

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 188069	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/27/2011
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NAME OF PROVIDER OR SUPPLIER MAYFAIR MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 3300 TATES CREEK ROAD LEXINGTON, KY 40502
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(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)	(X6) COMPLETION DATE
F 000	<p>INITIAL COMMENTS</p> <p>AMENDED</p> <p>A Standard Survey/Extended Survey as well as an Abbreviated Survey Investigating ARO KY00015291 was initiated on 01/25/11 and concluded on 01/27/11. ARO ##KY00015291 was unsubstantiated with no deficiencies. Deficiencies were cited at 42 CFR 483.10 Resident Rights, 42 CFR 483.15 Quality of Life, 42 CFR 483.35 Dietary Services, 42 CFR 483.65 Infection Control, and 42 CFR 483.75 Administration. The highest Scope and Severity being a "K". A Life Safety Code Survey was conducted on 01/25/11.</p> <p>Immediate Jeopardy was identified on 01/25/11. The facility was notified of Immediate Jeopardy on 01/26/11.</p> <p>An acceptable Allegation of Compliance, related to the Immediate Jeopardy, was received on 01/27/11. The Immediate Jeopardy was verified to be removed on 01/27/11.</p>	F 000		
F 364 SS=E	<p>483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP</p> <p>Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to provide food at the proper temperature.</p>	F 364	<p>F 364</p> <ol style="list-style-type: none"> 1) The nursing staff offered to replace or heat food that was served at temperatures below desired point of service temperatures for resident. 2) The Dietary Director interviewed residents on both units to find out specifics about the cold food concern on 2/25/11. A dietary task force was formed 2/04/11 consisting of dietary, nursing and administrative staff to determine the best means of service food to the residents located on the wings at the proper temperatures. On 1/28/11 the Dietary Director in-serviced the dietary staff on dividing the number of resident trays delivered to the units to ensure adequate time for the nursing assistants to pass the tray and maintain appropriate serving temperatures at the point of service. On 2/25/11 the DON in-serviced nursing staff on serving meal trays to the units to maintain appropriate serving temperatures. The Dietary Director/Designee will audit food temperatures five times a week for two weeks to ensure food temperatures are maintained and weekly thereafter. Any non compliance will be reported to the Administrator weekly in the At Risk meeting. Nursing staff will ask residents upon service if the food temperatures are appropriate and if not will replace or heat food items immediately. The Resident Council will be interviewed by Dietary Director at their monthly meeting to ensure foods are being served at the correct temperature. 4) Information from the dietary audits will be forwarded to the daily morning administrative meeting by the dietary manager and reviewed for compliance. The weekly food temperature audits, by the dietary manager, will be forward for review by the monthly Resident Council. Results of the food temp audits will be taken to the quarterly QA by the administrator for review. 	3/02/11

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Beverly Martin</i>	TITLE <i>Administrator</i>	(X8) DATE 3/01/11
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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 364	Continued From page 1 The findings include: During the Group Interview unsampled residents voiced concerns that food was sometimes cold when served on each unit. Interview with Resident #11 on 01/27/11 at 11:30 AM revealed his/her breakfast was not hot on that morning. A test tray was ordered on 01/26/11 after receiving complaints from residents and family members. Observation revealed the test tray was delivered on the North Unit. Further observation revealed temperatures were taken by the facility's Certified Dietary Manager at 8:30 AM. The scrambled eggs were 122 degrees Fahrenheit (F); sausage and gravy at 124 degrees F; and, the pancakes were 122 degrees F. Further observation revealed the temperature of the milk on the test tray was 52 degrees F; and, the orange juice was also 52 degrees F.	F 364		
F 371 SS=E	483.35(l) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	F 371 1) The Administrator immediately removed the carafe from the nursing wing and instructed the dietary staff to dispose of it. 2) The Dietary Director inspected all serving items 1/27/11 and disposed of items that were in bad repair. All items have been replaced. 3) On 1/28/11 the Dietary Director in-serviced the dietary staff on proper washing and inspection of service items to	3/09/11

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F 371	<p>Continued From page 2</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to serve and prepare food under sanitary conditions.</p> <p>The findings include:</p> <p>Observation of tray pass on 01/26/11 at 7:25 AM revealed Certified Nursing Assistant (CNA) #1 brought a carafe of coffee from the kitchen. The outside of the carafe appeared to be soiled with coffee splashes and appeared to be stained with a brownish substance. He/she returned the carafe to the kitchen and returned with another carafe of coffee. This carafe had a dried brown substance around it, approximately two (2) inches from the bottom of the carafe. Further observation revealed a split from the top of the carafe to the bottom of the carafe.</p> <p>Interview, on 01/26/11, during tray pass with CNA #1 revealed both carafes appeared dirty or stained and she would not want to drink coffee out of them. She stated she had never noticed dirty carafes prior to that day.</p> <p>Interview, on 01/26/11, during tray pass with Licensed Practical Nurse #6 revealed the carafe appeared stained. She also stated she had never noted the stained carafes before that day.</p>	F 371	<p>ensure food is served under sanitary conditions.</p> <p>4) The Dietary Director will audit equipment monthly by visual inspection. Any noncompliant service items will be reported to the administrator and disposed of immediately. The Dietary Director will replace any disposed of items and report findings to the monthly safety committee and report quarterly to the QA committee for follow up.</p> <p>F441</p> <p>1. On 1/26/11 1:10 concentration disinfectant cleaner "Dispatch" was used to immediately clean 100% of the (Blood Glucose Monitors) BGM in the facility according to policy and procedure by DON, SDC, Unit Managers, and MDS Nurse. Medical Director was contacted by the Administrator regarding the 3 Nurses identified on 1/25/11 as not following facility Policy and Procedure for cleaning BGM. The Medical Director gave orders on 1/26/11 for all Residents receiving BGM to have a Hepatic Panel and CBC drawn. Family ct/or Responsible Party and Residents informed of need to obtain lab work. All lab work obtained and results completed on 1/27/11. One Resident lab work returned with inactive Hepatitis B on 1/27/11. This Resident has a diagnosis of Hepatitis B by history. All Residents were negative for infections One Resident admitted on 1/21/11 continued low RBC count. Medical Director was notified on 1/26/11 of all results by the DON. Resident with low RBC count was transferred per physician orders on</p>	3/27/11
F 441 SS=K	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and</p>	F 441		

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F 441	<p>Continued From page 3</p> <p>to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it -</p> <p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review (of Centers for Disease Control and</p>	F 441	<p>1/29/11 for a scheduled blood transfusion. All Nurses were In-Serviced by 2/13/11 on proper policy and procedure for cleaning BGM by SDC, DON, Unit Managers and required to provide a return demonstration/competency by 2/13/11 before they could work on the unit. The 3 Nurses identified on 1/25/11 as not following BGM cleaning procedure were counseled by the DON on 1/26/11. Re-education to the 3 Nurses identified on 1/25/11 as not following policy and procedure were audited each day worked as providing BG monitoring to diabetic Residents from 1/26/11 through 2/9/11 by SDC, DON, Unit Managers, MOS. On 1/31/11 Registered Nurse (RN) #2 was counseled by the DON on using proper policy and procedures for hand washing, use of PPE and dressing changes. RN # 2 completed nursing competencies for hand washing, use of PPE and dressing changes. RN # 2 was required to do a return demonstration prior to completing dressing changes on the residents</p> <p>2. All new Nurses will be oriented and receive education per BGM policy and procedure for cleaning and location of product by, SDC. Each new licensed Nurse will be required to perform a return demonstration of the cleaning of the BGM. A competency and audit tool will be completed by the SDC on all new licensed staff prior to providing BG monitoring to Resident to perform BGM until they have demonstrated competency by the SDC. All Nurses were educated on locations of disinfectant cleaner "Dispatch," by SDC, DON and Unit Managers by 2/13/11.</p>	

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F 441	<p>Continued From page 4</p> <p>Prevention(CDC) guidelines, manufacturer's instructions, and the facility's policy and procedure,) It was determined the facility failed to establish and maintain an infection control program to ensure a safe environment and to help prevent the development and transmission of infection as evidenced by the facility's failure to ensure staff properly disinfected shared blood glucose monitors after each use and failed to ensure staff was knowledgeable related to the facility's policy regarding blood glucose monitor cleaning. This affected two (2) sampled residents (Resident #1 and #3) and twenty-one (21) unsampled residents, out of a selected sampled of twenty-three (23) residents. On 01/25/11, facility staff was observed using a blood glucose monitor to test Residents #1 and #3's blood sugar levels without disinfecting the device between each use. The facility identified twenty-three (23) residents, who require blood glucose monitoring for which this failure has a likelihood to affect. Additionally, staff failed to adhere to infection control practices with hand washing for Resident #6.</p> <p>The failure of the facility to ensure proper infection control practices were followed, placed residents in the facility at risk for serious harm, injury, impairment or death. Immediate Jeopardy was identified on 01/25/11 and was removed on 01/27/11, after an acceptable Credible Allegation of Compliance (AoC) was received. Further observations, staff interviews, and in-service record reviews were conducted to verify removal of Immediate Jeopardy. The facility remained out of compliance at a lower scope and severity of and "E", a pattern deficiency with potential for more than minimal harm, for all residents with a diagnosis of Diabetes Mellitus who received blood</p>	F 441	<p>Audits will be conducted 2 times a month on all three shifts and both North and South Wings and will be performed by DON, SDC, Unit Manager and MDS to insure on-going compliance for the next 90 days. If 100% compliance, then will perform annual competency for licensed Nursing staff on locations of disinfectant cleaner "Dispatch," and cleaning policy and procedure for BGM. All nurses were in-serviced by the SDC and DON on the proper policy and procedure for hand washing, use of PPE and dressing changes and required to provide a return demonstration/ competency by 2/13/11.</p> <p>3. The SDC/IP will collect, analyze and provide infection data and trends to nursing staff and health care practitioners; consult on infection risk assessment and prevention control strategies; provide education and training; and implement evidenced-based infection control practices. Infection control audits (hand washing, glucometer cleaning and disinfecting, location of Dispatch, PPE, and clean dressing techniques) will be performed by the SDC-IP, DON, ADON, UM, on 10% of the licensed nursing staff on North and South Wings for all shifts on a weekly basis. Any issues of non-compliance will be corrected immediately by the SDC-IP and reported to the DON and Administrator. After 100% compliance over a two week period, infection control audits will be performed by the SDC-IP, DON, ADON, UM on 5 % of the licensed staff on North and South Wing for all shifts on a weekly basis. Any issue of non-compliance will be corrected immediately by the SDC-IM and reported to the DON and Administrator. After 100% compliance over another 2 week period, infection control audits will be performed by the SDC-IP, DON, ADON, UM on 3 % of the licensed staff on the North and South Wings for all shifts on a monthly basis for three months. Any issues of non-compliance will be corrected immediately by the SDC and reported to the DON and Administrator. The result of the above listed audits will be reported in the weekly infection control meeting by the SDC-IP. The infection control committee to include but not limited to: Administrator, DON, ADON, UM, SDC-IP,</p>	

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F 441	<p>Continued From page 5</p> <p>glucose monitoring, in order for facility to implement monitoring and a surveillance program.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Review of the Centers for Disease Control and Prevention details if blood glucose meters are shared, the device should be cleaned and disinfected after every use. Review of the facility policy, Glucometer-Cleaning, Cleaning of Equipment in Personal Contact, dated 08/2010, revealed: "clean medical device surfaces when visible blood or bloody fluids are present by wiping with a cloth dampened with soap and water to remove any visible organic material before disinfection; if no visible organic material is present, disinfect the exterior surfaces after each use using a cloth or wipe with either an EPA-registered detergent/germicide with a tuberculoid or HBV/HIV label claim, or a dilute bleach solution of 1:10 to 1:100 concentration; disinfect according to guidelines provided by the manufacturer in relation to product kill time...; wipe dry or allow to air dry between cleaning and between each patient ..." Review of the blood glucose monitor manufacturer's instructions revealed that the blood glucose monitor should be cleaned between each use. <p>Observation, on 01/25/11 at 4:10 PM, revealed Licensed Practical Nurse (LPN) #1 went into the room of Resident #1 and Resident #3 with a caddy that contained a blood glucose monitor, alcohol preps, lancets, cotton balls, and test strips. LPN #1 was observed testing the blood sugar for Resident #1. After she completed the blood sugar testing, she went to Resident #3 and completed a blood sugar test with the same</p>	F 441	<p>Housekeeping/Laundry Director and Maintenance Director. This information will be forwarded to the Weekly at Risk Meeting to include but not limited to: Administrator, DON, UM, Social Services, Dietary Director, and Restorative nurse. At Risk weekly reports and infection control reports will be forwarded to the quarterly QA Meeting for evaluation, education and implementation of changes in policy and procedure if appropriate. Any areas of concern throughout the month for infection control requiring notification of the Medical Director by the Administrator or DON will be reviewed at the quarterly QA Meeting for evaluation, education, changes in policy and procedure and follow up with the QA team.</p> <p>4. All audits will be reviewed in the weekly At Risk Meeting (the committee consist of but not limited to: Administrator, DON, ADON, UM, Dietary Director, Social Services and Restorative Nurse) and will be forward to the monthly Infection Control Meeting and the results to the quarterly QA Meeting.. Infection Control weekly reports will also be brought to monthly QA Meeting for evaluation, education and implementation of changes in policy and procedure.</p>	
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F 441	<p>Continued From page 6</p> <p>monitor. Observation revealed she did not clean the monitor between Resident #1's test and Resident #3's test.</p> <p>Interview with LPN #1, on 01/25/11 at 4:20 PM, revealed she had completed a total of five (5) residents' blood glucose tests, three other residents prior to the observation of Resident #1 and Resident #3. She stated she cleans the monitor with alcohol after she has completed the glucose tests for all the residents.</p> <p>Interview with LPN #2, on 01/25/11 at 4:05 PM, revealed she used alcohol preps to clean the monitor between resident use.</p> <p>Interview with Registered Nurse (RN) #1 on 01/25/11 at 4:20 PM, revealed she used alcohol preps to clean the monitor between resident use.</p> <p>On 01/25/11 at 4:45 PM, observation of the caddies the facility provided for the blood glucose monitor and supplies on both units revealed no evidence the bleach wipes were available. On 01/25/11 at 4:45 PM, observation of the medication rooms on both units revealed no evidence the bleach wipes were available.</p> <p>Record review revealed the facility trained staff on the Cleaning of Equipment in Personal Contact policy in 09/2010, and the three licensed staff (LPN #1, #2 and RN #1) had attended the training. However, interview and observation revealed staff did not follow the facility's policy as evidenced by not cleaning the device after each resident use and the type of disinfectant used.</p> <p>On 01/25/11 at 4:30 PM, the Director of Nursing revealed it was the facility's policy to clean the</p>	F 441		

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F 441	<p>Continued From page 7</p> <p>monitors between each resident use with bleach wipes. She further stated she was unaware staff was not using the bleach wipes to clean the monitors and was unaware staff was not cleaning the glucose monitors after each use. She stated cleaning the monitors with alcohol was unacceptable. She further revealed the facility had no system in place to monitor staff to ensure they were following the Cleaning of Equipment in Personal Contact policy.</p> <p>2. Review of the facility's Handwashing/Hand Hygiene policy (revised June 2010) revealed staff were to wash their hands prior to donning gloves and after removing gloves.</p> <p>Review of the Personal Protective Equipment (PPE) -Using Gloves Policy (revised August 2009) revealed sterile gloves were to be used for invasive procedures and to decrease the risk of infection when changing dressings.</p> <p>Review of the the facility's Dressing, Dry/Clean Policy (revised August 2009) revealed staff should clean the bedside stand, establish a clean field, and place clean equipment on the bedside stand. Wash and dry hands thoroughly, put on clean gloves, remove the soiled dressing then pull glove over dressing and discard into plastic or biohazard bag. Hands should then be washed and dried thoroughly and apply clean gloves prior to cleaning and dressing the wound. Using a separate gauze for each cleansing stroke, the wound was to be cleansed from the least contaminated area to the most contaminated area (usually from the center outward). Dry gauze was to be used to pat the wound dry.</p> <p>Record review revealed Resident #6 was</p>	F 441		

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F 441	<p>Continued From page 8</p> <p>diagnosed with Urinary Tract Infection positive for Vancomycin Resistant Enterococcus (VRE), Urinary Incontinence, and a Surgical Wound of the Groin. Review of the Physicians Orders, dated 01/21/11, revealed dressing changes were to be performed every day.</p> <p>On 01/26/11 at 2:15 PM, observation revealed gowns, gloves, and masks were in the hall, in a container beside the resident's door. Observation of the dressing change and skin assessment for Resident #6, on 01/26/11 at 2:15 PM, revealed Registered Nurse (RN) #2 did not use sterile gloves during the dressing change as per the facility's policy. The nurse poured Normal Saline (NS) into the wound and placed gauze in the wound (2 times, used her hand) to absorb the NS then proceeded to measure the wound without changing gloves. The RN wiped the wound with NS-soaked gauze by holding the gauze in her hand. The RN did not use forceps or separate the gauze for each cleansing stroke. The nurse also did not clean the wound from least contaminated to most contaminated. The RN then held gauze in her hand while they poured Dakins solution on the gauze and packed the wound with the gauze using a Q-tip. The nurse touched the cotton of the Q-tip prior to packing the wound.</p> <p>Interview, on 1/27/11 at 3:30 PM with RN #2, revealed she was unaware that she didn't follow protocol/policy. The nurse then proceeded to explain how she should have performed the dressing change. She stated she thought nurses sometimes forget the proper procedures and thought all nurses there needed to have a refresher course.</p>	F 441		

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(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)	(X6) COMPLETION DATE
F 441	<p>Continued From page 9</p> <p>Interview, on 01/27/11 at 5:20 PM with the Director of Nursing (DON), revealed they will re-educate staff about infectious diseases, dressing changes, proper handwashing, PPE disposal, PPE use, finger sticke, glucometer use. Further interview revealed the facillty would audit for compliance with PPE for 1 week and then will perform random audits of PPE compliance.</p> <p>The Administrator and the DON were notified on 01/26/11 at 4:45 PM that Immediate Jeopardy (IJ) was determined to exist. The facillty provided an acceptable Credible Allegation of Compliance (AoC) on 01/27/11 at 9:15 AM, that alleged removal of the IJ, effective 01/27/11, based on the following correction:</p> <ol style="list-style-type: none"> 1) Glucose monitors were cleaned immediately upon identification of the concern per facility policy. 2) The Medical Director was notified of the concern and gave orders to obtain an acute Hepatic Panel and CBC (Complete Blood Count) on all residents who received blood glucose monitoring. 3) The licensed staff identified as not correctly cleaning the monitors were counseled and re-educated by the DON regarding the requirement of appropriate cleaning of the monitors with bleach wipes prior to use, between residents, and after use as per facility policy. 4) Licensed staff, assigned to perform blood glucose monitoring were re-educated on how and when to clean the monitors, by Nursing Administration and performed a return demonstration/competency evaluation. 	F 441		

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

PRINTED: 02/15/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185089	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/27/2011
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NAME OF PROVIDER OR SUPPLIER MAYFAIR MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 3300 TATES CREEK ROAD LEXINGTON, KY 40502
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(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)	(X6) COMPLETION DATE
F 441	<p>Continued From page 10</p> <p>5) On 01/26/11, Nursing Administration performed a 100% audit (by direct visual observation and utilization of a written audit tool) of the resident population who received blood glucose monitoring for compliance to ensure staff were correctly cleaning the monitors per the facility's policy.</p> <p>6) The facility placed the bleach wipes in each caddy used for blood glucose monitoring and at each nurses' station. Staff were educated on the location of extra disinfectant as well.</p> <p>7) To assure compliance with the facility's policy, Nursing Administration would monitor performance through direct observation and supervision daily on all three (3) shifts.</p> <p>8) A Quality Assurance Committee meeting was held on 01/26/11 regarding the plan to ensure appropriate cleaning of blood glucose monitors. The policy and procedure was reviewed and accepted.</p> <p>On 01/27/11, it was verified the immediacy of the IJ was removed and the facility had implemented corrective actions as alleged in the AoC, effective 01/27/11, based on the following:</p> <p>Observation of the blood glucose monitoring rounds on 01/27/11 at 3:40 PM, revealed LPN #2 cleaned the blood glucose monitor with Dispatch bleach wipes before and after performing the finger stick blood sugar on each resident, as per facility policy. Observation further revealed the Unit Manager observed the rounds for compliance.</p>	F 441		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185068	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/27/2011
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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)	(X6) COMPLETION DATE
F 441	<p>Continued From page 11</p> <p>Interview with LPN #2, on 01/27/11 at 3:45 PM, revealed she was aware of the policy and had been educated on the proper cleaning of the monitors before and after each use with Dispatch bleach wipes.</p> <p>Interview with the Unit Manager, on 01/27/11 at 3:50 PM, revealed she was observing for compliance with the facility's policy on cleaning the monitors with Dispatch bleach wipes before and after each use. She stated she would complete the audit form and report to the Administrator.</p> <p>Observation of the blood glucose monitoring rounds, on 01/27/11 at 4:00 PM, revealed RN #3 cleaned the blood glucose monitor with Dispatch bleach wipes before and after performing the finger stick blood sugar on each resident, as per facility policy. Observation further revealed the DON observed the rounds for compliance.</p> <p>Interview with RN #3, on 01/27/11 at 4:05 PM, revealed she had been educated on the facility policy related to the proper cleaning of the monitors with Dispatch bleach wipes before and after each use.</p> <p>Interview with the DON, on 01/27/11 at 4:10 PM, revealed she was observing for compliance with the facility's policy on cleaning the monitors with Dispatch bleach wipes before and after each use. She stated she would complete the audit forms and report to the Administrator.</p> <p>Observation of the blood-glucose monitoring rounds, on 01/27/11 at 10:55 AM, revealed LPN #4 cleaned the blood glucose monitor with Dispatch bleach wipes before and after</p>	F 441		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185069	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/27/2011
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NAME OF PROVIDER OR SUPPLIER MAYFAIR MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 3300 TATES CREEK ROAD LEXINGTON, KY 40502
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F 441	<p>Continued From page 12</p> <p>performing the finger stick blood sugar on each resident, as per facility policy. Observation further revealed the DON observed the rounds for compliance.</p> <p>Interview with LPN #4, on 01/27/11 at 10:55 AM, revealed she had been educated by the facility on proper cleaning of the blood glucose monitors as per the facility's policy. She stated that monitors should be cleaned with Dispatch bleach wipes before and after each use.</p> <p>Interview with the Unit Manager, on 01/27/11 at 11:00 AM, revealed she was observing for compliance with the facility's policy on cleaning the monitors with Dispatch bleach wipes before and after each use. She stated she would complete the audit form and report to the Administrator.</p> <p>Review of the residents' records revealed the Hepatic Panels and CBCs were completed for all residents with Diabetes Mellitus on 01/26/11, as ordered.</p> <p>On 01/27/11, a review of the education documentation revealed the facility had conducted education and competency testing on all licensed staff. A review of the monitoring forms confirmed the facility had conducted monitoring on 01/26/11 and 01/27/11, as planned.</p> <p>The facility remained out of compliance at a lower scope and severity of an "E", a pattern deficiency with potential for more than minimal harm, for all residents with a diagnosis of Diabetes Mellitus who received blood glucose monitoring. In order for facility to implement monitoring and a surveillance program.</p>	F 441		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185069	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/27/2011
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NAME OF PROVIDER OR SUPPLIER MAYFAIR MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 3300 TATES CREEK ROAD LEXINGTON, KY 40502
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F 490 SS=K	<p>483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING</p> <p>A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to administer the infection control program in a manner that maintained an ongoing effective facility-wide infection prevention and control program that 1) provided on going surveillance and monitoring to ensure staff was following the facility's policy, 2) trained staff on preventing the spread of infectious diseases by appropriate cleaning/disinfecting blood glucose monitors, and 3) designated an infection control nurse to conduct process and outcome surveillance system, in monitoring staff practices that related to dressing changes and blood glucose monitor maintenance.</p> <p>The failure of the facility to ensure proper infection control practices were followed, placed residents in the facility at risk for serious harm, injury, impairment or death. Immediate Jeopardy was identified on 01/25/11 and was removed on 01/27/11, after an acceptable Credible Allegation of Compliance (AoC) was received and further observations, in-service record reviews and staff interviews were conducted to verify removal of the jeopardy. The facility remained out of compliance at a lower scope and severity of "E", a pattern deficiency with potential for more than</p>	F 490	<p>P490</p> <ol style="list-style-type: none"> On 1/26/11 1:10 concentration disinfectant cleaner "Dispatch" was used to immediately clean 100% of the (Blood Glucose Monitors) BGM in the facility according to policy and procedure by DON, SDC, Unit Managers, and MDS Nurse. Medical Director was contacted by the Administrator regarding the 3 Nurses identified on 1/25/11 as not following facility Policy and Procedure for cleaning BGM. The Medical Director gave orders on 1/26/11 for all Residents receiving BGM to have a Hepatic Panel and CBC drawn. Family and/or Responsible Party and Residents informed of need to obtain lab work. All lab work obtained and results completed on 1/27/11. One Resident's lab work returned with inactive Hepatitis B on 1/27/11. This Resident has a diagnosis of Hepatitis B by history. All Residents were negative for infections. One Resident admitted on 1/21/11 continued to have low RBC count. Medical Director was notified on 1/26/11 of all results by the DON. Resident with low RBC count was transferred per physician orders on 1/29/11 for a scheduled blood transfusion. All Nurses were In-Serviced by 2/13/11 on proper policy and procedure for cleaning BGM by SDC, DON, Unit Managers and required to provide a return demonstration/competency by 2/13/11 before they could work on the unit. The 3 Nurses identified on 1/25/11 as not following BGM cleaning procedure were counseled by the DON on 1/26/11. Re-education to the 3 Nurses identified on 1/25/11 as not following policy and procedure were audited each day worked while providing BG monitoring to diabetic Residents from 1/26/11 through 2/9/11 by SDC, DON, Unit Managers, MDS nurse. 	3/2/11

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NAME OF PROVIDER OR SUPPLIER MAYFAIR MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 3300 TATES CREEK ROAD LEXINGTON, KY 40502
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F 490	<p>Continued From page 14</p> <p>minimal harm, for all residents with a diagnosis of Diabetes Mellitus, who received blood glucose monitoring, in order for facility to implement monitoring and a surveillance program.</p> <p>The findings include:</p> <ol style="list-style-type: none"> Based on observation, interview, and record review (of Centers for Disease Control and Prevention (CDC) guidelines, manufacturer's instructions, and the facility's policy and procedure,) it was determined the facility failed to establish and maintain an infection control program to ensure a safe environment and to help prevent the development and transmission of infection as evidenced by the facility's failure to ensure staff properly disinfected shared blood glucose monitors after each use and failed to ensure staff was knowledgeable related to the facility's policy regarding blood glucose monitor cleaning. This affected two (2) sampled residents (Resident #1 and #3) and twenty-one (21) unsampled residents, out of a selected sampled of twenty-three (23) residents. On 01/25/11, facility staff was observed using a blood glucose monitor to test Residents #1 and #3's blood sugar levels without disinfecting the device between each use. The facility identified twenty-three (23) residents, who require blood glucose monitoring for which this failure has a likelihood to affect. Additionally, staff failed to adhere to infection control practices with hand washing for Resident #6. Review of the Infection Control Policy and Procedure for the facility, revealed the facility should have an Infection Control Coordinator, in conjunction with the Quality Assessment and Assurance Committee to be responsible for 	F 490	<ol style="list-style-type: none"> All new Nurses will be oriented and receive education per BGM policy and procedure for cleaning and location of product by SDC. Each new licensed Nurse will be required to perform a return demonstration of the cleaning of the BGM. A competency and audit tool will be completed by the SDC on all new licensed staff prior to providing BG monitoring to Residents. New Licensed staff must demonstrate competency prior to being allowed to perform BGM on the unit by the SDC. All Nurses were educated on locations of disinfectant cleaner "Dispatch," by SDC, DON and Unit Managers by 2/13/11. Day shift, Evening shift and Night shift, North and South units, will be audited two times a month. The audits will be performed by DON, SDC, Unit Manager and MDS to ensure on-going compliance for the next 90 days when 100% compliance is met, then the SDC-IP will perform annual competency for licensed Nursing staff on locations of disinfectant cleaner "Dispatch," and cleaning and disinfecting policy and procedure for BGM. The Administrator has assigned the SDC as the Infection Preventist Nurse, effective 2/20/11. The SDC/Infection Nurse will be responsible for providing process and outcome surveillance and monitoring to insure follow through, train staff on preventing spread of infectious disease by appropriate cleaning/disinfecting of blood glucose monitors and monitor staff practices related to dressing changes. The SDC will conduct training, competencies and audits as it relates to identified areas of concern. The Administrator and DON will review the 24 Hour Report and weekly infection control report in the daily clinical meeting and 	

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STATEMENT OF DEFICIENCIES NO PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185069	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/27/2011
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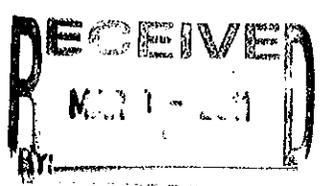
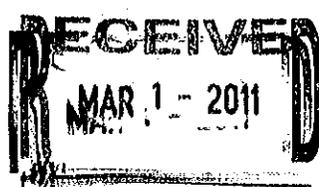
NAME OF PROVIDER OR SUPPLIER MAYFAIR MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 3300 TATES CREEK ROAD LEXINGTON, KY 40502
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F 490	<p>Continued From page 15</p> <p>keeping the infection control program and practices current. Review of the Infection Control Coordinator Policy revealed the Coordinator was responsible for monitoring of the facility's established infection control policies and practices.</p> <p>Interview with the Director of Nursing (DON)/Infection Control Coordinator, on 01/25/11 at 4:45 PM and again on 01/27/11 at 8:15 PM, revealed she had conducted in-services training for all licensed staff in 09/2010 on the Cleaning of Equipment in Personal Contact policy, to include disinfecting the exterior surfaces of blood glucose monitors with a dilute bleach solution of 1:10 to 1:100 concentration after each use. Interview further revealed she had not conducted any surveillance or monitoring to ensure staff was following the policy and was unaware the bleach wipes were not being utilized by the facility staff during blood glucose monitoring. She further stated the facility could do better on monitoring and should have been conducting audits and competencies for staff.</p> <p>Interview with the Administrator, on 01/27/10 at 7:00 PM, revealed she did not know why the staff was not following the policy because they had been educated in 09/2010. She stated the facility did not have an Infection Control Committee, and even though the DON had conducted education the facility had not completed follow-up and monitoring. She further stated the Infection control program needed more focus on prevention and surveillance.</p>	F 490	<p>Weekly at Risk meeting.. The Administrator will notify the Medical Director immediately of an infection control concerns or monitoring.</p> <p>4. The Administrator will review audits and the minutes from the At Risk Meeting and will be an active member of the Infection Control Committee. Any infection control areas of concern through out the month will be reported to the Medical Director by the Administrator for evaluation and follow up. The Infection Control report will be forward to the quarterly QA for evaluation, implementation and education.</p>	

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 185069	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 1/27/2011
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NAME OF PROVIDER OR SUPPLIER MAYFAIR MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 3300 TATES CREEK ROAD LEXINGTON, KY
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
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<p>F 160</p>	<p>483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH</p> <p>Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to convey resident funds to the individual administering the resident's estate within thirty (30) days.</p> <p>The findings include:</p> <p>Closed record review of one deceased unsampled resident revealed a date of death of 10/06/10. Further review revealed the resident's account was not closed out until 11/08/10. Additionally, review of resident funds revealed account balances belonging to two (2) other unsampled residents from 2009.</p> <p>Interview with the Business Office Manager on 01/27/11 at 4:15 PM revealed he/she was aware that checks needed to be sent out no later than thirty (30) days following the death of a resident. The Business Office Manager stated the two unsampled residents' accounts had balances because the accounts gained interest the same month they were closed. The Business Office Manager recognized this as a concern, as families were not receiving the full balances due them.</p> <div style="text-align: center;">   </div>
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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

The above isolated deficiencies pose no actual harm to the residents

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NAME OF PROVIDER OR SUPPLIER MAYFAIR MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 3300 TATES CREEK ROAD LEXINGTON, KY 40502
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K 000 K 029 SS=D	<p>INITIAL COMMENTS</p> <p>A Life Safety Code survey was initiated and concluded on January 25, 2011. The facility was found to not meet the minimal requirements with 42 Code of the Federal Regulations, Part 483.70. The highest Scope and Severity deficiency identified was an "F".</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure hazardous areas were protected, according to NFPA standards. This deficiency has the potential to affect one (1) smoke compartment and twenty-four (24) residents.</p> <p>The findings include:</p> <p>Observation, on 01/25/11 at 12:00 PM, with the Maintenance Director, revealed chemicals stored in the housekeeping office without a self-closing device on the door.</p>	K 000 K 029	<p>K 029</p> <ol style="list-style-type: none"> 1) The Maintenance Director installed a self-closing lock on the housekeeping door on 1/31/11. 2) The Maintenance Director inspected all offices for storage of chemicals on 2/01/11. None were found. Eight other chemical storage areas have self-closing locks. 3. The Administrator in-serviced all department managers on NFPA 101 Life Safety Code Standard related to storage of chemicals in offices on 2/18/11. 4. The Maintenance Director/ Designee will check offices weekly to insure that chemicals are not being stored inappropriately. Any issues of noncompliance will be corrected immediately and reported to the Administrator. Information will be given to the Safety Committee monthly and reported to QA quarterly for follow up by the Administrator. 	3/01/11

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FEB 21 2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Gene L. Martin</i>	TITLE <i>Administrator</i>	(X6) DATE <i>2/21/11</i>
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A deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that the safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 029	<p>Continued From page 1</p> <p>Interview, with the Maintenance Director, on 1/25/2011 at 12:00 PM, indicated that he would place a self-closing device on the door.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exit doors had the proper signage. The deficiency affects all residents and staff in the facility. This is a repeat deficiency from the Life Safety Code survey completed on 03/25/10.</p> <p>The findings include:</p> <p>Observation on 01/25/11 at 10:55 AM, revealed seven (7) sets of exit doors in the facility without the proper signage indicating the doors would release within (15) seconds. This observation was confirmed with the Maintenance Director.</p> <p>Interview, with the Administrator, on 01/25/20 at 4:00 PM, indicated that the signs would be on the doors by the end of the day.</p> <p>Reference: NFPA 101 (2000 Edition) 7.2.1.6.1 Delayed-Egress Locks</p>	K 029	<p>K 038</p> <p>1) The 15 second signage was posted on the seven (7) set of exit doors on 1/31/11 by the Maintenance Director and the Administrator.</p> <p>2) All facility exit doors have been reviewed by the Maintenance Director on 1/31/11. All doors meet the code for proper signage.</p> <p>3) Nine (9) facility exit doors will be checked five times a week during maintenance rounds by the Maintenance Director/Designee for proper signage five days a week on going. Maintenance will correct immediately any noncompliance issues will be reported to the Administrator.</p> <p>4) Facility exit door audits will be reported to the monthly Safety Committee by the Maintenance Director and reported quarterly to the QA committee for follow up.</p>	3/01/11
K 038 SS=F		K 038		

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K 038	Continued From page 2 On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS	K 038	K 072	
K 072 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the corridors were maintained free from obstructions related to full instant use in the case of fire or other emergencies. The deficiency affects all residents and staff in the facility. This is a repeat deficiency from the Life Safety Code survey completed on 03/25/10.</p> <p>The findings include:</p> <p>Observation on 01/25/11 at 11:00 AM, revealed clean linen carts outside of rooms numbered 204, 220, and 117. Further observation revealed medication carts and ice/drink carts next to the nurse's stations on the North and South Wings. A chair was also found next to the exit on the North Wing corridor across from the library. Corridors are intended for means of egress, internal traffic</p>	K 072	<p>1) The linen cart, treatment cart and ice cart were removed from the corridors on 1/26/11 by Administrator. Four other hallways were assessed on 1/26/11 by the DON and items removed to ensure means of egress and full instant use in case of fire or other emergency.</p> <p>2) Laundry and Nursing Staff in-service was completed by Administrator on 2/23/10 regarding life safety code K072 regarding linen, ice and treatment carts. Means of egress are to be continuously maintained free of obstruction or impediments for use in case of emergency.</p> <p>3) The DON/clinical staff will ensure that the ice cart and treatment cart moves freely down the corridor room to room during resident care and stored in the designated areas after resident care by visual inspection. The linen carts will be stored in the lounge area at each nurse's</p>	3/01/11

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185089	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 01/26/2011
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NAME OF PROVIDER OR SUPPLIER MAYFAIR MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 3300 TATES CREEK ROAD LEXINGTON, KY 40502
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K 072	Continued From page 3 and emergency use, not storage spaces. These observations were also confirmed with the Maintenance Director. Interview with the Administrator on 01/25/11 at 4:00 PM, indicated that the carts and chair would be moved.	K 072	station and the staff will access linens from this area. The laundry staff will delivery the linen carts directly to the lounge daily. The Housekeeping/Laundry Director will monitor five times weekly for two weeks to ensure the	
K 073 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure that no combustible decorations were used in the facility, according to NFPA standards. The deficiency affects all residents and staff in the facility.</p> <p>The findings include:</p> <p>Observation on 01/25/11 at 11:00 AM with the Maintenance Director, revealed ten (10) resident rooms with hanging decorations on the doors that were not flame retardant. The resident rooms were numbered 103, 109, 122, 214, 215, 217, 219, 220, 222, and 224.</p> <p>Interview, with the Maintenance Director, on 01/25/11 at 11:00 AM, revealed they were unaware of the requirement that the decorations had to be flame retardant.</p> <p>Reference: NFPA 101 (2000 Edition) 19.7.5.4 Combustible decorations shall be prohibited in any health care occupancy unless they are flame-retardant.</p>	K 073	<p>linen, ice and treatment carts are not impeding the egress for fire or other emergency. Any noncompliance will be reported to the DON/Unit Manager for immediate correction. 4) The weekly cart audit will be reviewed on a monthly basis by the safety committee and forwarded to QA quarterly for follow up by the Administrator.</p> <p>K 073</p> <p>1) The hanging decoration on resident doors in rooms 103, 109, 122, 214, 215, 217, 219, 220, 222, and 224 were removed by the Administrator on 1/28/11. The Maintenance Director sprayed with a flame retardant all hanging decorations on 2/15/11 and were logged. 2) The Maintenance Director reviewed all resident doors and</p>	3/01/11

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185069	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 01/25/2011
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NAME OF PROVIDER OR SUPPLIER MAYFAIR MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 3300 TATES CREEK ROAD LEXINGTON, KY 40502
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K 076 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure oxygen cylinders were stored according to NFPA standards. This is a repeat deficiency from the Life Safety Code survey completed on 03/25/10.</p> <p>The findings include:</p> <p>Observation on 01/25/11 at 12:00 PM, revealed twelve (12) oxygen cylinder tanks stored in the resident shower room on the South Wing. The oxygen tanks were also stored within five (5) feet of combustible storage. The crash cart was also stored next to the oxygen tanks. This observation was also confirmed with the Maintenance Director.</p> <p>Interview, with the Administrator, on 1/25/2011 at 4:00 PM, indicated that the tanks would be moved to another area for storage.</p>	K 076	<p>rooms and sprayed the combustible decorations with flame-retardant on 2/15/11. All items have been logged and labeled and will be re-sprayed in six months to insure effectiveness of the flame retardant.</p> <p>3) On 2/28/11 the Resident Council will be made aware of the NFPA 101 Life Safety Code Standard related to furnishings or decorations of highly flammable character and the need for the flame retardant by the Activity Director if items are to remain in the facility. Any new items brought into the facility must be non-combustible or given immediately to the Maintenance Director to be made flame retardant. On 2/16/11 the Administrator made the President of the Family Council and the facility Ombudsman aware of this code. All new residents/family members will receive notification of this code upon admission and the need for items to flame retardant. The Maintenance Director/Designee will audit rooms and doors on a weekly basis to insure that any new items are flame retardant. If</p>	
K 130	<p>NFPA 101 MISCELLANEOUS</p>	K 130	<p>any items are found they will be immediately corrected by the Maintenance Director and reported to the Administrator.</p>	

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NAME OF PROVIDER OR SUPPLIER MAYFAIR MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 3300 TATES CREEK ROAD LEXINGTON, KY 40502
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K 130 SS=D	<p>Continued From page 5</p> <p>OTHER LSC DEFICIENCY NOT ON 2786</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain doors within a required means of egress. They shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. This deficiency affected (1) one smoke compartment and 24 residents.</p> <p>The findings include:</p> <p>Observation on 01/25/11 at 11:00 AM with the Maintenance Director, revealed that an unapproved lock (slide bolt type) was installed on the inside of the door in the rehabilitation unit. Further observation on 01/25/11, revealed a dead bolt lock on the outside of the laundry room with keyed access on the inside.</p> <p>Interview, with the Maintenance Director, on 01/25/11 at 11:00 AM, indicated that he would remove the slide bolt lock and change the keyed lock on the laundry room door.</p> <p>NFPA 101 (2000 Edition) 19.2.2.2.4 Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side.</p>	K 130	<p>2) The facility has one designated storage area for full and empty oxygen. The facility has contracted with a DME to provide oxygen delivery as needed to insure that extra storage of E size oxygen cylinder tanks will not be necessary. The Maintenance Director reviewed all other areas for noncompliance of oxygen storage. E-tanks in racks were removed from the therapy area. The DME was called to remove additional storage racks and E tank canisters on 1/28/11.</p> <p>3. The DON/Unit Manager will audit the oxygen storage area three times weekly for four weeks to ensure the staff is maintaining compliance of proper storage of E tank canisters. Any noncompliance will be corrected immediately by the DON. All audits will be reported to the Safety Committee by the DON monthly and referred to the quarterly QA for follow up.</p> <p>4) All oxygen storage audits will be reported in the weekly At Risk meeting by UM and forward to the Safety Committee monthly by DON. Staff will be monitored and counseled for non</p>	

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K 130 SS=D	<p>Continued From page 5</p> <p>OTHER LSC DEFICIENCY NOT ON 2786</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain doors within a required means of egress. They shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. This deficiency affected (1) one smoke compartment and 24 residents.</p> <p>The findings include:</p> <p>Observation on 01/25/11 at 11:00 AM with the Maintenance Director, revealed that an unapproved lock (slide bolt type) was installed on the inside of the door in the rehabilitation unit. Further observation on 01/25/11, revealed a dead bolt lock on the outside of the laundry room with keyed access on the inside.</p> <p>Interview, with the Maintenance Director, on 01/25/11 at 11:00 AM, indicated that he would remove the slide bolt lock and change the keyed lock on the laundry room door.</p> <p>NFPA 101 (2000 Edition) 19.2.2.2.4 Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side.</p>	K 130	<p>4) Facility exit doors will be checked five times per week during maintenance rounds by the Maintenance Director/Designee to ensure the exit doors are maintained within means of egress. Maintenance will correct immediately any noncompliance issues and report to the administrator for follow up. Nine facility exit door audits will be reported to the Safety Committee monthly by the Maintenance Director and reported quarterly by the Maintenance Director to the QA committee for follow up.</p>	

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K 130 SS=D	<p>Continued From page 5</p> <p>OTHER LSC DEFICIENCY NOT ON 2786</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain doors within a required means of egress. They shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. This deficiency affected (1) one smoke compartment and 24 residents.</p> <p>The findings include:</p> <p>Observation on 01/25/11 at 11:00 AM with the Maintenance Director, revealed that an unapproved lock (slide bolt type) was installed on the inside of the door in the rehabilitation unit. Further observation on 01/25/11, revealed a dead bolt lock on the outside of the laundry room with keyed access on the inside.</p> <p>Interview, with the Maintenance Director, on 01/25/11 at 11:00 AM, indicated that he would remove the slide bolt lock and change the keyed lock on the laundry room door.</p> <p>NFPA 101 (2000 Edition) 19.2.2.2.4 Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side.</p>	K 130	<p>compliance of the policy as needed by DON, SDC and UM.. All results of the oxygen storage audit will be forwarded by the DON to the quarterly QA meeting for review and follow up.</p> <p>K 130</p> <ol style="list-style-type: none"> 1) On 1/27/11 the Maintenance Director removed the unapproved lock from the inside of the rehabilitation door. On 1/28/11 the Maintenance Director removed the dead bolt lock on the outside of the laundry door and replaced it with a keypad lock. 2) The Maintenance Director reviewed all egress doors on 1/28/11 to ensure that all doors are maintained within a required means of egress. There were no other noncompliant locking devices. 3) The Administrator in-serviced the maintenance staff on approved locking devices for egress doors on 2/18/11. 	3/01/11