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

PRINTED: 06/03/2013
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
	185069		C 05/17/2013

NAME OF PROVIDER OR SUPPLIER: MAYFAIR MANOR

STREET ADDRESS, CITY, STATE, ZIP CODE: 3300 TATES CREEK ROAD, LEXINGTON, KY 40502

(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 Recertification Survey and an Abbreviated Survey investigating KY#00020130 and KY#00020191 was initiated on 05/15/13 and concluded on 05/17/13. KY#00020130 was substantiated with deficiencies cited. KY#00020191 was unsubstantiated with no deficiencies. Deficiencies were cited with the highest Scope and Severity of a "D".	F 000	RECEIVED JUN 14 2013 BY: ____	
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of facility's policy, it was determined the facility failed to implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents for one (1) of eleven (11) sampled residents (Resident #2). Two (2) allegations of abuse involving Resident #2 were reported to the facility administration; however, there was no documented evidence that one (1) of the allegations was thoroughly investigated and reported to State Agencies in accordance with State Law. The findings include:	F 226	F 226 1. The facility completed an investigation on resident # 2 per policy, suspending the employee, reporting this incident to OIG and completing this investigation timely. The incident that occurred on 4/23/13 and the allegation of wanting to slap the resident was combined into one investigation because we were not aware of this allegation prior to 4/23/13. If the investigations had been done separately the same conclusion would have been found. 2. During the investigation stage of alleged abuse the interviewer (DON, Administrator, and Social Services) will ask the resident/family if any prior alleged abuse has occurred that has not been reported and make that allegation a separate allegation of abuse and a separate investigation. 3. During investigate phase the DON, Administrator, Social Service will review the information collected to insure that all pertinent information has been included. The report will be reviewed by the Corporate Clinical Nurse to ensure completion. 4. All OIG investigations will be presented to the quarterly Quality Assurance Committee to include the Administrator and the Medical Director for review and follow-up for any further recommendations.	6-30-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kay McCoy RN | TITLE: Director of Nursing | (X6) DATE: 6/14/13

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 226	Continued From page 1 Review of the facility "Abuse, Neglect and Misappropriation Policy", revised 03/13, revealed all allegations of abuse were to be reported immediately to the charge nurse and/or Administrator of the facility. The charge nurse was to immediately notify the Administrator, Director of Nursing (DON) and/or Abuse Coordinator as appropriate. The Administrator and/or DON would notify State Agencies according to their reporting guidelines. Further review revealed the Administrator/designee would make all reasonable efforts to investigate and address alleged reports, concerns, and grievances. Review of Resident #2's medical record, revealed diagnoses of Non Alzheimer's Dementia, Cerebral Vascular Accident (CVA), Anxiety and Depression. Review of the Quarterly Minimum Data Set (MDS), dated 03/19/13, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) of six (6) out of fifteen (15). Observation of Resident #2, on 05/15/13 at 3:00 PM, revealed the resident was in bed lying on her/his back with oxygen on at one (1) liter per Nasal Cannula. Interview with the resident at the time of the observation revealed a few weeks ago a State Registered Nursing Assistant (SRNA), SRNA #5, had taken her/him in the bathroom and told her/him to stand up and hold on to the rail for incontinence care and she/he told the SRNA that she/he couldn't stand. She/he further stated SRNA #5 was rude and hateful to her/him and transferred her/him by herself from the wheelchair to the bed although the resident was to have two (2) staff to assist with transfers.	F 226		

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F 226	Continued From page 2 Continued interview revealed a few months prior to this incident the same SRNA threatened to "smack my face". Resident #2 stated she/he was not smacked although this made her/him nervous and she/he reported it to the Unit Manager and was interviewed related to the incident. Interview with Resident #2's daughter, on 05/15/13 at 3:15 PM and 05/16/13 at 6:20 PM, verified she was in Resident #2's room when SRNA #5 took the resident to the bathroom and asked the resident to stand up. She stated Resident #2 told the SRNA she/he could not stand and was afraid she/he would fall. She further stated SRNA #5 then transferred the resident to bed for incontinence care and then transferred the resident back to the wheelchair by herself. She stated SRNA #5 was rough with the resident during the transfer and was verbally abusive to Resident #2 while she was in the room. Further interview revealed a few weeks prior to this incident Resident #2 had told her an SRNA was talking mean to her/him. She stated Resident #2 voiced that the SRNA got in the resident's face and stated, "I could just smack you". She stated she did not report the allegation because the resident did not know who the SRNA was. However, during the incident related to the transfer, Resident #2 told her it was the same SRNA, SRNA #5. Continued interview revealed she was interviewed by the DON related to the incident she had witnessed; however, she did not remember if the allegation related to the threat to smack Resident #2 was discussed although she thought Resident #2 had reported it to facility staff. Review of the facility investigation revealed the	F 226		

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F 226	Continued From page 3	F 226		

allegation related to verbal abuse and transfers was reported to Administration on 04/23/13 and the investigation was initiated on 04/23/13 and concluded on 04/26/13 by the Administrator and the DON. Further review revealed the allegation of abuse was found to be unsubstantiated by the facility. The investigation included an interview with SRNA #5, a statement from SRNA #5, an interview with Resident 2's daughter, and an interview with Resident #2. However, there was no documented evidence of an investigation related to the allegation of SRNA #5 threatening to smack Resident #2.

Interview, on 05/16/13 at 6:35 PM, with the Unit Manager (UM), revealed she and the DON interviewed Resident #2 at the same time and Resident #2 expressed concerns that SRNA #5 wanted the resident to stand alone and acted like she (SRNA #5) was irritated because the resident could not stand alone. The UM stated she thought she found out about the allegation related to SRNA #5 threatening to smack Resident #2 during the same interview with Resident #2 when the verbal abuse and transfers were being investigated.

Interview, on 05/15/13 at 2:30 PM, with SRNA #5 indicated she was interviewed related to the allegation of verbal abuse and the allegation of threatening to smack Resident #2 by the DON, and she thought she was interviewed on both issues at the same time. SRNA #5 denied both the allegations.

Interview, on 05/16/13 at 4:45 PM, with the Social Service Director revealed she had interviewed Resident #2 and the resident's daughter related

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F 226	Continued From page 4	F 226		

to the allegation of verbal abuse and improper transfer, and was unaware of any allegation related to SRNA #5 threatening to smack Resident #2.

Interview with the DON, on 05/16/13 at 7:00 PM and 05/17/13 at 11:55 AM, revealed that during the investigation related to the verbal abuse and concern with toileting and transfers, she interviewed Resident #2 and asked she/he if there was any prior concerns with this SRNA. She stated Resident #2 then told her SRNA #5 had bent down in her/his ear and whispered, " I am going to slap you in the face". She stated she reported this to the Administrator; however, neglected to refer to this allegation in the investigation. She indicated she interviewed SRNA #5 and Resident #2 about the allegation of threatening to smack/slap the resident during the same interview in which she asked about the toileting, transfers and the rudeness. She stated she did not know why she did not include this allegation in the statements and interviews she received. Further interview revealed she had not informed the Social Services Director about the allegation of the threat by SRNA #5 to smack/slap Resident #2.

Interview, on 5/17/13 at 10:53 AM, with the Administrator revealed the DON told her that during her interview with Resident #2 related to the allegation of verbal abuse, she had asked the resident if there had been prior issues with this SRNA. She further stated she was told by the DON that Resident #2 stated SRNA #5 had told the resident she wanted to smack her/him and the resident had not reported it because she wanted to give the SRNA another chance.

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F 226	Continued From page 6 Further interview revealed she and the DON did three (3) abuse investigations at the same time and she had not realized the DON had not written anything in the investigation related to the threat of smacking the resident in the investigation. Further interview revealed she and the DON had done this investigation and she had reviewed it. She indicated the investigation was not thorough as there was no documentation in reference to the allegation of SRNA #5 threatening to smack/slap Resident #2, and she also indicated this allegation should have been reported to state agencies.	F 226		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280	F 280: 1. Resident #2 was assessed and chart reviewed on 5-17-13 related to the pacemaker and the need for pacemaker checks. The daughter and Attending Physician were notified. The Attending Physician referred pacemaker and pacemaker checks to the Cardiologist. The Cardiologist was notified and requested that the resident's pacemaker be checked at facility and was aware that the pacemaker box for resident #2 was non-functioning. The Cardiologist office reordered a functioning pacemaker box to be delivered to facility. On June 5, 2013 the pacemaker box was received at facility and the pacemaker check was successfully transmitted. Next recheck has been scheduled 9-12-13. Resident #2's Plan of Care was reviewed and updated on 5-17-13 by the Director of Nursing to include the pacemaker and pacemaker checks.	6-30-13

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F 280	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's guideline, it was determined the facility failed to revise the Comprehensive Plan of Care for one (1) out of eleven (11) sampled residents (Resident #2). Resident #2's care plan was not revised related to the pacemaker and the need for pacemaker checks. The findings include: Review of the facility Care Plan Guideline, dated 12/10, revealed the resident's care plan provided guidance to all staff caring for the resident and communicated changes in care to all direct care staff. An interdisciplinary approach to identification of problems and developing solutions and goals provides individualization and coordination of resident care. The Care Plan was reviewed, revised and updated quarterly and more frequently if warranted by a change in the resident's condition. Review of Resident #2's medical record revealed the facility admitted the resident on 12/24/12 with diagnoses which included Non Alzheimer's Dementia, Cerebral Vascular Accident (CVA), Congestive Heart Failure, Hypertension, and Pacemaker. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 03/19/13, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) of six (6) out of fifteen (15). Review of the medical record revealed there was	F 280	2. All residents were audited for presence of pacemaker by 5-20-13. Audit results were reviewed and all residents with pacemakers were scheduled with follow-up pacemaker checks and/or appointments with cardiologists. The Comprehensive Plan of Care of all residents with pacemakers were reviewed and revised by the Minimum Data set coordinator. 3. A spread sheet calendar was developed June 1, 2013 for tracking pacemaker check due dates and will be updated as new residents are admitted with pacemakers and as changes in due dates occur. These dates will be added to that monthly Medication Treatment Administration Sheets (MAR) during monthly change over. IDT will review each Comprehensive Plan of Care with any resident admission or change in condition in the clinical meeting. 4. The Director of Nursing/ Assistant Director of Nursing/Unit Manager will conduct audit at beginning of each month to ensure scheduled pacemaker checks have been included on monthly MAR and that the Comprehensive Plan of Care is accurate. Audits will be 100% complaint for four months and will continue bimonthly for four months. Audit results will be reported to the quarterly quality assurance committee to include the Administrator and the Medical Director for review and follow-up for further recommendations.	

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F 280	Continued From page 7 no documented evidence of pacemaker checks. Review of the Comprehensive Plan of Care revealed there was no Care Plan related to the pacemaker and the need for pacemaker checks. Interview, on 05/17/13 at 3:40 PM, 4:00 PM and 4:45 PM, with the Director of Nursing (DON), revealed there was no specific policy related to pacemaker checks. She stated after surveyor inquiry, she called the Cardiologist and found out the pacemaker checks had not been done either here or at the office although the resident was admitted to the facility on 12/24/12. Continued interview revealed normally the family brought in the box in which to check the pacemaker and arrangements were made to have the pacemaker checked either at the facility or at the Cardiologist office. She stated she assumed the pacemaker checks were being done because the resident's pacemaker box was in the medication room; however, she found out that day the box had been turned off. Continued interview revealed there should have been a Care Plan related to the pacemaker, with interventions as to what to do related to pacemaker checks. She stated the MDS Coordinator who developed and revised care plans was not at the facility and was unavailable for interview. Interview, on 05/17/13 at 4:20 PM, with the Attending Physician revealed pacemakers were to be checked every six (6) to twelve (12) months based on necessity and type of pacemaker. He stated he would have staff refer to the Cardiologist related to the pacemaker checks. Continued interview revealed nursing should have followed up on the pacemaker checks.	F 280		

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F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of facility's policy, it was determined the facility failed to ensure services were provided by the facility in accordance with the Comprehensive Plan of Care for one (1) of eleven (11) sampled residents (Resident #2). Resident #2's Comprehensive Plan of Care was not followed on 04/23/13 when the resident was transferred with one (1) staff member instead of two (2). The findings include: Review of the facility Care Plan Guideline, dated 12/10, revealed the resident's care plan provides guidance to all staff caring for the resident and communicates changes in care to all direct care staff. An interdisciplinary approach to identification of problems and developing solutions and goals provides individualization and coordination of resident care. Review of Resident #2's clinical record revealed diagnoses which included Non Alzheimer's Dementia, Cerebral Vascular Accident (CVA), and	F 282	1. State Registered Nursing Assistant (SRNA) #5 was coached and counseled on 4-30-13 by the Director of Nursing regarding following the SRNA plan of care for resident #2 with emphasis on transfers. 2. On 4-30-13, SRNA #5 was educated by the Director of Nursing that the SRNA plan of care for all residents must be read and followed to ensure care is provided in accordance to the documented SRNA care plan. 3. Staff Development Coordinator (SDC) will educate clinical staff by June 30, 2013 to utilize the SRNA plan of care in order to provide guidance in transfers for residents, to communicate and changes in resident care and to ensure care is provided in accordance to the SRNA care plan. The SDC, Assistant Director of Nursing/Unit Manager will continue to educate and monitor staff for non-compliance with transfers and following the plan of care. 4. The Director of Nursing/Assistant Director of Nursing/Unit Manager/SDC will monitor weekly 20% of the facility residents to ensure transfers are provided to each resident per the SRNA plan of care. The audit will continue until 100% compliant for four weeks and then bi-monthly for four weeks and then monthly for three months. All non-compliance for transfers of resident will be reported immediately to the Director of Nursing and Administrator. The staff member responsible for non-compliance will be coached and disciplined accordingly. Results for non-compliance will be reported to the quarterly quality assurance committee to include the Administrator and the facility Medical Director for review and follow up for further recommendations.	6-30-13

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F 282	Continued From page 9	F 282		

Arthritis. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 03/19/13, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) of six (6) out of fifteen (15). Further review revealed the facility assessed the resident as requiring extensive assistance of two (2) staff for transfers and toileting.

Review of the Falls Care Area Assessment Summary dated 09/20/12 revealed the resident had a history of falls and the risk factors and complications included a History of a Pelvic Fracture, and Spinal Stenosis.

Review of the Comprehensive Plan of Care dated 09/20/12 revealed the resident was at risk for a fall related injury with a goal that the resident would not sustain a fall related injury by utilizing fall precautions. The interventions included assistance of two (2) with transfers and toileting.

Review of the Nursing Assistant Care Record, dated 04/13 revealed the resident was to be toileted and transferred with the assist of two (2).

Review of the facility investigation revealed an incident occurred on 04/23/13 at 2:30 PM which was reported by Resident #2 related to verbal abuse and State Registered Nursing Assistant (SRNA) #5 was accused. The final investigation dated 04/26/13 revealed the facility was unable to substantiate abuse. The investigation stated the employee admitted to being in a hurried situation in order to get the resident bathed in time for a beauty shop appointment and the SRNA denied any inappropriate behavior.

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F 282	Continued From page 10 Interview with Resident #2 on 05/15/13 at 3:00 PM revealed three (3) to four (4) weeks ago SRNA #5 had taken her/him in the bathroom and told her/him to stand up and hold on to the hand rail for incontinence care and she/he told the SRNA that she/he couldn't stand. She/he further stated SRNA #5 was rude and hateful to her/him and transferred her/him by herself from the wheelchair to the bed although the resident was to have two (2) staff to assist with transfers. Interview with Resident #2's daughter, on 05/15/13 at 3:15 PM and 05/16/13 at 6:20 PM, revealed she witnessed SRNA #5 take the resident to the bathroom and ask the resident to stand up on 04/23/13. She stated Resident #2 told the SRNA she/he could not stand and was afraid she/he would fall. She further stated SRNA #5 then transferred the resident to bed for incontinence care and then transferred the resident back to the wheelchair by herself. Interview, on 05/15/13 at 2:30 PM, with SRNA #5 indicated she was interviewed related to an allegation of verbal abuse and questioned as to how the resident was transferred on 04/23/13. She stated she had not checked the Nursing Assistant Care Record which was hanging on the inside of the resident's closet prior to caring for the resident on that date and was unaware there was to be two (2) staff to transfer the resident. She stated she was in a hurry to get the resident cleaned up to go to the beauty shop and encouraged the resident to stand at the rail in the bathroom and was told by the resident and the resident's daughter the resident was unable to stand. She stated she independently transferred the resident to the bed for incontinence care and	F 282		

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

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FORM APPROVED
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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
	185069		C 05/17/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAYFAIR MANOR	3300 TATES CREEK ROAD LEXINGTON, KY 40502

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F 282	Continued From page 11 then transferred the resident back from the bed to the wheelchair. Interview with the DON, on 05/16/13 at 7:00 PM and 05/17/13 at 11:55 AM, revealed that during the investigation related to the verbal abuse and concern with toileting and transfers, she noted SRNA #5 did not follow the Care Plan related to two (2) assist to transfer and toilet the resident even after Resident #2 told the SRNA he/she required two (2) people to transfer her/him. Interview, on 5/17/13 at 10:53 AM, with the Administrator revealed during the investigation it was noted SRNA #5 did not properly transfer Resident #2 and there was a potential for falls.	F 282		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of facility's policy, it was determined the facility failed to ensure each resident receives adequate supervision and assistance devices to prevent accidents for one (1) of eleven (11) sampled residents (Resident #2).	F 323	F323: 1. State Registered Nursing Assistant (SRNA) #5 was coached and counseled by the Director of Nursing on 4-30-13 for not following the State Registered Nursing Assistant plan of care regarding transfers which resulted in skin tear of resident #2 and that resident #2 SRNA plan of care should have been followed. 2. On 4-30-13, SRNA #5 was educated by the Director of Nursing that the SRNA plan of care for all residents must be followed regarding transfers to prevent injury and to ensure residents remain as free of accidents as possible.	6-30-13

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F 323	Continued From page 12	F 323	3. Staff Development Coordinator (SDC) will educate clinical staff by June 30, 2013 to utilize the SRNA plan of care for guidance of resident care to ensure residents remain as free of accident hazards and injury as possible. The SDC, Assistant Director of Nursing/Unit Manager will continue to educate and monitor staff regarding following the plan of care to avoid accidental injury to residents.	
	Resident #2 was transferred by one (1) staff member instead of two (2) staff members as per the Comprehensive Plan of Care on 04/23/13 causing the potential for an accident. The resident sustained a skin tear to the left lower extremity which was noted shortly after the transfer.		4. The Administrator/Director of Nursing/Assistant Director of Nursing or Unit Manager will review each incident to determine cause of injury. Any findings of non-compliance of following the SRNA care plan which resulted in injury will be reported to the Administrator and Director of Nursing. The staff member responsible for non-compliance will be coached and disciplined accordingly. Results for non-compliance will be reported to the quarterly quality assurance committee to include the Administrator and the facility Medical Director for review and follow up for further recommendations.	
	The findings include:			
	Review of the Fall Policy, dated 04/20/12, revealed it was the intent of the facility to provide residents with assistance and supervision in an effort to minimize the risk of falls and fall related injuries. A Comprehensive Plan of Care will be implemented with an individualized goal and interventions specific to each resident.			
	Review of Resident #2's medical record revealed diagnoses which included Non Alzheimer's Dementia, Cerebral Vascular Accident (CVA), and Arthritis. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 03/19/13, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) of six (6) out of fifteen (15). Further review revealed the facility assessed the resident as requiring extensive assistance of two (2) staff for transfers and toileting.			
	Review of the Comprehensive Plan of Care, dated 09/20/12, revealed the resident was at risk for a fall related injury with a goal that the resident would not sustain a fall related injury by utilizing fall precautions. The interventions included assistance of two (2) with transfers and toileting.			

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F 323	Continued From page 13 Review of the Nursing Assistant Care Record dated 04/13 revealed the resident was to be toileted and transferred with the assist of two (2). Review of the facility investigation revealed an incident occurred on 04/23/13 at 2:30 PM which was reported by Resident #2 related to verbal abuse. Further review revealed the resident sustained a skin tear to the left lower leg and State Registered Nursing Assistant (SRNA) #5 was accused. The final Investigation dated 04/26/13 revealed the facility was unable to substantiate abuse. The Investigation stated the employee admitted to being in a hurried situation In order to get the resident bathed in time for a beauty shop appointment and SRNA #5 denied any Inappropriate behavior. Interview with Resident #2, on 05/15/13 at 3:00 PM, revealed three (3) to four (4) weeks ago an SRNA had taken her/him in the bathroom and told her/him to stand up and hold on to the rail for incontinence care and she/he told SRNA #5 that she/he couldn't stand. She/he further stated SRNA #5 was rude and hateful to her/him and transferred her/him by herself from the wheelchair to the bed although the resident told SRNA #5 there was to be two (2) staff to assist with transfers. She was "rough as a cobb". Interview with Resident #2's daughter, on 05/15/13 at 3:15 PM and 05/16/13 at 6:20 PM, revealed she witnessed SRNA #5 to take the resident to the bathroom and ask the resident to stand up. She stated Resident #2 told the SRNA she/he could not stand and was afraid she/he would fall. She further stated the SRNA then transferred the resident to bed for incontinence	F 323		

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F 323	Continued From page 14	F 323		

care and then transferred the resident back to the wheelchair by herself. She stated SRNA #5 was rough with the resident during the transfer from the bed to the wheelchair and the resident said "you're hurting my leg". She stated the resident's leg got caught between the Foley catheter bag and the wheelchair. Continued interview revealed the daughter then took the resident to the beauty shop.

Interview, on 05/17/13 at 10:15 AM, with the beautician revealed a few weeks ago Resident #2 had an area on the leg which was bleeding and the nurse came in to treat the area which was noted shortly after the resident arrived at the beauty shop.

Interview, on 05/17/13 at 2:45 PM, with Registered Nurse (RN) #1 revealed she was called to the beauty shop on 04/23/13 to assess Resident #2's leg and noted a skin tear. She stated the resident did not know what happened.

Review of the Nurse's Note, dated 04/23/13 at 2:30 PM, revealed this RN called to beauty shop and told the resident was bleeding. Area cleansed with Normal Saline and covered with a band aid.

Review of the Physician's Order obtained on 04/23/13, revealed orders to clean the left shin skin tear with Normal Saline and cover with a band aide daily until healed and as needed.

Interview, on 05/15/13 at 2:30 PM, with SRNA #5 indicated she was interviewed related to the allegation of verbal abuse. She stated she had not checked the Nursing Assistant Care Record

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F 323	Continued From page 15	F 323		

which was hanging on the inside of the resident's closet prior to caring for the resident on 04/23/13 and was unaware there was to be two (2) staff to transfer the resident. She stated she was in a hurry to get the resident cleaned up and stated she encouraged the resident to stand at the rail in the bathroom and was told by the resident and the resident's daughter the resident was unable to stand. She stated she independently transferred the resident to the bed for incontinence care and then transferred the resident back from the bed to the wheelchair. Further interview revealed the urinary catheter tubing got caught and the daughter adjusted it; however, she was unaware of a skin tear to the leg until she was interviewed by the Director of Nursing (DON).

Interview, on 05/16/13 at 6:35 PM, with the Unit Manager, revealed she and the DON interviewed Resident #2 at the same time and Resident #2 expressed concerns that SRNA #5 wanted the resident to stand alone and acted like she (SRNA #5) was irritated because the resident could not stand alone.

Interview with the DON, on 05/16/13 at 7:00 PM and 05/17/13 at 11:55 AM, revealed that during the investigation related to the verbal abuse and concern with toileting and transfers, she noted SRNA #5 did not follow the Care Plan related to two (2) assist to transfer and toilet the resident even after Resident #1 told the SRNA he/she required two (2) people to transfer her/him.

Interview, on 5/17/13 at 10:53 AM, with the Administrator revealed during the investigation it was noted SRNA #5 did not properly transfer Resident #2 and there was a potential for falls.

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F 323	Continued From page 16 She stated she was not sure if the skin tear was a result of the inappropriate transfer; however, the skin tear was noted shortly after the transfer.	F 323		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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	185069		05/17/2013

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MAYFAIR MANOR

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3300 TATES CREEK ROAD
LEXINGTON, KY 40502

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K 000	INITIAL COMMENTS CFR: 42CFR 483.70(a) SURVEY UNDER: 2000 Existing FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: One Story, Type III (200) Unprotected SMOKE COMPARTMENTS: Three COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM FULLY SPRINKLERED, SUPERVISED (Dry SYSTEM) EMERGENCY POWER: Type II Diesel A life safety code survey was initiated and concluded on 05/17/13. Mayfair Manor was in compliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire) with no deficiencies cited. The facility is licensed for ninety-eight (98) beds and the census was seventy (70) on the day of the survey.	K 000		

RECEIVED
JUN 14 2013
BY:

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Bruce Martin
TITLE:
(X6) DATE: 6/14/13

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.