

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

PRINTED: 08/14/2014  
FORM APPROVED  
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185400	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  07/31/2014
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NAME OF PROVIDER OR SUPPLIER  HEARTHSTONE PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 506 ALLENSVILLE ROAD ELKTON, KY 42220
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F 000	INITIAL COMMENTS  A Recertification Survey was conducted on 07/29/14 through 07/31/14 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 being a "F".	F 000		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  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.  This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the resident environment remains as free of accident hazards as is possible when an unlocked crash cart, containing syringes and intravenous (IV) access supplies, was stored on the hallway between the 200 and 300 Wings.  The findings include:  Interview with the Administrator, 07/31/14 at 2:55 PM, revealed there was no specific policy regarding the locking of the crash cart.  Observation of the Medication Room and general environment on 07/31/14 at 12:55 PM, revealed the unlocked crash cart in the 200 and 300 Hall	F 323	F 323  483.25(h) Free of Accident Hazards/Supervision/Devices (Crash Cart)  The corrective actions accomplished for those residents affected by the deficient practice were: * The crash cart was moved into a secure area away from residents access 7/30/14 by the DON. *A lock bar with break away zip ties was installed on the crash cart 7/30/24 by the DON.  The facility will identify other residents having the potential to be affected by the same deficient practice by: *All residents had the potential to be affected by the deficient practice.  The measures put into place to ensure that the deficient practice does not recur were: *The DON educated/in-serviced licensed staff on the safety issues related to ensuring the crash cart stays locked at all times 8/1/14—8/2014. * The Crash Cart Check Sheet was revised 8/5/14 by Administrator to include the question: "Is the Crash Cart locked."	8/22/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Isana Miller TITLE: Interim Administrator (X6) DATE: 8/22/14

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 323	Continued From page 1 offset, not in the line of vision from the nursing desk and no staff nearby.  Interview with Ward Clerk #1, on 07/31/14 at 1:25 PM, revealed the clerk was responsible to assess the crash cart on a weekly basis to ensure all contents of the cart were available and not expired. If anything was missing, it was the Ward Clerks job to alert the charge nurse. There were syringes and IV supplies available, in the top drawer of the cart and she stated there could have also been choking hazards with some of the supplies and she had worked there five (5) months and the cart had never been locked.  Interview with the Director of Nursing (DON), on 07/31/14 at 12:55 PM, revealed he had been at the facility approximately one (1) year and the cart had never been locked and stated there were no medications in the cart, only an Ambo Bag, blood pressure kit and syringes, however, he stated there were some wanderers in the building and this could pose a hazard.	F 323	The facility plans to monitor its performance to ensure the solutions are sustained by: * Quality Assurance form N-21 titled, "Nursing Safety Inspections" will be completed weekly for 2 weeks, then monthly for 2 months, then quarterly by DON.	
F 441 SS=D	Interview with the Administrator, on 07/31/14 at 2:55 PM, revealed this cart would be secured. 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 -	F 441	F 441 483.65 Infection Control, Prevent Spread, Linens (Incontinent care)  The corrective actions accomplished for those residents affected by the deficient practice were: *CNA #1 & CNA #2 were in-serviced 8/1/14 by DON on the current Infection Control and Incontinence Care policies to include changing gloves, hand washing and proper disposal of peri care items.	8/22/14

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F 441	<p>Continued From page 2</p> <p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(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.</p> <p>(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.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility policies, it was determined the facility failed to ensure proper incontinent care and appropriate hand washing and gloving technique during the performance of perineal (incontinence) care for one (1) of thirteen (13) sampled residents (Resident #8).</p> <p>The findings include:</p>	F 441	<p>The facility will identify other residents having the potential to be affected by the same deficient practice by:</p> <p>*All full time, part time and PRN CNA's were in-serviced in person or by phone 8/1/14—8/20/14 on the current Infection Control and Incontinence Care policies to include changing gloves, hand washing and proper disposal of peri care items. by the DON.</p> <p>The measures put into place to ensure that the deficient practice does not recur were:</p> <p>*The DON revised the Nursing Assistance Competency Evaluation 8/12/14 to include more in-depth information on hand washing, peri care, changing gloves and using hand sanitizer. The evaluation is completed annually along with each CNA's annual review by the DON or ADON.</p> <p>*Quality Assurance form IC-1 titled, "Infection Control Program" was revised 8/12/14 by Administrator to include, "Incontinence Care" under the observation section.</p> <p>The facility plans to monitor its performance to ensure the solutions are sustained by:</p> <p>*Quality Assurance form IC-1 titled, "Infection Control Program." will be completed monthly for 2 months, then quarterly by DON.</p>		

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F 441	Continued From page 3  Review of the facility's Gloves policy, last revised August 2001, revealed employees should be trained on glove use prior to completing tasks involving blood or body fluids and gloves must be worn once and discarded when handling blood or body fluids.  Review of the Handwashing policy, revised August 2001, revealed hands should be washed after touching blood or body fluids and before touching any resident again and the use of gloves should not replace handwashing.  Record review revealed the facility admitted Resident #8 on 10/23/13 with diagnoses which included Dementia and Delusional Disorder. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 07/08/14, revealed the facility assessed Resident #8's cognition as severely impaired with a Brief Interview for Mental Status (BIMS) score of "2" indicating the resident was not interviewable.  Review of the Physician's Order revealed Resident #8 was prescribed Cipro 500 milligrams (mg) twice daily for seven (7) days from 06/26/14 through 07/02/14 for a diagnosis of Urinary Tract Infection (UTI).  Observation, on 07/30/14 at 12:45 PM, revealed Certified Nurse Aide (CNA) #1 and CNA#2 were observed to ambulate Resident #8 to the bathroom. CNA #1 was observed to remove the soiled incontinence brief and cleanse Resident #8's rectal area; however, the CNA failed to cleanse the resident's perineal area. CNA #1 handed the soiled incontinence brief to CNA #2 who bagged the soiled brief. Further observation	F 441			

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F 441	<p>Continued From page 4</p> <p>revealed CNA #1 applied a clean incontinence brief, touched Resident #8, assisted Resident #8 to the wheelchair, touched the wheelchair, the lap buddy, and the nurses call light without removing his/her gloves and washing his/her hands. CNA #2 helped CNA #1 assist Resident #8 to the wheelchair and CNA #2 touched the resident, wheelchair, the lap buddy and bed linens without removing his/her gloves and washing his/her hands.</p> <p>Interview, on 07/31/14 at 7:50 AM with CNA #2, revealed he/she should have removed the gloves and washed his/ her hands after bagging the soiled brief and prior to touching the resident, wheelchair, lap buddy and bed linens.</p> <p>Interview, on 07/31/1214 at 8:00 AM with Licensed Practical Nurse (LPN) #1, revealed his/her expectallon was for staff to remove gloves and wash hands after touching a soiled brief, after providing incontinent care, prior to placing a clean incontinence brief and prior to touching other items.</p> <p>Interview, on 07/31/14 at 12:58 PM with the Director of Nursing (DON), revealed his/her expectation was for staff to wash hands and change gloves before, during and after incontinent care.</p> <p>Interview, on 7/31/14 at 3:15 PM with the Administrator, revealed Handwashing, Incontinent Care and Handling Biohazard Waste were components listed on the facility's Nursing Assistant Competency Evaluation.</p>	F 441			

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K 000	<p>INITIAL COMMENTS</p> <p>** AMENDED**</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01.</p> <p>PLAN APPROVAL: 1965.</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: Four (4) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system installed in in 1965, upgraded in 1994 with 43 smoke detectors and 9 heat detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system installed in 1965 and upgraded in 2011.</p> <p>GENERATOR: Type II generator installed in 1972. Fuel source is Natural Gas.</p> <p>A standard Life Safety Code Survey was conducted on 07/30/14. The facility was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for sixty (60) beds with a census of four-nine (49) on the day of the survey.</p> <p>The findings that follow demonstrate</p>	K 000		



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

*Elizabeth Kemp*

TITLE

*Vice President*

(X6) DATE

*9/16/14*

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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K 000	Continued From page 1 noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire).	K 000		
K 050 SS=F	Deficiencies were cited with the highest deficiency identified at "F" level. NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2  This STANDARD is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure fire drills were conducted quarterly on each shift at random times, in accordance with National Fire Protection Association (NFPA) standards. The deficient practice has the potential to affect four (4) of four (4) smoke compartments, all residents, staff and visitors. The facility has the capacity for sixty (60) beds and at the time of the survey, the census was forty-nine (49).  The findings include:  Fire Drill review, on 07/30/14 at 10:17 AM with the Maintenance Supervisor, revealed there was no	K 050	K 050 NFPA 101 Life Safety Code Standard The corrective action accomplished for residents affected by the deficient practice was: *Administrator completed a QA audit 3/28/14 of life safety related issues including ensuring that fire drills were being conducted monthly on alternating shifts-since the facility's last annual survey. The audit revealed that drills were being conducted monthly, but not on alternating shifts or per the posted schedule. An Action Plan was written to get the drills back per established schedule beginning in April. The audit revealed that drills were conducted as: Oct 2013 3p-11p Nov 2013 11p-7a Dec 2013 7a-3p Jan 2014 7a-3p Feb 2014 7a-3p Mar 2014 3p-11p Apr 2014 3p-11p May 2014 7a-3p June 2014 11p-7a July 2014 3p-11a  *The Action Plan written 3/28/14 is proven effective in ensuring the deficient practice will not recur.	8/22/14

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K 050	Continued From page 2 fire drill completed during the first quarter of 2014 on third shift.  Interview, on 07/30/14 at 10:18 AM with the Maintenance Supervisor, revealed he was unaware the fire drill was not conducted during the first quarter. He also revealed the facility had changed their schedule in March in order to keep the fire drills more organized.  The census of forty-nine (49) was verified by the Administrator on 07/30/14. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 07/30/14.  Actual NFPA Standard:  Reference: NFPA 101 (2000 edition) 19.7.1.2. Fire drills shall be conducted at least quarterly on each shift and at unexpected times under varied conditions on all shifts.	K 050	The facility will identify other residents having the potential to be affected by the same deficient practice by: *All residents had the potential to be affected by the deficient practice.  The measures put into place to ensure the deficient practice does not recur is: *The Maintenance Monthly Report that is turned in to the Administrator each month was updated 8/6/14 by the Administrator to include the question, "Was the fire drill conducted on the shift per established schedule." *Administrator reviewed the Quality Assurance form ES-6 titled, "Fire & Evacuation Drills." It contains sufficient questioning to monitor the fire drill schedule.  The facility plans to monitor its performance to ensure that solutions are sustained by: *Quality Assurance form ES-6 "Fire & Evacuation Drills will be completed monthly for 3 months then quarterly by the Maintenance Director.	
K 147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD  Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with National Fire Protection Association (NFPA) standards. The deficient practice has the potential to affect two (2) of four (4) smoke	K 147	K147 NFPA 101 LIFE SAFETY CODE STANDARD  The corrective actions accomplished for those residents affected by the deficient practice: *The power strip was removed and the mini-nebulizer was plugged into the appropriate outlet at the time it was discovered by the Maintenance	8/22/14

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K 147	<p>Continued From page 3</p> <p>compartments, forty (40) residents, staff and visitors. The facility has the capacity for sixty (60) beds and at the time of the survey, the census was forty-nine (49).</p> <p>The findings include:</p> <p>Observation, on 07/30/14 at 10:17 AM with the Maintenance Supervisor, revealed a mini-nebulizer plugged into a power strip located in room #312.</p> <p>Interview, on 07/30/14 at 10:18 AM with the Maintenance Supervisor, revealed he was unaware of the power strip located in the resident room. The facility does daily audits to ensure proper electric connections in the facility.</p> <p>Observation, on 07/30/14 at 11:00 AM with the Maintenance Supervisor, revealed an unlocked electrical panel located in the maintenance hall.</p> <p>Interview, on 07/30/14 at 11:01 AM with the Maintenance Supervisor, revealed he was unaware of the unlocked panel. He also revealed there was a contractor that had used the panel recently and must have left it locked.</p> <p>Observation, on 07/30/14 at 11:16 AM with the Maintenance Supervisor, revealed a power strip plugged into another power strip located in the medical records room.</p> <p>Interview, on 07/30/14 at 11:17 AM with the Maintenance Supervisor, revealed he was unaware of the power strip plugged into another power strip. The facility does daily audits to ensure proper electric connections in the facility.</p>	K 147	<p>Director on 7/30/14 in room #312.</p> <p>*The electrical panel located on the maintenance hall was locked 7/30/14 by the Maintenance Director.</p> <p>*The power strip that was plugged into another power strip in the medical records room was removed 7/30/14 by the Maintenance Director and plugged into the appropriate outlet. The facility identified other residents having the potential to be effected by the same deficient was:</p> <p>* On 7/30/14, the Maintenance Director checked each resident room to ensure that power strips were not in use.</p> <p>*On 7/30/14, the Maintenance Director checked all the electrical panels to ensure they were locked.</p> <p>*On 7/30/14, the Maintenance Director checked all the offices to ensure that no one else had a power strip plugged into another power strip. The measures put into place to ensure that the deficient practice does not recur.</p> <p>*On 7/28/14, the Administrator updated the previous notice posted throughout the facility prohibiting the use of extension cords and spray cans to include the regulation prohibiting the use of power strips.</p> <p>*The Maintenance Director will continue to monitor for power strips in resident room and improper use of power strips in offices during his daily rounds.</p> <p>*The Administrator revised the "Compliance Round Checklist for Department Heads 8/8/14 to include the question, "No extension cords or</p>	

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NAME OF PROVIDER OR SUPPLIER  HEARTHSTONE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 506 ALLENSVILLE ROAD ELKTON, KY 42220	
(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 147	<p>Continued From page 4</p> <p>The census of forty-nine (49) was verified by the Administrator on 07/30/14. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 07/30/14.</p> <p>Actual NFPA Standard: Reference: NFPA 99 (1999 edition)3-3.2.1.2 D Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.</p> <p>Reference: NFPA 70 (1999 Edition). 400-8. Uses Not Permitted Unless specifically permitted in Section 400-7, flexible cords and cables shall not be used for the following:</p> <ol style="list-style-type: none"> <li>1. As a substitute for the fixed wiring of a structure</li> <li>2. Where run through holes in walls, structural ceilings suspended ceilings, dropped ceilings, or floors</li> <li>3. Where run through doorways, windows, or similar openings</li> <li>4. Where attached to building surfaces Exception: Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of Section 364-8.</li> <li>5. Where concealed behind building walls, structural ceilings, suspended ceilings, dropped ceilings, or floors</li> <li>6. Where installed in raceways, except as otherwise permitted in this Code.</li> </ol>	K 147	<p>power strips in resident rooms. Medical equipment is plugged directly into a red plug.</p> <p>*Administrator revised the Quality Assurance form ES-3 titled, "Life Safety" 8/13/14 to include the questions: "Power strips are used appropriately in offices. There are no extension cords or power strips in resident rooms. Medical equipment is plugged directly into wall outlet. There are no open junction boxes." The facility plans to monitor its performance to ensure the solutions are sustained by: *Quality Assurance form ES-3 "Life Safety" will be completed monthly for 2 months then quarterly per regular QA schedule by the Maintenance Director.</p>	