

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185400	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/12/2024
NAME OF PROVIDER OR SUPPLIER Hearthstone Place		STREET ADDRESS, CITY, STATE, ZIP CODE 506 Allensville Road Elkton, KY 42220	

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)
<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>28193</p> <p>Based on interview, record review, and review of facility policy, the facility failed to initiate a new Level I Preadmission Screening and Resident Review (PASARR) for a resident who received new psychiatric diagnoses following admission. This affected one (1) of one (1) residents reviewed for PASARR requirements, (Resident (R)14.</p> <p>The findings include:</p> <p>An undated facility policy titled, Preadmission Assessment and Annual Resident Review (PASARR), revealed, The purpose of the Preadmission Assessment and Annual Resident Review Program (PASARR) policy and procedure is to develop guidelines for admission related to those individuals with mental illness and intellectual disabilities to ensure they receive the care and services needed in the most appropriate setting.</p> <p>R14's Pre-Admission Screening and Resident Review (PASARR) Nursing Facility Identification Screen (Level I), dated 07/15/2013, prior to R14's admission to the facility, revealed the resident did not have a major mental disorder, to include severe anxiety disorder, other psychotic disorders, or another mental disorder that may lead to a chronic disability. The Level I screening indicated the resident did not meet the criteria for mental illness or mental retardation.</p> <p>Review of R14's Admission Record revealed the facility admitted the resident on 07/16/2013. According to the Admission Record, the resident had a medical history that included diagnoses including psychosis due to a substance or known physiological condition (onset 08/07/2015), anxiety disorder (onset 10/22/2015), and major depressive disorder (onset 10/22/2015).</p> <p>Review of R14's Comprehensive Care Plan included a focus area initiated on 04/11/2014, which revealed the resident was non-complaint with care being provided as evidenced by a rejection of care and refusal of medications. Interventions directed staff to allow the resident to make as many choices as possible within limits (initiated 04/11/2014); to be alert to increased signs and symptoms of depression, and to promptly report to the physician symptoms such as crying, sadness, and verbalizing self-worth; and to notify the physician of unwillingness to accept care and/or medications (initiated 04/11/2014).</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of R14's Comprehensive Diagnostic Evaluation & Treatment Plan, dated 08/06/2015, revealed the Reason for Referral indicated delusional/anxiety. The record revealed the DSM - IV [Diagnostic and Statistical Manual of Mental Disorders - Fourth Edition] Diagnoses indicated the resident had diagnoses of generalized anxiety disorder, depression, vascular dementia with disturbance of mood and behavior with delusions, and psychosis.</p> <p>Further review of R14's Comprehensive Care Plan included a focus area revised on 04/10/2023, which revealed the resident was at risk for increased behaviors, altered mood state, and altered psychosocial well-being related to a diagnosis of cerebrovascular accident (CVA-Stroke), resulting in brain damage with moderate confusion, increased agitation and attention seeking behaviors. Interventions directed staff to be alert for expressions of mood indicators, behaviors, and/or altered psychosocial well-being (initiated 03/26/2014); document all displayed mood indicators/behaviors and determine effectiveness of interventions (initiated 03/26/2014); seek a psychiatric consultation as ordered (initiated 03/26/2014); assess for the cause of the increased mood indicators/behaviors (initiated 03/26/2014); and tell the resident to stop the exhibited behavior while immediately distancing the recipient/resident to prevent harm from aggression (initiated 08/16/2015).</p> <p>Review of R14's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/08/2024, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of nine (9) out of 15 indicating moderate cognitive impairment. Per the MDS, the resident had active psychiatric diagnoses of anxiety, depression, and psychotic disorder. Further review of the MDS, revealed the resident was receiving antidepressant medication during the assessment timeframe.</p> <p>Review of R14's Diagnosis Report, dated 09/11/2024, revealed diagnoses including manic psychosis (onset 08/07/2015), recurrent major depressive disorder (onset 10/22/2015), and anxiety disorder (onset 10/22/2015).</p> <p>Further review of R14's medical record revealed no other PASARR had been completed since admission to the facility. Additionally, there was no evidence to indicate a referral was made to the appropriate state-designated authority after receiving new psychiatric diagnoses.</p> <p>During an interview, on 09/12/2024 at 3:07 PM, the Medical Records Director (MRD) stated she had worked at the facility since 2008. She further stated when she was alerted there was a new admission coming to the facility, she accessed the electronic system to fill out the initial application for a Level I screening. If the application was positive, the state designated mental health authority would call the facility and start the process for a Level II evaluation to be completed. The MRD stated if a resident received a new psychiatric diagnosis, she logged into the electronic system and updated the diagnosis to see if it triggered a positive Level I screening. She further stated, when R14 received new diagnoses in 2015, she should have updated the diagnoses in the electronic system and completed another Level I screening to see if it triggered as positive.</p> <p>During an interview, on 09/12/2024 at 3:26 PM, the Director of Nursing (DON) stated she did not know anything at all about the PASARR process.</p> <p>During an interview, on 09/12/2024 at 4:07 PM, the Administrator stated he expected the PASARR assessments to be completed as appropriate.</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>28193</p> <p>Based on observation, interview, record review, and review of facility policy, the facility failed to ensure services provided by the facility met professional standards of quality for one (1) of three (3) residents observed during medication pass, (Resident (R)8.</p> <p>R8's Physician's Order sheet for 09/2024, revealed a current order for metformin hydrochloride (HCL) 1,000 milligrams (mg) with instructions to give one (1) tablet by mouth every morning at 9:00 AM. The Physician's Order sheet further revealed a current order for metformin HCL 500 mg with instructions to give one (1) tablet at 5:00 PM. During an observation of medication administration on 09/10/2024 at 9:08 AM, Kentucky Medication Aide (KMA)12 was unable to locate R8's metformin hydrochloride (HCL) 1,000 milligram (mg) tablets. Staff interviews revealed R8's metformin HCL 1,000 mg tablets had been reordered on 08/31/2024, but had not been delivered. Staff interviews further revealed they had been administering two (2) 500 milligram (mg) tablets of metformin HCL instead of the ordered 1,000 mg tablet for the 9:00 AM dose. Staff had not notified the physician, the 1,000 mg tablets were unavailable or followed up with pharmacy.</p> <p>The findings include:</p> <p>Review of the facility policy titled, Administering Medications, revised on 11/15/2011, revealed Medications will be administered in a timely manner and as prescribed by the resident's Attending Physician or the facility's Medical Director. The policy indicated, . The Director of Nursing Services is responsible for the supervision and direction of all personnel with medication administration duties and functions. Medications must be administered in a timely manner and in accordance with the Attending Physician's written/verbal orders. The policy further revealed . The individual administering the medication must ensure that the right medication, right dosage, right time and right method of administration are verified e.g. [exempli gratia, for example], review of drug label, physician's order, etc. [et cetera; and so forth] before the medication is administered.</p> <p>Review of R8's Admission Record revealed the facility admitted the resident on 08/02/2021. According to the Admission Record, the resident had a medical history that included a diagnosis of type 2 diabetes mellitus.</p> <p>Review of R8's Comprehensive Care Plan, revealed a focus area revised 02/25/2020, stating the resident was at risk for hyperglycemia and hypoglycemia related to a diagnosis of diabetes. Interventions directed staff to give diabetic medications as ordered by the physician (initiated 08/18/2021).</p> <p>Review of R8's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/08/2024, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of 11 out of 15, indicating moderate cognitive impairment. Further review revealed the facility assessed the resident as having an active diagnosis of diabetes mellitus.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of R8's Physician's Order sheet for 09/2024, revealed a current order dated 03/30/2024 for metformin hydrochloride (HCL) (medication used to treat type 2 diabetes) 1,000 milligrams (mg) with instructions to give one (1) tablet by mouth every morning at 9:00 AM. The Physician's Order sheet further revealed a current order dated 03/30/2024 for metformin HCL 500 mg with instructions to give one (1) tablet at 5:00 PM.</p> <p>During an observation of medication administration on 09/10/2024 at 9:08 AM, for R8, KMA12 was unable to find metformin 1,000 mg tablets in the medication cart. After looking in the medication room for back-up medication, the metformin 1,000 mg tablets could not be found.</p> <p>R8's MAR for the timeframe from 09/01/2024 through 09/10/2024, revealed staff documented the resident received metformin 1,000 mg on 09/01/2024 through 09/09/2024 and indicated the medication was not given on 09/10/2024.</p> <p>During an interview, on 09/11/2024 at 11:34 AM, the Director of Nursing (DON) stated R8 received metformin 500 mg in the evening and staff should have doubled up the 500 mg medication instead of leaving the resident without any of the medication for the 9:00 AM dose. When asked if it was acceptable to double up on medication to get the correct milligrams, she stated, That is what I would have done.</p> <p>During an interview, on 09/11/2024 at 2:51 PM, the Social Services Director (SSD), who was also a KMA, stated R8's metformin had been reordered on 08/31/2024 and still had not been delivered. She stated the MAR had been signed several times indicating the medication was administered. The SSD further stated R8 had not missed a dose when she had administered medications because she had given the resident two (2) 500 mg tablets of metformin to make 1,000 mg for the 9:00 AM dose.</p> <p>During a subsequent interview, on 09/12/2024 at 10:28 AM, the SSD stated she had passed medications to R8 on 09/01/2024 and 09/08/2024. She stated R8 had been out of metformin 1,000 mg tablets for a few days, but she was not exactly sure how many days. She further stated the resident could have been out of the 1,000 mg tablets on 09/01/2024 because she had told the nurse to reorder them on that date and had administered the resident two (2) of the resident's evening 500 mg metformin tablets on 09/08/2024 for the 9:00 AM dose. The SSD stated she had not called the physician about doubling up on the metformin because she did not have permission to call the doctor. She stated she was not sure if the nurse had called the physician related to this. She further stated she felt doubling up smaller doses of a medication was acceptable as long as the resident received the correct amount of the medication.</p> <p>During an interview, on 09/12/2024 at 12:01 PM, Licensed Practical Nurse (LPN) 27 stated she had passed medication to R8 on 09/06/2024 and 09/07/2024. She stated R8 had been out of metformin 1,000 mg for a few weeks and although the facility had an overflow of medications, the metformin was not included. LPN27 stated she had been administering two (2) 500 mg metformin tablets in order for the resident to receive the correct dose of medication. However, she further stated it was not acceptable to double up smaller doses of a medication to equal the prescribed amount. LPN27 stated the physician should be notified immediately if a medication refill was needed or if a new prescription needed to be written, but she had not called the doctor in reference to R8 being out of the metformin 1,000 mg tablets.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a phone interview, on 09/11/2024 at 4:04 PM, Pharmacist 23, from the facility's dispensing pharmacy, stated it would not be appropriate for facility staff to use two (2) metformin 500 mg tablets when they ran out of the 1,000 mg tablets. He stated doing this would cause them to run out of the 500 mg tablets before it was due to be refilled.</p> <p>During a follow up interview, on 09/12/2024 at 3:26 PM, the Director of Nursing (DON) stated if the orders were for metformin 1,000 milligrams (mg), give one (1) tablet by mouth every morning at 9:00 AM, it would not be appropriate for staff to administer two (2) 500 mg tablets. She stated when staff identified a resident was out of a medication, they should contact the pharmacy to send the medication. In the meantime, they would need to call the doctor to get an order if needed, and document the phone call in the nurse's notes.</p> <p>During an interview, on 09/12/2024 at 4:07 PM, the Administrator stated it was his expectation for staff to administer medications as ordered and to reorder medications as needed.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>45849</p> <p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>Based on observation, interview, record review, and review of facility policy, the facility failed to ensure staff provided assistance with activities of daily living (ADLs) for one (1) of one (1) sampled residents reviewed for ADLs, Resident (R)41.</p> <p>Although R41 had a contracture of the left hand, the facility failed to ensure R41's nails were trimmed.</p> <p>The findings include:</p> <p>Review of the facility's undated policy, titled Nail Care, revealed routine cleaning and inspection of nails will be provided during ADL care on an ongoing basis. Routine nail care, to include trimming and filing, will be provided on a regular schedule (such as weekly on Wednesday 3-11 shift). Nail care will be provided between scheduled occasions as the need arises. The resident's plan of care will identify the frequency of nail care to be provided; the type of nail care to be provided; the person(s) responsible for providing nail care such as licensed nurse, nurse aide, podiatrist, or activity professional.</p> <p>Review of R41's Admission Record revealed the facility admitted the resident on 07/05/2023. According to the Admission Record, the resident had a medical history that included diagnoses of cerebral infarction (stroke), hemiplegia and hemiparesis (weakness on one side of the body) affecting left non-dominant side, and contracture of muscle in the left hand.</p> <p>Review of R41's Comprehensive Care Plan, included a focus area initiated on 07/14/2023, revealing the resident was at risk for self-care deficit related to non-independence with ADLs, impaired mobility, weakness, and a diagnosis of cerebrovascular accident (CVA). Interventions directed staff to provide nail care per the facility policy.</p> <p>Review of R41's Annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/12/2024, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of 13 out of 15 indicating intact cognition. Further review revealed the facility assessed the resident as not having rejected care during the assessment period. Additional review revealed R41 required substantial/maximal staff assistance with personal hygiene.</p> <p>Review of R41's Kardex (a care plan that acts as a quick reference guide to the individual needs of residents), as of 09/12/2024, revealed no information related to nail care.</p> <p>Observation on 09/09/2024 at 11:26 AM, revealed R41 had long, jagged fingernails. R41's left hand was contracted. During a concurrent interview, R41 stated the fingernails on her left hand really need trimmed. Resident #41 stated she was concerned her fingernails would cause a wound on her contracted hand if they were not trimmed.</p> <p>Observation on 09/11/2024 at 2:45 PM, revealed R41's fingernails continued to be long and jagged. During a concurrent interview R41 stated, if staff did not trim her fingernails, the nails on her contracted hand would cut the skin.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During interview on 09/12/2024 at 10:45 AM, State Registered Nurse Aide (SRNA)1 stated the SRNAs trimmed resident fingernails unless the resident was diabetic. SRNA1 further stated she was unsure if R41 was diabetic, and she would need to ask the nurse. Additionally, SRNA1 stated R41 was compliant with care and did not refuse care.</p> <p>During interview on 09/12/2024 at 12:28 PM, SRNA10 stated she trimmed resident fingernails whenever she saw that it needed to be done, or whenever the resident requested their nails be trimmed. SRNA10 stated she was unaware of R41 asking for her nails to be trimmed. She stated R41s family trimmed her nails.</p> <p>During interview on 09/12/2024 at 1:32 PM, Licensed Practical Nurse (LPN)5 was asked to check R41's nails. LPN5 checked R41's nails and stated the activity department trimmed the resident's nails. LPN5 then picked up R41s left hand and stated staff had to be real careful with the resident's contracted hand because the nails would dig into the skin.</p> <p>During interview on 09/12/2024 at 1:38 PM, LPN7 stated the nurses trimmed diabetic resident's fingernails once a week. LPN7 further stated the SRNAs were responsible for trimming the non-diabetic resident's nails upon request or when the resident's nails needed cut or filed. LPN7 stated the SRNAs usually trimmed nails when they gave showers, but the nurse was not sure if nail trimming was documented anywhere. LPN7 stated it was important for R41 to receive routine and as needed nail care promptly due to the resident's hand contracture.</p> <p>During interview on 09/12/2024 at 2:49 PM, the Social Services Director (SSD) stated the SRNAs performed nail care for residents who were not diabetic. The SSD stated nail care should be performed on the resident's shower days, not a scheduled day, or just when the SRNA noticed the nails were long. The SSD stated she was not sure if nail care was documented anywhere.</p> <p>During interview, on 09/12/2024 at 3:42 PM, Occupational Therapist (OT)24 stated R41 was not diabetic so anyone could trim her nails.</p> <p>During interview, on 09/12/2024 at 2:52 PM, the Director of Nursing (DON) stated nail care was the responsibility of the treatment nurse. The DON further stated the facility did not currently have a treatment nurse, and therefore the SRNAs or nurses were to perform nail care. The DON stated she was not aware of any schedule for nail care; but nails were to be trimmed as needed on shower days. In further interview, the DON stated it was her expectation residents' nails would be clean, filed and not jagged.</p> <p>During interview, on 09/12/2024 at 3:16 PM, the Administrator stated it was his expectation for resident nail care to be performed routinely, and nails should be cleaned, trimmed, and not jagged.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28193</p> <p>Based on observation, interview, record review, and review of facility policy, the facility failed to ensure medications were obtained from the pharmacy in a timely manner for two (2) of three (3) sampled residents reviewed for pharmacy services, Resident (R)8 and R32. (Refer to F658)</p> <p>The findings include:</p> <p>Review of the facility policy titled, Administering Medications, revised on 11/15/2011, revealed, Medications will be administered in a timely manner and as prescribed by the resident's attending physician or the facility's Medical Director.</p> <p>1. Review of R32's Admission Record revealed the facility admitted the resident on 02/17/2020. According to the Admission Record, the resident's medical history included a diagnosis of atrial fibrillation.</p> <p>Review of R32's Comprehensive Care Plan, revealed a focus area revised 02/25/2020, stating the resident had a self-care deficit. Interventions directed staff to administer medications as ordered.</p> <p>Review of R32's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date of 07/08/2024, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of six (6) out of 15, indicating severe cognitive impairment. Further review of the MDS, revealed the resident received an anticoagulant medication.</p> <p>Review of R32's Physician's Order sheet, revealed a current order initiated 03/06/2024, for Eliquis (anticoagulant medication) five (5) milligram (mg) tablet, give one (1) tablet by mouth once a day for atrial fibrillation.</p> <p>During observation of medication pass, on 09/10/2024 at 8:40 AM, Kentucky Medication Aide (KMA)12 was unable to locate R32's Eliquis tablet in either the medication cart or the medication room.</p> <p>2. Review of R8's Admission Record revealed the facility admitted the resident on 08/02/2021. According to the Admission Record, the resident's medical history included a diagnosis of type 2 diabetes mellitus.</p> <p>Review of R8's Comprehensive Care Plan, revealed a focus area revised 02/25/2020, stating the resident was at risk for hyperglycemia and hypoglycemia related to a diagnosis of diabetes. Interventions directed staff to administer diabetic medications as ordered by the physician (initiated 08/18/2021).</p> <p>Review of R8's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/08/2024, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 11 out of 15, indicating moderate cognitive impairment. Additional review revealed the facility assessed the resident as having an active diagnosis of diabetes mellitus.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A Physician's Order sheet for R8 revealed a current order dated 03/30/2024, for metformin hydrochloride (medication used to treat diabetes mellitus), 1,000 milligrams, give one (1) tablet by mouth every morning.</p> <p>During an observation of medication pass, on 09/10/2024 at 9:08 AM, KMA12 was unable to find R8's metformin tablet in either the medication cart or in the medication room.</p> <p>During an observation, on 09/11/2024 at 12:12 PM, Licensed Practical Nurse (LPN)7 checked the medication cart and stated R8's metformin tablets were, Still not in the cart, and R32's Eliquis tablets were, Not in the cart either. LPN7 stated she looked for the stickers that should have been pulled from both medication boxes and faxed to the pharmacy in order to refill the medications, but could not find them. LPN7 then located a Refill Reorder Form with the sticker for R8's metformin tablets dated as faxed to the pharmacy on 08/31/2024. LPN7 was not able to locate a Refill Reorder Form with R32's sticker for Eliquis 5 mg. LPN7 stated, If we were having trouble getting the medication from pharmacy, we should pick up the phone and call.</p> <p>During an interview, on 09/12/2024 at 10:47 AM, KMA12 stated the process for reordering medications was to pull the sticker from the medication box and put the sticker on a pharmacy sheet. KMA 12 stated at the end of her shift, she would give it to the nurse on duty to fax to the pharmacy.</p> <p>During a telephone interview, on 09/11/2024 at 3:39 PM, Pharmacist15 stated R8's 1,000 mg metformin tablets were sent to the facility on [DATE] in a count of 30 pills. Pharmacist15 further stated R8's 1,000 mg metformin tablets had been filled again that morning, 09/11/2024, and would be in the facility's delivery that night. Further, Pharmacist15 stated R32's 5 mg Eliquis tablets had last been filled on 08/19/2024 in a count of 14 pills. Pharmacist15 stated R32's 5 mg Eliquis tablets had been filled again that morning and would be in the facility's delivery that night.</p> <p>During a telephone interview, on 09/11/2024 at 4:04 PM, Pharmacist23, from the facility's dispensing pharmacy, stated 30 tablets of R8's 1,000 mg metformin had last been sent out on 07/22/2024, and That order would not be enough medication to last until 09/11/2024. It should have been ordered sooner. Pharmacist23 also stated, regarding R32's 5 mg Eliquis tablets, A 14-day supply was dispensed on 08/19/2024, again, we are 23 days past the date it was filled, and only 14 tablets were sent. They ran out of medication prior to receiving the next shipment, which is being sent to them tonight, 09/11/2024. Pharmacist23 further stated, Both of those medications are in the facility's emergency kit and should have been pulled from it; however, if they had been pulled, we would have a pull slip, and we do not. Pharmacist23 stated the facility was on the box system, so there was not an alert for them to reorder medication, and when the medication was running low the facility had to notify the pharmacy.</p> <p>During an interview, on 09/12/2024 at 3:26 PM, the Director of Nursing stated she expected nursing staff to notify the pharmacy when they were out of a medication and have the pharmacy send it as soon as possible.</p> <p>During an interview, on 09/12/2024 at 4:07 PM, the Administrator stated he expected staff to reorder medication timely, as they needed to, and to have a process to ensure the facility received the medication that was ordered.</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>39438</p> <p>Based on interview, record review, facility document review, and review of facility policy, the facility failed to ensure pharmacy recommendations were acted upon timely for one (1) of five (5) sampled residents reviewed for unnecessary medications, Resident (R)10.</p> <p>The findings include:</p> <p>A facility policy titled, Medication Regimen Review, revised 06/02/2024, revealed, the consultant pharmacist will conduct MRRs (medication regimen reviews) if required under a Pharmacy Consultant Agreement and will make recommendations based on the information made available in the residents' health record. The facility should alert the medical director where MRRs are not addressed by the attending physician in a timely manner. The attending physician/prescriber should address the consultant pharmacist's recommendation no later than their next scheduled visit to the facility to assess the resident, per facility policy and state or federal regulations.</p> <p>Review of R10's Admission Record revealed the facility admitted the resident on 02/03/2023 and readmitted the resident on 11/06/2023. According to the Admission Record, the resident's medical history included diagnoses of hypertension and chronic combined systolic and diastolic heart failure.</p> <p>A Consultation Report, electronically signed by Pharmacist15, on 06/18/2024, revealed R10 received atenolol 50 milligrams (mg) twice a day for hypertension with the recommendation to consider adjusting the dose of atenolol to 25 mg twice daily for hypertension. Further review revealed the physician had not signed the report.</p> <p>Another Consultation Report, electronically signed by Pharmacist15 on 06/18/2024, revealed R10 received Myrbetriq (mirabegron) (a medication to treat overactive bladder) 50 mg daily with a recommendation to reduce Myrbetriq to 25 mg once daily. Further review revealed the physician had not signed the report.</p> <p>Another Consultation Report, electronically signed by Pharmacist15 on 06/18/2024, revealed R10 received tetrahydrozoline eye drops (an ophthalmic decongestant), which should be limited to 72 hours to avoid worsening symptoms with the recommendation to discontinue the tetrahydrozoline eye drops. Further review revealed the physician had not signed the report.</p> <p>Resident10's Physician's Order, dated 06/2024, contained the following orders: atenolol 50 mg with instructions to give one (1) tablet by mouth two (2) times a day; Myrbetriq extended release 50 mg tablet with instructions to give one (1) tablet by mouth once a day; and tetrahydrozoline eye drops 0.05% with instructions to instill one (1) drop into each eye two (2) times a day. R10's Physician's Orders, dated 07/2024, 08/2024, and 09/2024 contained the same orders for atenolol, Myrbetriq, and tetrahydrozoline. There was no indication the pharmacist recommendations from 06/18/2024 had been reviewed by the physician.</p> <p>(continued on next page)</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview, on 09/11/2024 at 11:27 AM, the Director of Nursing (DON) stated after the pharmacist visited the facility, within that same week, she received an email that contained the recommendations. She stated the pharmacist sent the June recommendations on 06/18/2024 per the date on the recommendation report, and she was not the DON at the facility at that time. The DON confirmed the physician had not responded to the recommendations for R10. The DON further stated, if the physician had responded to the recommendations, the recommendation report would have been signed and in the resident's chart under orders.</p> <p>During an interview, on 09/12/2024 at 8:33 AM, Pharmacist15 stated she came to the facility at least once a month to do a comprehensive regimen review for each resident. She stated after she completed the pharmacy reviews, they were posted on their website for the facility to review. Pharmacist15 stated, as a courtesy, she also emailed the pharmacy reviews to the DON and the Administrator. She stated she reconciled on the next visit to see if the recommendations had been reviewed by the provider. Pharmacist15 stated she did not see a response for the recommendations in June for R10. She reported the recommendations on 06/18/2024, and sent the report to the former DON, the Administrator, and a regional staff member. Pharmacist15 stated if she saw a follow up was not completed, then she would reissue the recommendations. She stated she expected staff to follow up on the recommendations by her next visit, the following month.</p> <p>During an interview, on 09/12/2024 at 9:39 AM, the Medical Director stated if a pharmacist made a recommendation, staff must let the physician know timely. The Medical Director stated, timely would be whatever the policy and procedure indicated. The Medical Director further stated R10 went to the hospital and the recommendations may have fell through during that time.</p> <p>During an interview, on 09/12/2024 at 8:55 AM, the Administrator stated the DON was responsible for making sure the pharmacist recommendations were followed up on by the provider. The Administrator stated the recommendations were communicated to him and the DON via email. The Administrator further stated it was his expectation for there to be a response and/or a follow-up to the recommendations.</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>28193</p> <p>Based on observation, interview, record review, and facility policy review, the facility failed to ensure the medication error rate was less than 5 percent (%). Observation of medication administration revealed there were two (2) errors out of 27 opportunities, which resulted in a medication error rate of 7.41%. This affected two (2) of three (3) residents observed during medication administration, Resident (R)8 and and R32. Refer to F658</p> <p>The findings include:</p> <p>A facility policy titled, Administering Medications, revised on 11/15/2011, revealed, Medications will be administered in a timely manner and as prescribed by the resident's attending physician or the facility's Medical Director. The policy further revealed the Director of Nursing Services is responsible for the supervision and direction of all personnel with medication administration duties and functions. Medications must be administered in a timely manner and in accordance with the attending physician's written/verbal orders. Should a drug be withheld, refused, or given other than at the scheduled time, the individual administering the medication must initial and circle the MAR (Medication Administration Record) space provided for that particular drug.</p> <p>1. Review of R32's Admission Record revealed the facility admitted the resident on 02/17/2020. Per the Admission Record, the resident's medical history included a diagnosis of atrial fibrillation.</p> <p>R32's current Physician's Order sheet for September 2024, contained an order initiated 03/06/2024 for Eliquis (anticoagulant medication used to prevent blood clots) 5 milligram (mg) tablet with instructions to give one (1) tablet by mouth once a day for atrial fibrillation.</p> <p>During an observation of medication pass, on 09/10/2024 at 8:40 AM, Kentucky Medication Aide (KMA)12 was unable to find Eliquis 5 mg in the medication cart for R32. KMA12 then looked in the medication room, but was not able to find the resident's Eliquis 5 mg tablets.</p> <p>R32's September 2024 Medication Administration Record (MAR), revealed staff initialed and circled the resident's 09/10/2024, 9:00 AM dose of Eliquis, indicating the medication was not administered.</p> <p>2. Review of R8's Admission Record revealed the facility admitted the resident on 08/02/2021. Per the Admission Record, the resident's medical history included a diagnosis of type 2 diabetes mellitus.</p> <p>R8's current Physician's Order sheet for September 2024, contained an order initiated 03/30/2024 for metformin HCL (hydrochloride) (a medication that lowers blood sugar levels) 1,000 mg with instructions to give one (1) tablet by mouth every morning.</p> <p>During an observation of medication pass, on 09/10/2024 at 9:08 AM, KMA12 was unable to find metformin 1,000 mg in the medication cart. After KMA12 checked the medication room for back-up medication, metformin 1,000 mg tablets could not be found for R8.</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>R8's September 2024 MAR, revealed staff initialed and circled the resident's 09/10/2024, 9:00 AM dose of metformin, indicating the medication was not administered.</p> <p>During an interview, on 09/12/2024 at 10:47 AM, KMA12 stated R32's Eliquis 5 mg tablets and R8's metformin 1000 mg tablets were not in the medication cart and she could not give them.</p> <p>During an interview, on 09/12/2024 at 3:26 PM, the Director of Nursing (DON) stated when the facility was out of a medication, she expected the nurses to contact the pharmacy and ask that they send the medication as soon as possible. She further stated, in the meantime, if the facility had to troubleshoot, the nurses should have called the doctor if needed.</p> <p>During an interview, on 09/12/2024 at 4:07 PM, the Administrator stated it was his expectation for medications to be given as ordered and to have a process to ensure the facility was receiving ordered medications.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>28193</p> <p>Based on observation, interview, record review, and review of facility policy, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.</p> <p>Staff failed to maintain infection control practices during urostomy care for Resident (R)2; during wound care for R26; and during medication administration for R4. Additionally, the facility failed to ensure staff was fit tested for a N95 respirator mask required for respiratory protection when working with Coronavirus Disease 2019 (COVID-19) positive residents. These failures had the potential to affect all residents that resided in the facility.</p> <p>The findings include:</p> <p>Review of the facility policy titled, Infection Prevention and Control Program, dated 01/01/2024, revealed, This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines. The policy further revealed, Standard Precautions: a. All staff shall assume that all residents are potentially infected or colonized with an organism that could be transmitted during the course of providing resident care services. b. Hand hygiene shall be performed in accordance with our facility's established hand hygiene procedures. c. All staff shall use personal protective equipment (PPE) according to established facility policy governing the use of PPE.</p> <p>1. Review of R2's Admission Record revealed the facility admitted the resident on 04/15/2024. According to the Admission Record, the resident's medical history included diagnoses of quadriplegia and other artificial openings of urinary tract status.</p> <p>Review of R2's Comprehensive Care Plan included a focus area revised 05/07/2024, which revealed the resident had a self-care deficit and required assistance with activities of daily living. Interventions included dependent for toileting hygiene.</p> <p>Review of R2's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/23/2024, revealed the facility assessed R2 as having a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated intact cognition. The MDS further revealed the resident was dependent on staff for toileting and had a urostomy.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an observation of urostomy care, for R2, on 09/12/2024 at 8:51 AM, Registered Nurse (RN)13 laid down a clean barrier on the bedside table, prepared the needed supplies, and then washed her hands. She stepped outside the resident's door and donned a gown and gloves for enhanced barrier precautions. RN13 then removed the soiled urostomy bag from the resident's abdomen and dropped the soiled bag onto the floor instead of into a trash receptacle. Without changing gloves or sanitizing or washing her hands, RN13 opened the new drainage bag and attached it to the drainage tubing and laid the new urostomy bag and tubing on top of the resident's bedding, without a barrier underneath. RN13 cleansed the urostomy site with warm washcloths, placed the soiled washcloths into a trash bag on the floor, then reached over and picked up the soiled urostomy bag from off the floor and placed it in the trash. Urine was observed running down the side of the resident's abdomen and RN13 retrieved a drainage pad and tucked it under the resident's abdomen with the same soiled gloves. With the same soiled gloves, RN13 applied skin prep adhesive around the stoma site, peeled the backing from the new urostomy bag, and adhered it to the resident's abdomen. RN13 then gathered the soiled drainage pad, placed it in the trash, doffed her gown and gloves, placed them in the trash, and exited the room without washing her hands. At no time after donning her initial gown and gloves did RN13 change her gloves or sanitize or wash her hands between clean and dirty processes of changing the urostomy bag and providing urostomy care.</p> <p>During an interview, on 09/12/2024 at 11:20 AM, RN13 stated she should have changed her gloves and washed her hands after taking off the dirty urostomy bag and before placing the clean urostomy bag to the resident's stoma site.</p> <p>During an interview, on 09/12/2024 at 3:26 PM, the Director of Nursing (DON) stated it was her expectation for the nurses to follow the proper infection control techniques they had been taught and to know when to change gloves.</p> <p>During an interview, on 09/12/2024 at 4:07 PM, the Administrator stated it was his expectation for urostomy care to be performed in a clinically sound manner and for staff to adhere to best practices.</p> <p>2. Review of R26's Admission Record revealed the facility admitted the resident on 10/25/2019. According to the Admission Record, the resident's medical history included diagnoses of peripheral vascular disease and chronic peripheral venous insufficiency.</p> <p>Review of R26's Annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/26/2024, revealed the facility assessed the resident as having a BIMS score of 13 out of 15, which indicated intact cognition. The MDS also revealed the resident had two (2) venous or arterial ulcers.</p> <p>Review of R26's Comprehensive Care Plan, revised on 11/01/2019, revealed a focus area stating the resident was at risk for cardiac problems due to diagnoses of peripheral vascular disease and venous insufficiency.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an observation of wound care for R26, on 09/12/2024 at 1:55 PM, Licensed Practical Nurse (LPN)7 opened wound care supplies in the hallway, on top of the treatment cart. LPN7 applied hand sanitizer to her hands, grabbed the wound care supplies, walked into R26's room and placed the supplies on a bedside table, without a clean barrier in place. LPN7 removed the soiled dressings from the resident's lower right leg, folded the dressings in half, and placed them on top of the resident's bed linens instead of in the trash. She then removed her soiled gloves and placed them on top of the bedside table next to the clean dressings. LPN7 re-gloved without sanitizing or washing her hands. LPN7 then cleansed the resident's right leg wound with a wound cleanser and gauze, poured collagen powder onto her right gloved hand and began patting it onto the wound bed, and sprayed the resident's leg with skin prep spray. LPN7 then removed her gloves, and without sanitizing or washing her hands, she re-gloved, cleaned the resident's left lower leg wound with wound cleanser and sprayed the resident's left leg with skin prep spray. When the wound care was complete, LPN7 gathered up the soiled dressings, empty dressing packaging and soiled gloves from on top of the bedside table, threw the items into the trash and removed her gloves. At no time during the wound care process did LPN7 sanitize or wash her hands between glove changes when going from dirty to clean processes.</p> <p>During an interview, on 09/12/2024 at 3:26 PM, the DON stated it was her expectation for the nurses to follow proper infection control technique in providing care for open wounds. Per interview, this would include placing clean supplies on a clean barrier, and washing hands or applying alcohol gel (hand sanitizer) between donning gloves. Further, staff should not contaminate clean items with dirty items during wound care, and should not open wound care supplies in the hallway.</p> <p>During an interview, on 09/12/2024 at 4:07 PM, the Administrator stated it was his expectation for wound care to be performed in a clinically sound manner and for staff to adhere to best practices.</p> <p>3. During an observation of medication pass on the 200 Hall, on 09/10/2024 at 8:17 AM, Kentucky Medication Aide (KMA)12 donned gloves and began preparing medications. KMA12 touched multiple surfaces on/in the medication cart, poured medications into her gloved hand, then placed the medications into a medication cup and administered the medications to R4.</p> <p>During an interview, on 09/12/2024 at 3:26 PM, the DON stated it was her expectation for the nursing staff to maintain standard precautions for medication distribution.</p> <p>During an interview, on 09/12/2024 at 4:07 PM, the Administrator stated it was his expectation for the nurses to administer medications appropriately.</p> <p>39438</p> <p>4. During an interview on 09/11/2024 at 3:05 PM, State Registered Nurse Aide (SRNA)8 stated she started working at the facility at the beginning of March. She stated she had not been fit tested for an N95 (respirator) mask. SRNA8 further stated she last cared for a resident with Coronavirus Disease 2019 (COVID-19) about one (1) month ago.</p> <p>During an interview, on 09/11/2024 at 3:18 PM, SRNA6 stated she started working at the facility two (2) years ago. She stated when she was assigned to a resident that had COVID-19, she wore an N95 mask, gloves, and gown. SRNA6 further stated she had not been fit tested for an N95 mask.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview, on 09/11/2024 at 3:30 PM, LPN7 stated she had been employed at the facility for eight (8) years. She further stated it had been a few weeks since she had provided care to a resident with COVID-19. In further interview, LPN7 stated she wore a gown, gloves, and an N95 mask when caring for residents with COVID-19; however, she had not been fit tested for an N95 mask.</p> <p>During an interview, on 09/11/2024 at 4:00 PM, Registered Nurse (RN)19 stated she had provided care to residents with COVID-19 about a month ago. She further stated when providing care to residents with COVID-19, she wore a gown, gloves, and N95 mask; however, she stated she had not been fit tested to wear an N95 mask.</p> <p>During an interview, on 09/12/2024 at 11:13 AM, Kentucky Medication Aide (KMA)20 stated he had been working in the facility since July. He further stated he had not been fit tested to wear an N95 mask.</p> <p>During an interview, on 09/12/2024 at 11:47 AM, RN9 stated she conducted COVID-19 tests during the facility's outbreak. However, she stated she had not been fit tested to wear an N95 mask.</p> <p>During an interview, on 09/12/2024 at 12:29 PM, RN21 stated she had been employed at the facility for almost three (3) years. She further stated she tested on e (1) resident during the COVID-19 outbreak, but had never been fit tested to wear an N95 mask.</p> <p>A document titled, Covid Tracing For Staff, revealed staff who cared for residents during the COVID-19 outbreak. SRNA6, LPN7, SRNA8, and RN9 were included on the document.</p> <p>During an interview, on 09/12/2024 at 2:06 PM; and 09/12/2024 at 5:31 PM, the DON confirmed the staff listed on the Covid Tracing For Staff were assigned to residents that had been diagnosed with COVID-19 during the outbreak. In further interview, the DON stated the facility used N95 masks if they had positive cases of COVID-19 in the building; however, fit testing had not been completed. The DON stated the facility was not aware of what fit testing was and the facility did not have a policy related to fit testing.</p> <p>During an interview, on 09/12/2024 at 3:51 PM, the Administrator confirmed they did not do fit testing for the N95 masks at the facility.</p>		