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

PRINTED: 08/20/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185178		08/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND OF LOUISVILLE	4200 BROWNS LANE LOUISVILLE, KY 40220

(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 standard recertification survey was initiated on 08/06/13 and concluded on 08/08/13 and a Life Safety Code survey was conducted on 08/07/13 with the highest scope and severity of an "F" with the facility having the opportunity to correct the deficiencies before remedies would be recommended for imposition. An abbreviated survey to investigate KY20492 was conduted in conjunction with the standard survey initiated on 08/06/13 and concluded on 08/08/13. The Division of Health Care unsubstantiated the allegation with no deficiencies cited.	F 000	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated.	
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy review, it was determined the	F 274	F274 It is the practice of this facility to ensure that a comprehensive assessment of a resident is conducted within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact	09/19/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: X Paul Ott
TITLE: X Asst. Administrator
(X6) DATE: X 09/06/13

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 274	Continued From page 1 facility failed to ensure one (1) of twenty-four (24) sampled residents (Resident #16) received a comprehensive assessment after a significant change. Resident #16 elected the Hospice benefit which required a review and revision of the care plan. The findings include: Review of the facility's policy regarding Significant Change, revealed the facility utilized the RAI Manual as their policy for a Significant Change. Review of the RAI Manual, Chapter 2, revealed a Significant Change Minimum Data Set (MDS) was required to be performed when a terminally ill resident enrolled in a Hospice program. The assessment date must be within fourteen (14) days from the effective date of the Hospice election. A Significant Change MDS must be performed regardless of whether an assessment was recently conducted on the resident. This was to ensure a coordinated plan of care between the nursing home and Hospice was in place. Observation of Resident #16, on 08/07/13 at 3:00 PM and 4:00 PM, revealed the resident sitting in the hallway in a wheel chair, dressed, clean and with a helmet in place. Review of the clinical record for Resident #16, revealed the facility admitted the resident with diagnoses of Dementia, Seizures, Traumatic Brain Injury, Expressive Aphasia, and Spasticity. The facility completed an admission Minimum Data Set (MDS) assessment on the resident on 02/14/13 which revealed the resident had a moderate cognitive impairment, required	F 274	on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** – A comprehensive assessment was completed on Resident #16 on 08/16/13 by the MDS Coordinator. **How you will identify other residents having the potential to be affected by the same deficient practice** – Current residents utilizing hospice benefits have the potential to be affected. Current residents utilizing the hospice benefit were reviewed to ensure a comprehensive assessment has been completed after the significant change and corrective actions were completed by the Administrative Director of Nursing or MDS Coordinator on or before 09/18/13. **What measures will be put into place or what systematic changes you will make to ensure the deficient practice does not recur**- On or before 09/18/13 the Administrative Director of Nursing and	

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F 274	Continued From page 2 extensive assistance with daily living tasks and was incontinent of bowel and bladder. On 03/26/13, the physician ordered Hospice care. The facility completed a Quarterly MDS assessment on 05/14/13. There was no evidence that the facility completed an MDS within 14 days of the Hospice election. Interview the MDS Coordinator #2, on 08/08/13 at 1:17 PM, revealed the facility discussed residents requiring an MDS at their morning meeting. She stated Resident #16 was not scheduled for a Significant Change MDS as the resident was on palliative care prior to becoming Hospice care. She stated there was a difference between palliative care and Hospice. However, she was not aware of the requirement for an MDS to be completed when a resident elected Hospice coverage. She stated the MDS Coordinators were responsible for completion of MDS assessments of residents in the facility. Interview with the MDS Coordinator #6, on 08/08/13 at 1:30 PM, revealed no Significant Change MDS was completed for Resident #16 when Hospice was elected. She stated the resident was on palliative care and did not require an MDS when Hospice was elected. She revealed she was not aware of the requirement for a Significant Change MDS to be completed when Hospice was elected. Interview with the Director of Nursing (DON), on 08/08/13 at 1:50 PM, revealed she was not aware that a significant change MDS was required when a resident elected hospice. The DON further stated she was responsible for the management of the nursing department.	F 274	MDS Coordinators will receive an in-service by the Regional Case Mix Specialist on completion of comprehensive assessments after a significant change. Residents who elect the hospice benefit will be reviewed by the Administrative Director of Nursing or the MDS Coordinator and will be scheduled for a comprehensive assessment. **How the corrective action(s) will be monitored to ensure that solutions are sustained** – An audit tool will be used by the Administrative Director of Nursing Services or the MDS Coordinator to ensure residents who utilize the hospice benefit have a comprehensive assessment within 14 days of the effective date of the hospice election. The audit tool will be completed weekly for 4 weeks, and monthly for 2 months. Continued audits will be performed and reported to the (QAPI) Quality Assurance and Performance Improvement Committee to measure compliance for an additional 2 quarters and then be reevaluated ongoing by the Committee to determine the need for continued monitoring. The audit tool results will be submitted to the (QAPI) Quality	

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F 279 F 279 SS=D	Continued From page 3 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to integrate the Hospice care plan with the facility's care plan for two (2) of twenty-four (24) sampled residents (Resident #2 and #16). The facility failed to develop a care plan to include hospice interventions when Resident #2 and #16 were admitted to hospice. The findings include:	F 279 F 279	Assurance and Performance Improvement Committee to validate the actions taken are effectively resolving the alleged deficiency beginning 09/18/13. F279 It is the practice of this facility to ensure the results of the assessment are used to develop, review and revise the resident's comprehensive plan of care. It is also the practice of this facility to develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are being furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under 483.25; and any services that would otherwise be required under	09/19/13

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F 279	Continued From page 4 Review of the facility's policy revealed the facility utilized the RAI Manual for care planning policies. Review of the RAI Manual, Chapter 4, revealed the Care Area Assessments when properly implemented, should help staff consider the resident as a whole with unique characteristics and strengths. Identify areas of concern that may warrant interventions. Develop interventions to help improve, stabilize or prevent decline and address the needs and desires for other important considerations. 1. Review of the clinical record for Resident #16, revealed the facility admitted the resident with diagnoses of Traumatic Brain Injury, Dementia, and Expressive Aphasia. The resident entered the Hospice program on 03/26/13. Review of the comprehensive care plan for Resident #16, dated 04/12/13, revealed Hospice was responsible for assisting with ADL care and pain management as needed. Hospice was to encourage the resident to attend activities and to visit to provide care and evaluation as needed. Review of the Hospice care plan for Resident #16, dated 07/16/13, revealed interventions for spiritual care, emotional support, family support, management of depression, assessment of medication effects on eating, socialization, prayer, pain relief, EMS DNR, comfort, reassurance, faith, use of volunteers to assist with needs, understanding of the disease process and how Hospice functioned. Other than pain relief, these interventions were not located on the resident's comprehensive care plan. Interview with MDS Coordinator #1, on 08/08/13	F 279	483.25 but are not provided due to the resident's exercise of rights under 483.10, including the right to refuse treatment under 483.10(b)(4). **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** – Resident #2 and Resident #24's care plans were reviewed by the MDS Coordinator on 08/08/13 to integrate the hospice care plan. **How you will identify other residents having the potential to be affected by the same deficient practice** – Current residents utilizing hospice benefits have the potential to be affected. Current residents utilizing the hospice benefit were reviewed to ensure the plan of care for hospice is integrated with the facility's plan of care utilizing the Hospice QAPI audit tool and corrective actions were completed by the Administrative Director of Nursing or MDS Coordinator on or before 09/18/13. **What measures will be put into place or what systematic changes you will make**	

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F 279	Continued From page 5 at 1:17 PM, revealed she was responsible for development of a new care plan, for Resident #16; however, a new care plan was not needed as the resident had not changed. She stated she was aware that a Hospice care plan was on the chart; however, she did not review or integrate the Hospice care plan with the facility's comprehensive care plan. She stated she should have reviewed the Hospice care plan and made it part of the facility care plan for Resident #16. Interview with the Director of Nursing, on 08/08/13 at 1:50 PM, revealed she was aware a new care plan was not completed for Resident #16. She stated the facility should have integrated the Hospice care plan with the facility care plan as required. 2. Observation, of Resident #2, on 08/08/13 at 11:12 AM, revealed Hospice Social Services Staff, arrived to the room, knocked on the door and entered the room while a skin assessment was in progress. She stated, she would come back later. Observation, of Resident #2's room, on 08/08/13 at 11:12 AM, revealed a bulletin board with a Hospice Certified Nurse Aide business card with a hand written Monday, Wednesday and Friday. Interview with Certified Nurses Aide (CNA) #11, on 08/08/13 at 11:12 AM, revealed the CNA business card on the bulletin board was for the CNA from Hospice. She reported she was not sure if those were the correct days they come. Clinical record review revealed Resident #2 was admitted to the facility on 09/18/12 with diagnoses	F 279	**to ensure the deficient practice does not recur-** On or before 09/18/13 Licensed Nurses will receive an in-service conducted by the Administrative Director of Nursing, MDS Coordinator, Director of Care Delivery or Nurse Supervisor that will cover but is not limited to the integration of hospice and facility plan of care. Residents who elect to utilize the hospice benefit will be reviewed by the Administrative Director of Nursing Services, MDS Coordinator or the Director of Care Delivery to ensure the hospice care plan is integrated with the facility care plan. **How the corrective action(s) will be monitored to ensure that solutions are sustained** – A Hospice QAPI Audit tool will be used by the Administrative Director of Nursing Services, the MDS Coordinator or the Director of Care Delivery to ensure residents who utilize the hospice benefit have integration between the hospice and facility care plan. The audit tool will be completed weekly for 4 weeks, and then monthly for 2 months. Continued audits will be performed and reported to the Quality Assurance and Performance Improvement (QAPI) Committee to	

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F 279	Continued From page 6 of Esophageal Cancer, Chronic Airway Obstruction, Hypotension, Anemia and Failure to Thrive. In addition, Hospice services were ordered by the physician. Review of the care plan, dated 08/08/13, for Resident #2 revealed it was not integrated with identifiable and defined Hospice services. The focus for Risk for Alteration in Hydration related to diagnosis of Esophageal Cancer, Hospice Care, and variable intake was created and initiated on 09/20/12. The one (1) intervention listed was to report changes related to signs of fluid deficit (tongue furrows, dry mouth, etc.) for nurse aide and nursing. The second intervention was to report changes related to signs of fluid overload such as shortness of breath, edema and mental status changes, etc, was added on 01/03/13 for nurse aide and nursing to follow. The care plan for Nutritional Status for potential weight loss related to swallowing difficulties, mechanically altered diet, Esophageal Cancer and Hospice care, was created and initiated on 09/20/12, dated 08/08/13, revealed the interventions included to provide a diet and snacks as ordered, supplements as ordered and to review weights and notify physicians and responsible party of significant weight change. The interventions listed were for nutritional services and the Registered Dietician to follow. The care plan for at Risk of Changes in Mood related to a terminal diagnosis and hallucinations with yelling out at times revealed the intervention of administer medication per physician orders and non pharmaceutical interventions of assessing for pain and treatment if needed, to reduce stimulation and provide activity of choice was created and initiated on 09/27/13. Attempt psychotropic drug reduction per physician orders	F 279	measure compliance for an additional 2 quarters and then be reevaluated ongoing by the Committee to determine the need for continued monitoring. The audit tool will be submitted to the Quality Assurance and Performance Improvement (QAPI) Committee to validate the actions taken are effectively resolving the alleged deficiency beginning 09/18/13.	

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F 279	Continued From page 7 and a psychiatric consult as needed was added to the interventions on 11/09/12. The care plan for Hospice care needed due to Cancer was initated on 05/24/13, and revealed Hospice was to assist with repositioning, assist with activities of daily living care and pain management as needed. Interview with Licensed Practical Nurse (LPN) #2, on 08/06/13 at 3:50 PM, revealed care plans were updated at the time orders were taken off. In addition, care plans were revised when the orders were taken off by the nurses.	F 279	F309 It is the practice of this facility to ensure that each resident must receive and the facility provides the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	09/19/13
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to follow a physician's order for one (1) of twenty-four (24) sampled residents Resident #15. The facility staff failed to remove the topical (skin) pain patch at bedtime as ordered for Resient #15. The findings include: The facility did not provide a policy on following	F 309	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** – Resident #15 was assessed on 08/07/13 by Director of Care Delivery with no ill effects noted from topical pain patch. **How you will identify other residents having the potential to be affected by the same deficient practice** – Current residents and new admissions have the potential to be affected. On or before 09/18/13 the Administrative Director of Nursing, Directors of Care Delivery and Nurse Supervisors will review current residents with topical pain patch orders to ensure physician orders were followed. Any areas of non-compliance found will be corrected by Administrative	

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F 309	Continued From page 8 physician orders. Review of the clinical record for Resident #15 revealed the facility admitted the resident to the facility on 04/23/13 with diagnoses of Dementia with Lewy and Parkinsonism. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 07/30/13, revealed the facility assessed the resident as having a Brief Interview of Mental Status (BIM) of six (6) indicating cognitive impairment. Review of the MAR revealed the resident had an order for a Lidoderm Patch for pain control to apply topically to the lower back every day and remove at bedtime every day. Review of the MAR for Resident #15 revealed the nurse initialed the MAR on 08/06/13 as having removed the pain patch at bedtime. On 08/07/13 at 9:45 AM during the Medication Pass with Licensed Practical Nurse (LPN) #5 revealed the Lidoderm pain patch, dated 08/06/13, was still in place on Resident #15's lower back. On 08/07/13 at 9:45 AM, interview with LPN #5 revealed the evening nurse should have removed the pain patch the night before at bedtime as ordered by the resident's physician. LPN #5 revealed leaving a patch on too long could cause a skin irritation. Interview with The Director of Clinical Delivery (DCD) for the 300/400 Unit, on 08/0713 at 12:00 PM, revealed leaving a pain patch on too long could cause a resident to have a skin irritation and and the nurse should have followed the	F 309	Director of Nursing, Directors of Care Delivery and Nurse Supervisors to include notification to physician and resident or resident responsible party. **What measures will be put into place or what systematic changes you will make to ensure the deficient practice does not recur-** LPN #6 was educated by Nurse Supervisor on 08/07/13 regarding medication administration standards of practice, medication management: documentation and demonstration of accurate medication administration skills validation without error. Current licensed nurses administering medications to residents were educated on medication management: documentation and medication administration standards of practice by Administrative Director of Nursing, Directors of Care Delivery and Nurse Supervisors, and required to successfully complete a medication administration skills validation without error on or before 09/18/13. Those licensed nurses unable to successfully complete a medication administration skills validation will be re-inserviced by Administrative Director of Nursing, Directors of Care Delivery and Nurse Supervisors and an additional	

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F 309	Continued From page 9 physicians's order to remove the patch at bedtime. Interview with LPN #6, on 08/07/13 at 3:30PM, revealed she should have followed the order as written by the physician and should have removed the patch at bedtime on the evening of 08/06/13. LPN #6 revealed she did not visualize the resident's lower back when attempting to remove the patch and must have felt a tissue or part of the resident's brief instead of the patch. LPN #6 said she felt something and removed it and rolled it into her glove and put the rolled up glove in the trash. LPN #6 revealed leaving a pain patch on too long could possibly cause skin irritation and may cause the next patch not to absorb properly. LPN #6 revealed leaving a patch on too long could also cause over absorption of the drug. Interview with the Direct of Nursing (DON), on 08/08/13 at 5:15 PM, revealed a nurse should always follow physicians' orders. The pain patch for Resident #15 should have been removed at bedtime as ordered by the physician.	F 309	medication administration skills validation will be completed until licensed nurse is able to demonstrate medication administration without error. To ensure deficient practice does not recur, new employees during orientation will be educated on the standards of practice for medication administration as well as complete a medication administration skills validation without error. Annually all licensed nurses will be required to complete a medication administration skills validation without error. **How the corrective action(s) will be monitored to ensure that solutions are sustained** – To ensure compliance Administrative Director of Nursing, Directors of Care Delivery and Nurse Supervisors will conduct medication administration skills validation of one nurse per shift using the medication QAPI audit tool weekly for 4 weeks, and then monthly for 2 months to ensure physician orders are being followed with results reported to the (QAPI) Quality Assurance and Performance Improvement Committee for review. Licensed nurses will be supervised by	
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review	F 364		

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Directors of Care Delivery and Nurse Supervisors to ensure accuracy and areas of non-compliance will be corrected immediately. Continued audits will be performed and reported to The Quality Assurance and Performance Improvement (QAPI) Committee to measure compliance for an additional 2 quarters and then reevaluated ongoing by the Committee to determine the need for continued monitoring. The audit tool will be submitted to the Quality Assurance and Performance Improvement (QAPI) Committee to validate the actions taken are effectively resolving the cited issues beginning 09/18/13.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	185178		08/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND OF LOUISVILLE	4200 BROWNS LANE LOUISVILLE, KY 40220

(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 364	Continued From page 10 and review of the facility's policy, it was determined the facility failed to provide two (2) of twenty-four (24) sampled residents and six (6) of seven (7) unsampled residents with food that was palatable and flavorful. (Residents #3, #14, and Unsampled Residents A, B, D, E, F, and G). At lunch on 08/06/13 at 12:13 PM, a test tray was sampled and the fish was determined to be dry and tough and the broccoli was found to be tasteless and mushy. In addition, the macaroni salad was found to be 50.9 degrees Farenheit (F). The findings include: Review of the facility's policy for Trayline Procedures, dated 03/20/10, revealed cold food should be held at temperatures that would ensure standards are met at time of delivery. Review of the facility's policy for Taste and Temperature Control, dated 03/20/10, revealed foods would meet expectations for palatable meals. Prior to the start of the meal period, there was an evaluation of the taste and temperature of food. Review of the past three (3) months of Resident Council meeting minutes revealed food complaints had been voiced in the meetings and there was evidence a resolution to those complaints were documented. The Quality of Life Group Interview, on 08/06/13 at 3:00 PM, with Unsampled Residents D, E, F and G revealed the food at the facility was not always palatable. Unsampled Residents D, E, F and G stated the soup made in the kitchen from scratch tasted watered down, the chicken and	F 364	F364 It is the practice of this facility to ensure that each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** – On or before 09/06/13 Dietary General Manager will update resident preferences and review alternate menu choices with Residents A,B,D,E,F,G,3 and 14. **How you will identify other residents having the potential to be affected by the same deficient practice** – Residents who receive a meal tray have the potential to be affected by the deficient practice. **What measures will be put into place or what systematic changes you will make to ensure the deficient practice does not recur**- Dietary General Manager inserviced cooks on proper cooking	09/19/13

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185178	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 08/08/2013
NAME OF PROVIDER OR SUPPLIER HEARTLAND OF LOUISVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 4200 BROWNS LANE LOUISVILLE, KY 40220	

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F 364	Continued From page 11 pork chops were served tough, the vegetables were overcooked and the food just did not taste good most of the time. Interview with the facility Ombudsman during the Quality of Life Group Interview on 08/06/13 at 3:20 PM, revealed she had multiple complaints from the facility residents about the food not being palatable over the past six (6) months. Observation of the meal service, on 08/06/13 at 11:17 AM, revealed pale greenish colored broccoli on the steam table. The pans holding the broccoli were filled with water. Breaded fish was also on the steam table and more fish was in the oven on warm. Macaroni salad was on several trays on the line over the steam table. A request for the temperature of the macaroni salad revealed it was at 54.1 degrees (F). The macaroni salad was removed and placed in the freezer. Observation of the tray pass on the 100 unit, on 08/06/13 at 12:12 PM, revealed a test tray was sampled by the Dietician and the Food Service Manager. The Food Service Manager obtained temperatures of the food and all were within range except for the macaroni salad, which was at 50.9 degrees (F). Observation and tasting of the test tray, on 08/06/13 at 12:12 PM, revealed the fish was tough and hard to cut with a knife. In addition the fish was dry. The broccoli had no flavor and was mushy in texture. Interview with the Food Service Manager, on 08/06/13 at 12:20 PM, revealed the broccoli might need more butter and the edges of the fish were	F 364	techniques with specific focus on temperature, taste and appearance on or before 08/28/13. Dietary General Manager will inservice dietary staff on proper food holding temperatures and methods on or before 09/02/13. **How the corrective action(s) will be monitored to ensure that solutions are sustained –** The Dietary General Manager or Kitchen Manager will audit food preparation and cooking processes twice a week for 4 weeks and then monthly for 2 months using the Food Safety Audit tool. The Dietary General Manager, Kitchen Manager or Registered Dietitian will conduct meal rounds and tray assessments with 5 residents weekly for 4 weeks and then monthly for 2 months with results noted and reported to the Quality Assurance and Performance Improvement (QAPI) Committee. Continued audits will be performed and reported to the (QAPI) Quality Assurance and Performance Improvement Committee to measure compliance for an additional 2 quarters and then be reevaluated ongoing by the Committee to determine the need for continued monitoring. The Committee will validate the actions taken are	

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F 364	Continued From page 12 a little tough. She stated the meal tasted good. Interview with the Dietician, on 08/06/13 at 12:23 PM, revealed the fish was spicy and the broccoli and macaroni salad were fine. She stated the macaroni salad tasted cool even thought the temperature was above the 41 degree (F) range. Interview with Unsampled Resident A, on 08/07/13 at 8:16 AM, revealed the food at the facility was frequently terrible and the resident would ask for a sandwich or soup. The resident stated the food had gone downhill in the last six (6) months. Interview with Resident B, on 08/07/13 at 8:20 AM, revealed the food was not good. The resident stated the kitchen did not pay attention to the residents likes and dislikes and just served whatever was on the steam table. The resident complained the food concerns were addressed with the Food Service Manager; however, no improvement was noted. Interview with Certified Nurse Aide (CNA) #8, on 08/07/13 at 9:30 AM, revealed she did receive complaints from residents regarding the food and the poor quality of the food. Interview with Resident #3, on 08/08/13 at 10:42 AM, revealed the food was awful. The resident stated the kitchen did not pay attention to residents' likes and dislikes, served tough and dry meat and food was often served cold. The resident complained that food dislikes were often served and there was very little seasoning used. The resident stated a friend would ensure the resident got some soup if the meal was bad. The resident stated complaining to the kitchen	F 364	effectively resolving the cited issues beginning 09/18/13 and will continue to evaluate until Issues are deemed corrected.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185178	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 08/08/2013
NAME OF PROVIDER OR SUPPLIER HEARTLAND OF LOUISVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 4200 BROWNS LANE LOUISVILLE, KY 40220	

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F 364	Continued From page 13 manager did little good. Interview with Resident #14, on 08/08/13 at 08/08/13 at 2:30 PM, revealed the food in the facility was not something one looked forward to; however, the resident refrained from further comment. Interview with the Food Service Manager, on 08/08/13 at 2:40 PM, revealed the fish served on 08/06/13 was dry along the edges related to the breading. She stated the chopped broccoli did have a lot of water on it. She revealed all complaints coming from the Resident Council were checked out and resolved. She stated the current menu had been in place since March 2013. She stated she would have to change the procedures for keeping cold food at the correct temperatures prior to serving. Review of the past three (3) months of Resident Council meeting minutes revealed food complaints had been voiced in the meetings and there was evidence a resolution to those complaints were documented. The Quality of Life Group Interview, on 08/06/13 at 3:00 PM, with Unsampled Residents D, E, F and G revealed the food at the facility was not always palatable. Unsampled Residents D, E, F and G stated the soup made in the kitchen from scratch tasted watered down, the chicken and pork chops were served tough, the vegetables were overcooked and the food just did not taste good most of the time. Interview with the facility Ombudsman during the Quality of Life Group Interview on 08/06/13 at 3:20 PM revealed she had multiple complaints	F 364		

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F 364	Continued From page 14 from the facility residents about the food not being palatable over the past six (6) months.	F 364	F371	09/19/13
F 371 SS=F	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 This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy review, it was determined the facility failed to store, prepare, distribute and serve food under sanitary conditions. The facility failed to ensure macaroni salad was at the proper temperature prior to serving residents. The facility failed to ensure left over food stored in the refrigerator was labeled and dated. The facility failed to ensure cold food was monitored and temperatures logged. The facility failed to ensure the kitchen was free of pests. The facility failed to ensure silverware was stored handle up, dishes were stored turned over, walls were clean and free of soiled paper signs. The findings include: Review of the facility's policy for Labeling, dated 04/07/06, revealed all foods placed in the refrigerator should be labeled with the name of	F 371	It is the practice of this facility to (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. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** – The 8 sandwiches and 10 plates of tuna identified as not being individually labeled and dated were discarded immediately on 08/06/13. Okolona Pest Control came to facility to evaluate issue with flies on 08/08/13 and 08/14/13. Existing bug light in kitchen was relocated on 08/09/13 and an additional bug light was added in kitchen on 08/20/13. The forks identified as being stored with the handle down and the dishware identified as being stored bowl side up were immediately rewashed on 08/08/13. Paper signs identified as soiled were removed on 08/10/13. The wall behind the three compartment sink was cleaned on 08/13/13.	

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F 371	Continued From page 15 the item, the date the item was placed in the refrigerator and date it was to be used. Review of the facility's policy for Sanitation, dated 03/20/10, revealed an effective and safe pest control program must be in place. Temperature logs are complete and kept on file. There were no guidelines for storing clean dishes and silverware. Review of the facility's policy for Cleaning, dated 03/01/03, revealed walls should be spot cleaned. Observation of the kitchen, on 08/06/13 at 8:20 AM, revealed eight (8) sandwiches, some with turkey and some with ham, in the walk-in refrigerator covered but not labeled or dated. In addition, ten (10) plates of tuna salad were stored and not labeled or dated. Interview with the Food Service Manager (FSM), on 08/06/13 at 8:25 AM, revealed the food was left-over from 08/05/13. She stated the food was not labeled and dated; however, the tray the food was sitting on did have a label and it was dated. Observation of the kitchen, on 08/06/13 at 11:15 AM, revealed the temperatures of the milk and the macaroni salad were not obtained prior to the start of tray service. Review of the Temperature Log, revealed no documentation that milk product temperatures were obtained on a routine basis. Observation of the kitchen, on 08/08/13 at 2:40 PM, revealed numerous flies landing on dishes and silverware. Forks were stored with the handle down. Dishware was stored bowl side up.	F 371	**How you will identify other residents having the potential to be affected by the same deficient practice** – Residents who receive a meal tray have the potential to be affected by the deficient practice. **What measures will be put into place or what systematic changes you will make to ensure the deficient practice does not recur-** The monthly cleaning log was revised on 08/29/13 to include the wall behind the three compartment sink. Dietary staff was inserviced by the Dietary General Manager on or before 09/02/13 on facility policy for labeling and dating, the proper procedure for storing dishes and silverware, the procedure for checking and recording temperatures, and the facility policy for cleaning. Newly hired dietary employees will be educated by on facility policy for labeling and dating, the proper procedure for storing dishes and silverware, the procedure for checking and recording temperatures, and the facility policy for cleaning during orientation. **How the corrective action(s) will be monitored to ensure that solutions are**	

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F 371	Continued From page 16 There were numerous soiled paper signs taped around the kitchen. The wall behind the three compartment sink was heavily soiled with dark drips and spatters. Interview with the FSM, on 08/08/13 at 2:40 PM, revealed flies were an ongoing problem and had been discussed with the past Administrator. She stated dishes were to be stored bowl side down and silverware was to be stored with handles up. She stated the wall should have been cleaned. She stated the soiled paper signs would be taken down. She stated the macaroni salad was not monitored for temperature because it was not on the menu.	F 371	**sustained** – Dietary General Manager or Kitchen Manager will conduct audits twice a week for 4 weeks, then monthly for 2 months using the Food Safety Audit tool with results noted and reported to the Quality Assurance and Performance Improvement (QAPI) Committee. These audits will include: pest control, food temperature logs, cleaning assignment logs, food labeling/dating, cleanliness, and dish and silverware storage. Areas of non-compliance will be addressed immediately. Continued audits will be performed and reported to the (QAPI) Quality Assurance and Performance Improvement Committee to measure compliance for an additional 2 quarters and then be reevaluated ongoing by the Committee to determine the need for continued monitoring. The Committee will validate the actions taken are effectively resolving the cited issues beginning 09/18/13 and will continue to evaluate until issues are deemed corrected.	
F 514 SS=D	483.75(l)(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 observation, interview, record review and review of the facility's policy it was determined the facility failed to ensure medical	F 514	F514 It is the practice of this facility to maintain clinical records on each resident	09/19/13

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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HEARTLAND OF LOUISVILLE	4200 BROWNS LANE LOUISVILLE, KY 40220

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F 514	Continued From page 17 records were accurately documented for three (3) of twenty-four 24 sampled residents and seven (7) unsampled residents, Resident #14, #15 and #16. The facility failed to ensure physician orders were signed timely for Resident #14 and Resident #16. In addition the nurse documented the removal of a medicated topical (skin) pain patch for Resident #15 when the patch was not removed. The findings include: 1. Review of the facility's Medication Administration: Transdermal Drugs Policy, dated 03/2010, revealed the nurse should open the Medication Administration Record (MAR) and review physician medication orders. No other policy concerning accurately documenting medical records were provided. Review of Resident #15's medical record revealed the facility admitted the resident to the facility on 04/23/13. Review of the physician orders revealed the resident was to receive a Lidoderm 5% patch, apply topically one patch to lower back every day, off at bedtime. Review of the MAR revealed the Lidoderm Patch for pain was to be applied topically to the lower back every day and removed every day at bedtime. The MAR revealed a nurse initialed the MAR on 08/06/13 as having removed the pain patch at bedtime. During observation of the Medication Pass, on 08/07/13 at 9:45 AM, with Licensed Practical Nurse (LPN) #5 revealed the Lidocaine pain patch, dated 08/06/13, was still in place on Resident #15's lower back.	F 514	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. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** – Residents# 14, #15 and #16 physician orders were reviewed for accuracy, signed and dated by the Physician on or before 09/18/13. Resident #15 suffered no ill effects from topical pain patch as per assessment by Director of Care Delivery on 08/07/13. **How you will identify other residents having the potential to be affected by the same deficient practice** – Current residents and newly admitted residents have the potential to be affected by the deficient practice. On or before	

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F 514	Continued From page 18 Interview with LPN #5, on 08/07/13 at 9:45 AM, revealed the patch should have been removed the night before at bedtime by the nurse on that shift. A nurse should never document a patch was removed when it was not removed. Interview with The Director of Clinical Delivery (DCD) for the 300/400 Unit, on 08/07/13 at 12:00 PM, revealed a nurse should never document a patch was removed when it was not removed. Interview with LPN #6, on 08/07/13 at 3:30 PM, revealed she should not have initialed the MAR that the patch had been removed. Interview with the Direct of Nursing (DON), on 08/08/13 at 5:15 PM, revealed a nurse should never initial a MAR that a pain patch had been removed. 2. Review of the facility's policy for Telephone and Verbal Orders, dated 08/2009, revealed telephone orders were to be signed and dated by the physician within a thirty (30) day time frame. Review of the clinical record for Resident #14, revealed physician orders for 06/01/13 through 06/30/13 were signed by the physician; however, they were not dated. Physician orders for 07/01/13 through 07/31/13 were not signed as of 08/04/13. Review of the clinical records for Resident #16, revealed physician orders for 03/26/13, 04/10/13 and 05/21/13 were signed and not dated. Review of physician orders for 05/01/13 through 05/31/13	F 514	09/18/13 current resident's medical records will be reviewed by Medical Records, Administrative Director of Nursing Services, Directors of Care Delivery or Nurse Supervisor for accuracy of monthly orders and ensure signature and date of Physician. **What measures will be put into place or what systematic changes you will make to ensure the deficient practice does not recur-** LPN #6 was educated by Nurse Supervisor on 08/07/13 regarding medication administration standards of practice, medication management: documentation and demonstration of accurate medication administration skills validation without error. Current licensed nurses administering medications to residents were educated on medication management: documentation and medication administration standards of practice by Administrative Director of Nursing, Directors of Care Delivery and Nurse Supervisors, and required to successfully complete a medication administration skills validation without error on or before 09/18/13. Those licensed nurses unable to successfully complete a medication	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND OF LOUISVILLE	4200 BROWNS LANE LOUISVILLE, KY 40220

(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 514	Continued From page 19 were signed on 07/21/13. Physician orders for 07/01/13 through 07/31/13 were signed; however, they were not dated. Interview with Licensed Practical Nurse #3, on 08/08/13 at 11:15 AM, revealed the nursing staff checked the charts and ensured physician orders were signed and dated. She stated the physician was called if orders were due to be signed. She stated she thought the physicians had 60 days to sign orders. Interview with Licensed Practical Nurse #4, on 08/08/13 at 11:20 AM, revealed the physician had 60 days to sign orders. She stated the physician was notified by phone or when visiting the facility by the nurse to sign orders. She stated the physician should sign and date the orders.	F 514	administration skills validation will be re-inserviced by Administrative Director of Nursing, Directors of Care Delivery and Nurse Supervisors and an additional medication administration skills validation will be completed until licensed nurse is able to demonstrate medication administration without error. To ensure deficient practice does not recur, new employees during orientation will be educated on the standards of practice for medication administration as well as complete a medication administration skills validation without error. Annually licensed nurses will be required to complete a medication administration skills validation without error. On or before 09/18/13 Administrative Director of Nursing, Directors of Care Delivery and Nurse Supervisors will in-service Licensed Nurses and Medical Records Director on medication management: documentation and obtaining physician signatures with dates within 10 days on all admission, readmission and telephone orders received. Medical Records director will complete the Health Information	

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Management orientation utilizing the clinical resource manual on or before 09/18/13.

How the corrective action(s) will be monitored to ensure that solutions are sustained – On or before 09/18/13 using a Physician Services QAPI audit tool, Administrative Director of Nursing Services, Medical Records Director, Directors of Care Delivery or Nurse Supervisor will audit 10 residents, weekly for 4 weeks, and then monthly times 2 months to ensure physician signatures and dates on new orders occur within 10 days, with results reported to the Quality Assurance and Performance Improvement (QAPI) committee. Continued audits will be performed and reported to the Quality Assurance and Performance Improvement (QAPI) Committee to measure compliance for an additional 2 quarters and then reevaluated ongoing by the Committee to determine the need for continued monitoring. The audit tool will be submitted to the Quality Assurance and Performance Improvement (QAPI) Committee to validate the actions taken are effectively resolving the cited issues beginning 09/18/13.

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

PRINTED: 08/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED
	185178		08/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND OF LOUISVILLE	4200 BROWNS LANE LOUISVILLE, KY 40220

(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	INITIAL COMMENTS CFR: 42 CFR §483.70 (a) BUILDING: 01 PLAN APPROVAL: 1970 SURVEY UNDER: 2000 Existing FACILITY TYPE: S/NF DP TYPE OF STRUCTURE: One (1) story with a partial basement, Type III (211) SMOKE COMPARTMENTS: Eleven (11) on the Ground Floor and two (2) in the Basement. FIRE ALARM: Complete fire alarm system with heat and smoke detectors. SPRINKLER SYSTEM: Automatic (dry) sprinkler system, hydraulically designed. GENERATOR: Type II, 150 KW generator installed in 2006. Fuel source is diesel. A standard Life Safety Code survey was conducted on 08/07/13. Heartland of Louisville was found not to be in compliance with the Requirements for Participation in Medicare and Medicaid. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)	K 000	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated. K029 It is the practice of this facility to ensure that one hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from bottom of the door are permitted.	09/19/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: X Paul Cote
TITLE: X Asst. Administrator
(X6) DATE: X 09/06/13

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 F level.	K 000		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements for Protection of Hazards, in accordance with NFPA standards. The deficiency had the potential to affect three (3) of eleven (11) smoke compartments, approximately fifty (50) residents, staff and visitors. The facility has one-hundred and seventy-eight (178) certified beds and the census was one-hundred and thirty (130) on the day of the survey. The findings include: 1. Observation, on 08/07/13 at 10:50 AM, with the Maintenance Director revealed the Mechanical Room located within the Staff Break	K 029	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** – Self closure devices were placed on the biohazard room in the basement and on the biohazard room on the Pathways Unit on 08/08/13. The four openings in the interior walls in the mechanical room located within the staff break room were repaired on 08/08/13. **How you will identify other residents having the potential to be affected by the same deficient practice** – Current residents have the potential to be affected by this deficiency **What measures will be put into place or what systematic changes you will make to ensure the deficient practice does not recur-** All doors leading to hazardous storage areas were checked for a self-closing device by the Maintenance Assistant on 08/29/13. Safety Committee (HR Director, Staffing Coordinator, Maintenance, Housekeeping, Laundry, C.N.A.) was inserviced by Assistant Administrator on doors requiring self-closure devices on 08/28/13.	

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K 029	Continued From page 2 Room had an approximately twelve (12) inch by twelve (12) inch opening, and three (3) small one (1) inch by one (1) inch openings in the interior drywall and would not resist the passage of smoke in the event of an emergency. Interview, on 08/01/13 at 10:50 AM, with the Maintenance Director revealed he was not aware of the openings in the interior drywall of the Mechanical Room and acknowledged the room would not resist the passage of smoke in the event of an emergency. 2. Further observations, on 08/07/13 between 2:25 PM and 3:03 PM, with the Maintenance Director revealed both of the doors to the Bio-hazard Rooms located in the Pathways Hall and in the Basement did not have self-closing devices installed on each of the doors. Each door had a sign displayed, advising Staff to keep the doors closed at all times. Further interviews, on 08/07/13 between 2:25 PM and 3:03 PM, with the Maintenance Director revealed he was not aware of the requirement for the Bio-hazard Room doors to be equipped with a self-closing device and the sign advising to keep the door closed was insufficient for code compliance Reference: NFPA 101 (2000 Edition). 19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided	K 029	**How the corrective action(s) will be monitored to ensure that solutions are sustained** – Safety Committee (HR Director, Staffing Coordinator, Maintenance, Housekeeping, Laundry, C.N.A.) will conduct audits to validate self-closing doors to hazardous areas function properly, once a week for 4 weeks, monthly times 2 months and quarterly for 2 quarters and report audit findings to the Quality Assurance and Performance Improvement Committee for ongoing review until issue is deemed corrected. Areas of non-compliance will be corrected immediately. The Quality Assurance and Performance Improvement (QAPI) committee will validate the actions taken are effectively resolving the cited issues beginning 09/18/13.	

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K 029	Continued From page 3 with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft2 (9.3 m2) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.	K 029		
K 066 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored	K 066		

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DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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K 066	Continued From page 4 and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the three (3) designated outdoor smoking areas; two (2) for Residents and one (1) for Staff, were properly equipped for safe smoking, in accordance with NFPA standards. The deficiency had the potential to affect residents, staff and visitors. The facility has one-hundred and seventy-eight (178) certified beds and the census was one-hundred and thirty (130) on the day of the survey. The findings include: Observations, on 08/07/13 between 2:15 PM and 2:55 PM, with the Maintenance Director revealed the designated, outdoor smoking area for	K 066	K066 It is the practice of this facility to ensure that smoking regulations are adopted and include no less than the following provisions: (1)Smoking is prohibited in any room, ward or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2)Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3)Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4)Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** – Approved metal containers	09/19/13

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K 066	Continued From page 5 residents in the Life Skill Unit (LSU) did not have an approved metal container with a self-closing lid to empty the ash trays into and a fire blanket readily available for usage. The designated outdoor smoking area for the residents in the central court yard did not have an approved metal container with a self-closing lid, to empty ashtrays into available for usage. The designated outdoor smoking area for the Staff, located near the Service Entrance, did not have a fire extinguisher and an approved metal container with a self-closing lid, to empty ash trays into, available for usage. Interviews, on 08/07/13 between 2:15 PM and 2:55 PM, with the Maintenance Director revealed he was not aware of the requirements of the two (2) designated, outdoor smoking areas for Residents to have an approved metal container with a self-closing lid to empty ash tray into and a fire blanket readily available for usage; and the designated outdoor smoking area for the Staff to have a fire extinguisher and a metal container with a self-closing lid to empty ash trays into, readily available for usage. Reference: NFPA 101 (2000 edition) 19.7.4* Smoking. Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such areas shall be posted with signs that	K 066	with self-closing lids to empty ash trays were placed in the three smoking areas on 08/21/13. A fire extinguisher was placed in the employee smoke area on 08/21/13. Life Skills Unit smoking area continues to have a fire blanket readily available for usage. **How you will identify other residents having the potential to be affected by the same deficient practice** – Current smoking residents have the potential to be affected by this deficiency. **What measures will be put into place or what systematic changes you will make to ensure the deficient practice does not recur**- Maintenance Director and Maintenance Assistant were educated on smoking regulations by Assistant Administrator on 08/27/13. **How the corrective action(s) will be monitored to ensure that solutions are sustained** – Maintenance Director and Maintenance Assistant will audit all smoke areas weekly to ensure hot ash dumps with lids are present and used correctly. Audits of smoking areas will be completed once a week for 4 weeks, monthly times 2 months and then	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED
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K 066	Continued From page 6 read NO SMOKING or shall be posted with the international symbol for no smoking. Exception: In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (2) Smoking by patients classified as not responsible shall be prohibited. Exception: The requirement of 19.7.4(2) shall not apply where the patient is under direct supervision. (3) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. Reference: S & C Letter: 12-04-NH; Date: November 10, 2011 Subject: Alert: Smoking Safety in Long Term Care Facilities	K 066	quarterly for 2 quarters with audit findings reported to the Quality Assurance and Performance Improvement (QAPI) Committee for ongoing review until issue is deemed corrected. Areas of non-compliance will be corrected immediately. The Quality Assurance and Performance Improvement (QAPI) committee will validate the actions taken are effectively resolving the cited issues beginning 09/18/13.	
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2	K 147	K147 It is the practice of this facility to ensure that electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code 9.1.2	09/19/13

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K 147	Continued From page 7 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 NFPA standards. The deficiency had the potential to affect one (1) of eleven (11) smoke compartments on the Ground Floor, approximately forty (40) residents, staff, and visitors. The facility has one-hundred and seventy-eight (178) certified beds and the census was one-hundred and thirty (130) on the day of the survey. The findings include: Observation, on 08/07/13 at 12:03 PM, with the Maintenance Director revealed three (3) motorized patient lift chargers were plugged into a power strip located in the Arcadia Hall Linen Closet. Interview, on 08/07/13 at 12:03 PM, with the Maintenance Director revealed he was aware of the requirements for the usage of power strips; however, he was not aware of the three (3) motorized patient lift chargers plugged into a power strip located in the Arcadia Hall Linen Closet. 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	K 147	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** –The 3 charging units for patient lifts in the Arcadia Hall linen closet were removed from the power strip and plugged into proper electrical outlet on 08/08/13. **How you will identify other residents having the potential to be affected by the same deficient practice** – Current residents have the potential to be affected by this deficiency. All linen closets in the facility were inspected by Maintenance Assistant on 08/29/13 and no areas were identified as having medical equipment/charging devices plugged into a power strip. **What measures will be put into place or what systematic changes you will make to ensure the deficient practice does not recur-** Safety Committee (HR Director, Staffing Coordinator, Maintenance, Housekeeping, Laundry, C.N.A.) was inserviced by Assistant Administrator on proper use of power strips on 08/28/13. **How the corrective action(s) will be monitored to ensure that solutions are**	

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K 147	Continued From page 8 the need for extension cords or multiple outlet adapters.	K 147	**sustained** – Safety Committee (HR Director, Staffing Coordinator, Maintenance, Housekeeping, Laundry, C.N.A) will audit linen closets to ensure power strips are not being used in these areas. Safety Committee (HR Director, Staffing Coordinator, Maintenance, Housekeeping, Laundry, C.N.A) will conduct audits of linen closets once a week for 4 weeks, monthly times 2 months and quarterly for 2 quarters and report audit findings to the Quality Assurance and Performance Improvement Committee for ongoing review until issue is deemed corrected. Areas of non-compliance will be corrected immediately. The Quality Assurance and Performance Improvement (QAPI) committee will validate the actions taken are effectively resolving the cited issues beginning 09/18/13.	

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