STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185142	A. BUILDING _____ B. WING _____	**02/19/2014**

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0282 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Provide care by qualified persons according to each resident's written plan of care.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the Hospital's Office Follow-up Report, and the facility's Condition Change of a Resident policy, it was determined the facility failed to ensure services were provided by qualified persons in accordance with each resident's written plan of care for one (1) of seven (7) sampled residents (Resident #1). The facility failed to monitor Resident #1 according to the care plan while receiving [MEDICAL CONDITION] treatment. On [DATE], Resident #1 started [MEDICAL CONDITION] for [MEDICAL CONDITION]. The care plan included to monitor for an increased temperature, signs/symptoms of infection, nausea, vomiting, diarrhea, abdominal cramping, increased fatigue, sores in the mouth, sore tongue, skin breakdown, and signs/symptoms of dehydration while receiving [MEDICAL CONDITION]. On [DATE] at 5:29 PM, the facility documented the resident had a temperature of 100.5 degrees Farenheit (F); however, there was no documented evidence the licensed staff monitored the resident according to the care plan at that time or throughout the remainder of the shift. In addition, there was no documented evidence the resident was monitored on the next shift (on [DATE] 11:00 PM-7:00 AM). The resident was found in bed deceased , on [DATE] at 8:00 AM with visible signs of rigor mortis. The facility's failure to ensure each resident was provided services by qualified persons in accordance with each resident's written plan of care has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on [DATE] and determined to exist on [DATE]. The facility was notified of the Immediate Jeopardy on [DATE]. An acceptable Allegation of Compliance (AoC) was received on [DATE] alleging the removal of Immediate Jeopardy on [DATE]. The State Survey Agency validated, on [DATE], the Immediate Jeopardy was removed on [DATE], as alleged. The scope and severity was lowered to a D at 482.20 Resident Assessment, F-282 and 485.25 Quality of Care, F-309 while the facility develops and implements the Plan of Correction (PoC) and the facility's Performance Improvement Committee monitors the effectiveness of the systemic changes. The findings include: Review of the facility's Condition Change of a Resident policy, last revised [DATE], revealed staff was to monitor and assess the resident's condition and response to interventions until stable. Record review revealed the facility admitted Resident #1 on [DATE] with [DIAGNOSES REDACTED]. Review of the Quarterly Minimum Data Set (MDS) assessment, dated [DATE], revealed the facility assessed the resident as cognitively intact with a Brief Interview for Mental Status (BIM) score of 14 indicating the resident was interviewable. Review of the Comprehensive Care Plan for [MEDICAL CONDITION], initiated [DATE], revealed the nurses needed to monitor the resident for signs and symptoms of infections, nausea, vomiting, diarrhea, abdominal cramping, increased fatigue, sores in the mouth, sore tongue, skin breakdown, and signs/symptoms of dehydration while having [MEDICAL CONDITION]. Review of the Hospital's Office Follow-up Report, dated [DATE], revealed Resident #1 began treatment for [REDACTED]. Review of the Nurse's Notes, dated [DATE] at 10:30 PM, revealed the resident was complaining of nausea, vomiting and diarrhea and had a temperature of 101.8 degrees F. The physician was notified with new orders received for [MEDICATION NAME] (anti-nausea) suppositories for the nausea, and Tylenol suppositories for the increased temperature. On [DATE] at 2:27 PM, the resident was moved to a private room to protect him/her from other people due to a low blood count. The resident was still complaining of nausea and vomiting. Review of the Weights and Vital Signs Summary, revealed Resident #1 had a temperature of 98.3 degrees F. orally on [DATE] at 11:09 PM, 99.3 degrees F. tympanic on [DATE] at 2:26 PM and an increased temperature of 100.5 degrees F orally (normal 97XXX,[DATE].7 orally) on [DATE] at 5:29 PM. Record review revealed there was no documented evidence the LPN addressed the resident's increased temperature and no documented evidence the nurse monitored the resident for signs and symptoms of infections, nausea, vomiting, diarrhea, abdominal cramping, increased fatigue, sores in the mouth, sore tongue, skin breakdown, and signs/symptoms of dehydration per care plan at that time or throughout the remainder of the shift on [DATE]. In addition, there was no documented evidence the licensed staff monitored the resident from [DATE] at 11:00 PM through [DATE] at 7:00 AM. Review of the Nurse's Notes, dated [DATE] at 8:00 AM, revealed the resident was found in bed deceased with signs of lividity, blood pooling in the lowest parts of the body with darkening of the skin in the independent parts of his/her body. In addition, it was noted rigor had set in as illustrated by the fixed position of the resident's limbs. Interview with Licensed Practical Nurse (LPN) #5, on [DATE] at 3:00 PM, revealed he was the ,[DATE] PM shift nurse, on [DATE]. LPN #5 stated he talked to the resident around 6:00 PM when he was checking the resident's feeding tube for placement and residual prior to starting the tube feeding. He stated at that time the resident had no complaints. He stated he was made aware the resident had a temperature of 100.5 degrees F later in the shift; however, the resident refused a Tylenol suppository. He stated he was supposed to document the refusal on the back of the MAR; however, review of the MAR, dated [DATE], revealed no evidence of the resident's refusal of the medications. Interview with Certified Nurse Aide (CNA) #8, on [DATE] at 1:55 PM, revealed she worked on [DATE] from 11:00 PM to 7:00 AM. She obtained the resident's temperature at the beginning of the shift; however, she could not remember the results. There was no documented evidence of the temperature. Interview with LPN #1, on [DATE] at 2:40 PM and on [DATE] at 10:50 AM, revealed she was the nurse on [DATE] from 11:00 PM to 7:00 AM. She stated she visualized the resident at the beginning of her shift around 11:00 PM and the resident had an oxygen saturation of 96 percent (%). She stated she asked the resident how he/she was feeling and the resident responded the same. She stated she did not assess the resident throughout the rest of the shift. Interview with the resident's Oncologist (cancer physician), on [DATE] at 4:40 PM, revealed he would have expected vital signs every shift with routine monitoring of Resident #1, per the facility's change in condition policy. Interview with the Director of Nursing (DON), on [DATE] at 3:50 PM, revealed she would expect staff to follow the care plan and document any signs/symptoms the resident may be experiencing. She would expect nursing to document an assessment every shift on Resident #1 as he/she was having side effects from the [MEDICAL CONDITION] treatment. She revealed an assessment should have included skin color, warmth, respirations, and abdominal distention. She stated there was no specific facility policy related to nursing assessments. The facility implemented the following actions to remove the Immediate Jeopardy: - On [DATE], all current residents were assessed head to toe by the DON, Unit Managers, Case Management, Staff Development Coordinator, and a Registered Nurse. All current resident care plans were reviewed to ensure the interventions were appropriate and implemented in accordance with the care plan. Care plans were revised, if indicated. - On [DATE], the RN Staff Development Coordinator and/or DON, and/or Unit Managers initiated additional assessment and care plan education with all licensed nurses related to the use of the facility's Pharmacy website to look up side effects of medications, observing for side effects, updating the resident care plans with serious side effects for high risk medications, and reporting to the physician serious medication side effects. Education would be ongoing until all licensed nurses had attended. Any licensed nurse that had not received the education by [DATE], would not be allowed to work until receiving the education. - On [DATE], the DON also implemented a 72 hour Alert Charting tool as a guide to document evidence of resident assessment and following the care plan. The RN Staff Development Coordinator and/or DON, and/or Unit Managers educated all licensed nurses to initiate one of these assessment tools for any resident noted with a change in condition. The tool cues every shift to assess and document on the resident noted with a change in condition for 72 hours or until the condition change had resolved. - The Unit Managers and or RN Weekend Supervisor would make daily observations of resident samples on each

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185142	A. BUILDING _____ B. WING _____	02/19/2014

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0282 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	(continued... from page 1) nursing unit to ensure the licensed nurses were completing accurate, thorough, and timely assessments of the residents; they would also validate by interview and observation that the licensed nurses were following the care plans and documenting accurate, thorough, and timely resident information. They would review all new physician orders, 72 hour alert charting tools, care plan updates, and shift reports daily until deemed necessary by the Performance Improvement Committee. The findings would be documented on the Resident Change of Condition/Assessment audit tool with the date/initial of the physician's orders [REDACTED]. - The audit findings would be reviewed weekly by the Performance Improvement Committee. ** The State Survey Agency validated the corrective action taken by the facility as follows: Verified documentation of a head to toe nursing assessment with care plan review for all in-house residents, completed on [DATE]. Interviews with the SDC and DON, on [DATE] at 9:30 AM and 9:35 AM respectively, revealed nursing assessments to include head to toe skin assessments and vitals sign and review of all resident care plans were completed on all residents to ensure any change in conditions were identified and care plans were complete and accurate. Review of in-service/education records, dated [DATE], revealed all licensed staff was inserviced on the stop and watch early warning tool, Situation, Background, Assessment and Recommendation (SBAR) interact tool, condition change of a resident policy/procedure, 72 hour charting checklist, high alert medications, resident refusal of care policy/procedure, documentation do's and don'ts reference guide, assessment in the computer system, care path interact tools, care plans policy/procedure, and the change in condition audit tool. The 72 hour monitoring tool was verified in effect for residents with a change in condition or any new order received. Verified documentation of the change in condition audit, the tool has been in effect since [DATE] with no concerns. Interviews with RN Unit Manager (UM), LPN UM, RN #2, LPN #1, LPN #5, LPN #6, LPN #7, LPN #8, and LPN #9 on [DATE] at 4:30 PM, 4:38 PM, and 4:45 PM, and on [DATE] at 10:15 AM, 10:25 AM, 10:30 AM, 10:45 AM and 11:00 AM respectively, revealed they were inserviced related to the SBAR, Stop and Watch, side effects, 72 hour charting tool and care plans. The RN and LPN UMs revealed they were conducting audits and reviewing physician orders, 72 hour alert charting tools, care plan updates, and shift reports daily to ensure accurate and timely resident assessments were completed by staff. Interview with the Pharmacist Consultant, on [DATE] at 10:55 AM, revealed he reviewed all residents medications to ensure no other resident were on [MEDICAL CONDITION] medications. Interviews with the Executive Director (ED) and DON, on [DATE] at 11:20 AM and 11:30 AM respectively, revealed Performance Improvement (PI) meetings were being conducted weekly with one scheduled for [DATE]. They stated the last time they had one was [DATE] and they went over the audit tools and discussed what would be monitored. They stated on [DATE] they would look for any trends or concerns that had been identified, and update on the education. They revealed they would continue weekly meetings until compliance was sustained. They revealed they also had daily meetings (Mon-Fri) to discuss any concerns with the audit tools. The meeting was more detailed and resident specific.
F 0309 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	**Provide necessary care and services to maintain the highest well being of each resident** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the facility's Condition Change of a Resident policy, and the Hospital Office Follow-up Report, it was determined the facility failed to ensure each resident was provided the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the plan of care for one (1) of seven (7) sampled residents (Resident #1). The facility failed to provide ongoing assessments for Resident #1 while on [MEDICAL CONDITION] and after staff identified an increased temperature. Resident #1 started [MEDICAL CONDITION] for [MEDICAL CONDITION] on [DATE]. The resident began having nausea, vomiting, diarrhea, and a temperature of 101.8 degrees Farenheit (F) on [DATE], with a new order from the resident's primary physician which included Tylenol 650 milligrams (mg) suppository every six (6) hours as needed for an increased temperature. Labwork was collected on [DATE] with results received on [DATE], indicating a low white blood cell count of 0.9 (normal 4XXX,[DATE].0) The resident was moved to a private room at this time on reverse isolation precautions, as a nursing intervention. The Oncologist ordered [MEDICATION NAME] injections, to increase the resident's white blood cell count. On [DATE] at 5:29 PM, the facility documented the resident's temperature of 100.5 degrees F; however, there was no documented evidence of a resident assessment or administration of medication for the increased temperature at that time. In addition, there was no documented evidence the licensed staff had conducted ongoing assessments of Resident #1 for the remainder of that shift, until 11:00 PM; and on the next shift (,[DATE] AM on [DATE]). Resident #1 was found in bed deceased , on [DATE] at 8:00 AM, with signs of lividity, blood pooling in lowest parts of his/her body with darkening of the skin in the independent parts of the body, and rigor set in as illustrated by the fixed position of the resident's extremities. (Refer to F282) The facility's failure to ensure each resident received necessary care and services related to the failure to provide an on-going assessment of Resident #1 after a change in condition has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on [DATE] and determined to exist on [DATE]. The facility was notified of the Immediate Jeopardy on [DATE]. An acceptable Allegation of Compliance (AoC) was received on [DATE] alleging the removal of Immediate Jeopardy on [DATE]. The State Survey Agency validated, on [DATE], the Immediate Jeopardy was removed on [DATE], as alleged. The scope and severity was lowered to a D at 482.20 Resident Assessment, F-282 and 485.25 Quality of Care, F-309 while the facility develops and implements the Plan of Correction (PoC) and the facility's Performance Improvement Committee monitors the effectiveness of the systemic changes. The findings include: Review of the Condition Change of a Resident policy, revised [DATE], revealed staff was to monitor and assess the resident's condition and response to interventions until stable. Record review revealed the facility admitted Resident #1 on [DATE] with [DIAGNOSES REDACTED]. Review of the Quarterly Minimum Data Set (MDS) assessment, dated [DATE], revealed the facility assessed the resident's cognition as cognitively intact with a Brief Interview for Mental Status (BIMS) score of 14 which indicated the resident was interviewable. The resident was a full code. Review of the Hospital's Office Follow-up Report, dated [DATE], revealed Resident #1 began [MEDICAL CONDITION] for gastric [MEDICAL CONDITION] (cancer) on [DATE]. Review of the Comprehensive Care Plan for [MEDICAL CONDITION], initiated [DATE], revealed an intervention for nurses to monitor the resident for an increased temperature, signs/symptoms of infection, nausea, vomiting, diarrhea, and abdominal cramping and signs/symptoms of dehydration while having [MEDICAL CONDITION]. Review of the Nurse's Notes, dated [DATE], revealed the resident complained of nausea, vomiting, and diarrhea with a temperature of 101.8 degrees F. An order was received for [MEDICATION NAME] (antiemetic) 12.5 milligrams (mg) suppository every four hours as needed for nausea/vomiting, and Tylenol (fever reducer) 650 mg suppository every six hours as needed for increased temperature. Review of the Laboratory Report, received [DATE], revealed a white blood cell count of 0.9 (normal 4XXX,[DATE].0). Review of the Nurse's Notes, dated [DATE] at 2:27 PM and 4:59 PM, revealed Resident #1 was moved to a private room in reverse isolation for a low white blood cell count. Review of the Weights and Vital Signs Summary, dated [DATE] at 5:29 PM, revealed a temperature of 100.5 degrees F orally (normal 97XXX,[DATE].7 orally); however, review of the Nurse's Notes for [DATE] and the [DATE] Medication Administration Record [MEDICATION ADMINISTRATION RECORD DETAILS REDACTED]. In addition, further review revealed no documented evidence ongoing assessments were conducted for Resident #1 from the time the temperature was identified on [DATE] at 5:29 PM until the resident was found deceased in bed on [DATE] at 8:00 AM. Interview with Licensed Practical Nurse (LPN) #5, on [DATE] at 3:00 PM, revealed he was the 3 PM-11 PM shift nurse, on [DATE]. He stated he was aware the resident had a temperature of 100.5 degrees; however, the resident refused a Tylenol suppository. He stated he was supposed to document the refusal on the back of the MAR; however, review of the MAR, dated [DATE], revealed no evidence of the refusal. Interview with Certified Nurse Aide (CNA) #8, on [DATE] at 1:55 PM, revealed she worked on [DATE] from 11:00 PM to 7:00 AM. She stated she obtained the resident's temperature at the beginning of the shift; however, she could not remember the results. She stated the resident had complained his/her stomach was hurting and wanted his/her feeding shut off. She stated she told LPN #1. She stated she checked on the resident several times and he/she was still in bed and she thought the resident was asleep. She stated it was dark and the lights were off. Interview with LPN #1, on [DATE] at 2:40 PM and on [DATE] at 10:50 AM, revealed she was the nurse on [DATE] from 11:00 PM to 7:00 AM. She stated the resident was visualized at the beginning of her shift and had an oxygen saturation of 96 percent (%). She asked the resident how he/she was feeling and the resident responded the same. She told the resident to use the call light if he/she needed assistance. She stated the aide reported to her that the resident wanted his/her feeding tube turned off. She stated she went to the room approximately ten (10) minutes after the aide told her. The LPN stated the resident had his/her back to her and was in the fetal position. She stated she did not bother him/her, just noted that the pump was turned off and it was still hooked to the resident. She stated she should have assessed the resident and talked to the resident about why the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185142	A. BUILDING _____ B. WING _____	**02/19/2014**

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0309 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	(continued... from page 2) pump was turned off. The LPN revealed she went back in between ,[DATE]:30 AM to turn the pump back on, but did not assess the resident at the time. She stated the resident was in the same position. Review of the Nurse's Note, dated [DATE] at 8:00 AM, revealed Resident #1 was found with no respirations, pulse, heartbeat and no blood pressure. No Cardiopulmonary Resuscitation was started due to signs of lividity, blood pooling in the lowest parts of body with darkening of the skin in the independent parts of the body, and rigor set in as illustrated by the fixed position of the resident's extremities. Interview with LPN #2, on [DATE] at 9:32 AM, revealed she came on shift around 6:45 AM on [DATE], and received report from LPN #1 about 7:15 AM. The LPN stated LPN #1 told her Resident #1's feeding tube was turned off around 2:00 AM because his/her stomach was aching. LPN #2 revealed she entered Resident #1's room at 8:00 AM, and knew immediately that the resident was deceased . She revealed the resident was laying on his/her right side facing the door. The resident had no pulse, blood pressure, was not breathing, and had no heartbeat, and the resident was extremely cold and stiff. Interview with the resident's Oncologist, on [DATE] at 4:40 PM, revealed he would have expected vital signs every shift with routine monitoring of Resident #1, per the facility's change in condition policy. Interview with the Director of Nursing (DON), on [DATE] at 3:50 PM, revealed the resident was in reverse isolation precautions as a nursing intervention. She stated she expected nursing to document an assessment every shift on Resident #1 as he/she was having side effects from the [MEDICAL CONDITION] treatment. She revealed an assessment should have included skin color, warmth, respirations, and abdominal distention. She revealed there was no specific facility policy related to nursing assessments. The facility implemented the following actions to remove the Immediate Jeopardy: - On [DATE], all current residents were assessed head to to by the DON, Unit Managers, Case Management, Staff Development Coordinator, and a Registered Nurse. All current resident care plans were reviewed to ensure the interventions were appropriate and implemented in accordance with the care plan. Care plans were revised, if indicated. - On [DATE], the DON conducted assessment education with LPN #1, who provided care for Resident #1, including assessments for gastrostomy tube verification, gastric residual checks, flushing gastrostomy tubes, and documentation skills. - On [DATE], the RN Staff Development Coordinator and/or the DON and/or Unit Managers initiated education with all Licensed Nurses related to the use of Situation, Background, Assessment and Recommendation (SBAR)/interact program for identification of resident changes in condition. The assessment and care plan education consisted of the use of Interact III Critical Pathways, use of shift reports to communicate resident status, follow up assessment and monitoring of residents with a change of condition using an alert charting system. Education would be ongoing until all licensed nurses have attended. Any licensed nurse that had not received the education by [DATE], would not be allowed to work until receiving the education. - On [DATE], the DON and Consultant Pharmacist audited all in-house residents for physician orders [REDACTED]. - On [DATE], the RN Staff Development Coordinator and/or DON, and/or Unit Managers initiated additional assessment and care plan education with all licensed nurses related to the use of the facility's Pharmacy website to look up side effects of medications, observing for side effects, updating the resident care plans with serious side effects for high risk medications, and reporting to the physician serious medication side effects. Education would be ongoing until all licensed nurses have attended. Any licensed nurse that had not received the education by [DATE], would not be allowed to work until receiving the education. - On [DATE], the DON also implemented a 72 hour Alert Charting tool as a guide to document evidence of resident assessment and following the care plan. The RN Staff Development Coordinator and/or DON, and/or Unit Managers educated all licensed nurses to initiate one of these assessment tools for any resident noted with a change in condition. The tool cues every shift to assess and document on the resident noted with a change in condition for 72 hours or until the condition change had resolved. - The Unit Managers and or RN Weekend Supervisor would make daily observations of resident samples on each nursing unit to ensure the licensed nurses were completing accurate, thorough, and timely assessments of the residents; they would also validate by interview and observation that the licensed nurses were following the care plans and documenting accurate, thorough, and timely resident information. They would review all new physician orders, 72 hour alert charting tools, care plan updates, and shift reports daily until deemed necessary by the Performance Improvement Committee. The findings would be documented on the Resident Change of Condition/Assessment audit tool with the date/initial of the physician's orders [REDACTED]. - The audit findings would be reviewed weekly by the Performance Improvement Committee. ** The State Survey Agency validated the corrective action taken by the facility as follows: Verified documentation of a head to toe nursing assessment with care plan review for all in-house residents, completed on [DATE]. Interviews with the SDC and DON, on [DATE] at 9:30 AM and 9:35 AM respectively, revealed nursing assessments to include head to toe skin assessments and vitals sign and review of all resident care plans were completed on all residents to ensure any change in conditions were identified and care plans were complete and accurate. Interview with LPN #1 revealed she received the assessment education related to gastrostomy tubes, resident change in condition, updating care plans, 72 hour alert charting, and documentation skills. Review of in-service/education records, dated [DATE], revealed all licensed staff was inserviced on the stop and watch early warning tool, SBAR interact tool, condition change of a resident policy/procedure, 72 hour charting checklist, high alert medications, resident refusal of care policy/procedure, documentation do's and don'ts reference guide, assessment in the computer system, care path interact tools, care plans policy/procedure, and the change in condition audit tool. Verified documentation of an audit of medications for in-house residents on [DATE] and no residents were currently taking [MEDICAL CONDITION] agents. Verified the audit per interview with the consultant pharmacist. 72 hour monitoring tool-- verified in effect for residents with a change in condition or any new order received. Verified documentation of the change in condition audit, the tool has been in effect since [DATE] with no concerns. Interviews with RN Unit Manager (UM), LPN UM, RN #2, LPN #1, LPN #5, LPN #6, LPN #7, LPN #8, and LPN #9 on [DATE] at 4:30 PM, 4:38 PM, and 4:45 PM, and on [DATE] at 10:15 AM, 10:25 AM, 10:30 AM, 10:45 AM and 11:00 AM respectively, revealed they were inserviced related to the SBAR, Stop and Watch, side effects, 72 hour charting tool and care plans. The RN and LPN UMs revealed they were conducting audits and reviewing physician orders, 72 hour alert charting tools, care plan updates, and shift reports daily to ensure accurate and timely resident assessments were completed by staff. Interview with the Pharmacist Consultant, on [DATE] at 10:55 AM, revealed he reviewed all residents' medications to ensure no other residents were on [MEDICAL CONDITION] medications. Interviews with the DDCO, ED and DON, on [DATE] at 11:20 AM and 11:30 AM respectively, revealed Performance Improvement (PI) meetings were being conducted weekly with one scheduled [DATE]. They stated the last time they had one was [DATE] and they went over the audit tools and discussed what would be monitored. They stated in the next PI meeting they would look for any trends or concerns that had been identified, and update on the education. They revealed they would continue weekly meetings until compliance was sustained. They revealed they also have daily meetings (Mon-Fri) to discuss any concerns with the audit tools, it was more detailed and resident specific.
F 0322 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Give proper treatment to residents with feeding tubes to prevent problems (such as aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, nasal-pharyngeal ulcers) and help restore eating skills, if possible.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the facility's policy/procedures, it was determined the facility failed to ensure a resident who was fed by gastrostomy tube received the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, and metabolic abnormalities for one (1) of seven (7) sampled residents (Resident #1). The findings include: Review of the facility's Tube Placement Verification and Gastric Residual Volume (GRV) policy/procedure, released 04/28/13, revealed GRV was checked in enterally fed patients to protect against aspiration pneumonia and to monitor tolerance of enteral feeding and gastric emptying. The placement of the gastric tube was checked by aspiration to validate that the tube was in the stomach. The frequency of placement verification and GRV was before each feeding and/or flush via syringe, and every 6-8 hours for a gastrostomy tube depending on the patient's tolerance of feeding. Review of the Flushing Feeding Tube policy/procedure, revised 04/28/11, revealed the feeding tube was flushed before initiating a pump feeding, in order to maintain patency. Record review revealed the facility admitted Resident #1 on 05/24/13 with [DIAGNOSES REDACTED]. Review of the Quarterly Minimum Data Set (MDS) assessment, dated 11/24/13, revealed the facility assessed the resident as cognitively intact. Review of the physician's orders [REDACTED]. Check tube placement before initiation of formula, medication administration, and flushing the tube, or at least every eight (8) hours. Check and record residuals every 8 hours. If residuals were greater than 180 ml, hold the feeding and call the physician. Interview with Certified Nurse Aide (CNA) #8, on 02/06/14 at 2:25 PM and on 02/07/14 at 9:20 AM, revealed she worked on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185142	A. BUILDING _____ B. WING _____	**02/19/2014**

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0322 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 3) 01/31/14, starting at 11:00 PM. She stated she answered the call light for Resident #1, who had a request to turn off his/her enteral feeding as his/her stomach was hurting; however, she could not remember an exact time of the request. She revealed it was reported to Licensed Practical Nurse (LPN) #1. Further interview revealed the resident had a history of [REDACTED]. Interview with LPN #1, on 02/06/14 at 2:40 PM, and on 02/10/14 at 10:50 AM, revealed CNA #8 reported the resident's enteral feeding was turned off, on 01/31/14, sometime between 11:30 PM and 11:45 PM. She revealed it was not uncommon for the resident to turn off his/her enteral feeding as his/her stomach felt full. LPN #1 stated she went into the resident's room approximately ten (10) minutes later, and the enteral feeding was off. She stated she did not speak to the resident as his/her back was turned away from her and she did not conduct an assessment of the resident at that time. She revealed between 3:00 AM and 3:30 AM, she went back into the room and turned the resident's enteral feeding on. She did not flush the feeding tube, check placement, residual, or assess the resident prior to the initiation of the feeding. Interview with the Primary Physician, on 02/07/14 at 9:50 AM and on 02/11/14 at 9:45 AM, revealed he was not specifically aware of the resident having his enteral feeding turned off due to stomach issues. He revealed it would not be uncommon as the resident was receiving a high rate of feeding. He expected the nursing staff to check the residual and hold the feeding, if necessary. He expected staff to follow the orders per the facility protocol. Interview with the Oncologist, on 02/11/14 at 11:10 AM, revealed the resident was receiving [MEDICAL CONDITION] for a gastric mass. He indicated the mass could cause fullness when the enteral feeding was initiated. He indicated if he had been made aware of the problem, he would possibly have decreased the rate of enteral feeding. Interview with the Registered Dietician, on 02/11/14 at 10:00 AM, revealed she was not aware of the resident having issues with his/her enteral feeding at night. She would expect staff to notify her as she would have assessed the resident for further problems. Interview with the Director of Nursing (DON), on 02/11/14 at 10:15 AM, revealed she expected staff to follow the physician's orders [REDACTED].