immediately resolved by LPN #1 giving omitted medications after errors identified. Medication Pass process reviewed with LPN#1 on 12/23/2013. Unit Coordinator and/or DON will complete a medication pass audit with 5 nurses on both units on 12/26/2013 and 12/27/2013 to identify any other potential deficient practices that are occurring. A mandatory in service of all nurses regarding medication pass process was completed on 12/23/2013, 12/26/2013 and 12/27/2013 and will be repeated for nurses and CMTs again in 6 months.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  
*Deborah C. King RN DON* TITLE *DON* (X6) DATE *12/27/13*

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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 332	<p>Continued From page 1</p> <p>9:00 AM, revealed Licensed Practical Nurse (LPN) #1 to administer only one (1), not the Physician ordered two (2), Neurontin 100 mg capsule to Resident #9. Continued observation revealed LPN #1 revealed Resident #9's Mucinex 600 mg was not administered as ordered.</p> <p>Interview with LPN #1 on 12/04/13 at 9:15 AM, revealed she had only administered Resident #9 one (1) Neurontin capsule; however, should have given two (2) as ordered. She stated additionally she had not administered the patient's Mucinex. LPN #1 stated the medication pass process is to check the Medication Administration Record (MAR), pull the medication, recheck the medication packet against the MAR before it was opened and again before it was signed off. LPN #1 further stated she should have followed this process and if she had she would not have made the medication errors.</p> <p>Interview with the Director of Nursing (DON) on 12/05/13 at 3:00 PM, revealed the staff were to use a three (3) part check system when administering medications. First staff were to check the MAR, pull the medication from the medication cart; then check the medication packet against the MAR before opening the medication packet, looking for the name of medication, the dose and the time the medication was to be given; finally the medication packet was to be rechecked against the MAR as the medication was being signed out. She indicated LPN #1 should have followed this process to prevent medication errors.</p>	F 332	<p>F332 continued</p> <p>Unit coordinators will audit 5 nurses on med pass weekly beginning 12/30/2013 for 4 weeks and then 5 monthly for 6 months and then 5 quarterly for 1 year to ensure sustained compliance with med pass process. The Pharmacy consultant will also one nurse medication pass monthly beginning January for one year. The QA nurse will monitor the weekly and monthly audits of medication pass observations and report to QA quarterly for at least 1 year.</p>		

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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 12/04/13. 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 two (102) the day of the survey.</p>	K 000		
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE

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DEC 27 2013

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

*Radina Atkins RN DMW*

TITLE

*DMW*

(X6) DATE

*12/27/13*

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