

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

PRINTED: 07/30/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185277	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 07/16/2014
NAME OF PROVIDER OR SUPPLIER  HERITAGE HALL HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 331 SOUTH MAIN STREET LAWRENCEBURG, KY 40342	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS  An Abbreviated Survey investigating KY#00021929 was initiated on 07/14/14 and concluded on 07/16/14. KY#00021929 was unsubstantiated with an unrelated deficiency cited at a scope and severity of a "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 514 SS=D	483.75(f)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE  The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.  The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.  This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's Clinical Practice Guideline, it was determined the facility failed to maintain clinical records on each resident in accordance with accepted professional standards and practices that are accurate, complete and organized clinical information about each resident that is readily accessible for resident care for one (1) out of six (6) sampled residents (Resident #1). Record review revealed Resident #1 received a	F 514          F514	Chart/MAR/TAR audit of resident #1 completed 7/16/2014 by DON to assess for completion of documentation. No harm found to resident. Re-education provided to Nurse#1. Unit Coordinators to complete 100% MAR/TAR and physician's orders audit to ensure all orders were followed and documented appropriately to be completed by 8/31/2014.	9/1/2014

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AUG 18 2014

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AUG - 8 2014  
BY:

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

*Daniel Gravitt*

TITLE

*Administrator*

(X6) DATE

*8-8-14*

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.

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F 514	Continued From page 1 respiratory treatment on 07/04/14; however, review of the Medication Administration Record (MAR) the documentation was incomplete, without all the required information.  The findings include:  Review of facility's Clinical Practice Guideline, titled "Delivery of Aerosols to the Upper Airway", undated, revealed documentation guidelines which included date, time, type, and length of treatment. Also included in documentation guidelines were record breath sounds before and after, effectiveness of the treatment, and signature and title of person administering the treatment.  Review of the clinical record for Resident #1 revealed the facility admitted Resident #1 originally on 05/09/07 with diagnoses which included Hypoglycemia, Chronic Obstructive Pulmonary Disease, Chronic Renal Disease, Dementia, Depression, Pneumonia, and Septicemia.  Review of Resident #1's medical record revealed a Physician's Orders, dated 07/01/14, to administer Ipratropium/Albuterol Neb treatment (The combination of Albuterol and Ipratropium comes as a solution to inhale by mouth using a nebulizer machine which turns the medication in a mist that can be inhaled to relax and open the air passages to the lungs to make breathing easier.) to be given every four (4) hours as needed. Further review of the Physician's orders revealed instructions to record the number of minutes spent with the patient (resident) each treatment, including set up, administration, and monitoring. Additional instructions included heart	F514 cont.	Incomplete documentation found will be immediately addressed with appropriate nurse/CMT with appropriate re-education and disciplinary action. This audit will continue to be done weekly by unit coordinators to ensure complete and accurate records. The findings will be presented to QA committee quarterly  DON/ADON to in service all nurses/CMT regarding completion of medication/treatment/nebulizer documentation by 8/15/2015 and every 3 months for 6 months.	9/1/2014

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F 514	Continued From page 2 rate before and after, respirations, lung sounds before and after, skin color, presence of cough/sputum, and oxygen saturation level.  Further record review revealed a Nursing Note, dated 07/04/14 at 6:55 PM, written by Licensed Practical Nurse (LPN) #1 which documented Resident #1 received a PRN (as needed) "neb treatment" (Nebulizers are used to administer medicines for treating respiratory diseases like Asthma, Cystic Fibrosis, and Chronic Obstructive Pulmonary Disease.) administered by LPN #1.  Review of Resident #1's MAR, dated July, 2014 revealed no documentation of Ipratropium/Albuterol Nebulizer treatment being given on 07/04/14 and no documented evidence the heart rate was monitored before and after, respirations, lung sounds before and after, skin color, record of number of minutes spent with patient (resident), cough/sputum, oxygen saturation, as well as no signature/initials of person administering the medications.  Interview with LPN #1, on 07/15/14 at 3:40 PM, revealed she did listen to Resident #1's lungs before and after giving the nebulizer treatment on 07/04/14 but did not document the assessments. LPN #1 stated she should have documented the information in order to review what the lungs sounds, as well as the other vital signs requested, to be able to provide a history. LPN #1 further stated all nurses should be documenting requested assessments during a PRN nebulizer treatment.  Interview with the Director of Nursing (DON), on 07/16/14 at 2:20 PM, revealed she would expect all nurses to assess the resident before and after	F 514			

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F 514	Continued From page 3 a nebulizer treatment. The DON stated the assessment was a guideline, not a policy that nurses should follow. The DON further stated the Medication Record should have been filled out without any blanks and should include the required assessments.  Interview with the Administrator, on 07/16/14 at 3:15 PM, revealed her expectation of her staff would be to accurately complete the Medication Administration Record with required information.	F 514		