

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

PRINTED: 11/13/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185197	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 11/13/2013
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NAME OF PROVIDER OR SUPPLIER NORTHPOINT/LEXINGTON HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1500 TRENT BOULEVARD LEXINGTON, KY 40515
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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)	(X5) COMPLETION DATE
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{F 000}

INITIAL COMMENTS

An offsite revisit was conducted and based on the acceptable POC the facility was deemed to be in compliance as alleged on 10/16/13.

{F 000}

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

Acceptable
10/16/13 compliance date

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NAME OF PROVIDER OR SUPPLIER NORTHPOINT/LEXINGTON HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1500 TRENT BOULEVARD LEXINGTON, KY 40515	

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F 000 INITIAL COMMENTS

An Abbreviated Survey investigating KY#00020789 was initiated on 10/09/13 and concluded on 10/10/13. KY#00020789 was unsubstantiated with a related deficiency.

F 226 483.13(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 policy, it was determined the facility failed to implement their Abuse Policy and Procedures regarding reporting abuse to the appropriate state agencies for three (3) of three (3) sampled residents (Resident #1, #2 and #3).

Resident #1 placed his/her hands on Resident #2's breast on 09/20/13, and grabbed Resident #3's breast on 09/21/13; however, there was no documented evidence the state agencies were notified of the allegations until 09/23/13.

The findings include:
Review of the facility's, "Reporting Abuse to Facility Management" Policy, revised 10/12, revealed when an alleged or suspected case of mistreatment, neglect, injuries of unknown source, or abuse was reported, the facility Administrator, Director of Nursing (DON), or

RECEIVED
OCT 29 2013

F 000 Submission of this response and plan of correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited, and is also not to be construed as an admission of interest against the facility, the Administrator, employees, agents or other individuals who may be discussed in this response and plan of correction. In addition, preparation and submission of this plan of correction does not constitute an admission of agreement of any kind by the facility or the correctness of any conclusion set forth in this allegation by the survey agency. Accordingly, the facility has prepared and submitted this plan of correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a plan of correction within (10) days of the survey as a condition to participate in Title 18 and Title 19 programs.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Cynthia Horn

TITLE
Administrator

(X6) DATE
October 29, 2013

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NAME OF PROVIDER OR SUPPLIER NORTHPOINT/LEXINGTON HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1500 TRENT BOULEVARD LEXINGTON, KY 40515	

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F 226 Continued From page 1
individuals would immediately notify the following persons or agencies of such incident as indicated by State or Federal Licensure Policy. This was to include; the State Licensing/Certification Agency, the Ombudsman, the resident's representative, Adult Protective Services, Law Enforcement officials, the Attending Physician and the Medical Director.

1. Review of Resident #1's medical record revealed an admission date of 09/20/13, and diagnoses which included Alzheimer's Disease, Psychosis, and Dementia with Behavioral Disturbance. Review of the Admission Minimum Data Set (MDS) Assessment dated 10/14/13, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) of a four (4) indicating cognitive impairment.

Review of a Nurse's Note dated 09/20/13 at 10:40 PM, for Resident #1, revealed the resident was noted to place his/her hands on the breasts of another resident. Further review revealed Resident #1's family was notified to come and sit with the resident and, every fifteen (15) minute checks were initiated. Further review of the Nurse's Note revealed new orders were obtained from the Physician's Assistant (PA).

Review of Resident #2's medical record revealed a readmission date of 02/24/12 and, diagnoses which included Alzheimer's Disease, Psychosis, Depression, and Anxiety. Review of the Quarterly MDS dated 07/30/13, revealed the facility had assessed the resident as having a BIMS score of fourteen (14) which indicated Resident #2 was cognitively intact. Review of a Nursing Note dated 09/20/13 at 10:45 PM, revealed a State Registered Nurses Aide (SRNA) observed a

F 226 The submission of the plan of correction within this time frame should in no way be considered or construed as agreement with the allegations of non-compliance or admission by the facility. This plan of correction is submitted as facility's credible allegation of compliance

Corrective action completed by October 16, 2013

Residents # 1, #2 and #3 were observed and interviewed by social services on 10/10/2013. Upon assessment through interview and observation each resident is functioning within their normal routines with no concerns identified.

The facility reviewed the last 3 months incident reports including any reportable incidents to ensure abuse and neglect prevention procedures, Investigative protocols and reporting standards were

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F 226 Continued From page 2
resident placing his/her hands on Resident #2's breast and, Resident #2 got up and walked away.

Review of the facility investigation revealed an incident occurred on 09/20/13 at 10:40 PM, related to Resident #1 and Resident #2 where an inappropriate interaction occurred when Resident #1 placed his/her hands on Resident #2's chest. However, there was no documented evidence the initial Report of the incident was faxed to state agencies prior to 09/23/13 at 3:49 PM.

2. Further review of Resident #1's medical record revealed a Nurse's Note dated 09/21/13 at 10:15 AM, which stated the resident was noted to ambulate at the nurse's station with his/her son following when Resident #1 turned around and walked away from his/her son. Further review of the Nurse's Note revealed Resident #1 sat in a chair beside another resident. The Nurse's Note stated Resident #1 was witnessed by the nurse to put his/her left arm around the other resident and, reach around with the right arm and grab the other resident's breast.

Review of Resident #3's medical record revealed an admission date of 07/08/13 and, diagnoses which included Alzheimer's Disease, Anxiety, and Depression. Review of the Quarterly MDS Assessment dated 07/19/13 revealed the facility assessed the resident as having a BIMS score of a five (5) indicating cognitive impairment. Review of a Nurse's Note dated 09/21/13 at 10:30 AM, for Resident #3, revealed the resident was involved in an interaction with another resident and staff intervened and removed Resident #3 from the situation.

Review of the facility investigation revealed an

F 226 followed. No concerns identified with no negative outcomes to residents reviewed.

On 10/10/2013 the Social Service Director initiated re-education to all staff including administration on Abuse & Neglect Policy and Procedure related to the screening, training, prevention, identification, investigation, protection and timely reporting/response. Education completed on 10/16/2013.

The QA committee will complete Abuse Prevention Auditing Monthly with auditing to include Investigation and Report of Alleged Violations until substantial compliance is met.

Residents #1, #2, and #3 have been observed weekly for two weeks by social service, each continue to function at baseline incidents occurring after hours or weekends will be reported to the ADM/and or DON by the House Supervisor/Charge Nurse to discuss interventions or need of

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F 226	Continued From page 3 incident occurred on 09/21/13 at 9:30 AM, related to Resident #1 attempting to "hug" Resident #3 and touching Resident #3's chest. However, there was no documented evidence the Initial Report of the incident was faxed to state agencies prior 09/23/13 at 3:46 PM. Interview, on 10/09/13 at 5:30 PM, with the Administrator, revealed she was informed of the allegations immediately and was out of town. She stated she did a conference call with the Social Services Director (SSD) and took action and, was more focused on the safety of Resident #1 and the other residents. She stated this was inappropriate contact related to a confused resident and at first she did not think this was reportable. However, after discussing the situations with the Corporate Office, felt the incidents needed to be reported. She further stated the state agencies were to be notified within twenty-four (24) hours of an allegation of abuse and the final investigation was to be sent to state agencies within five (5) days.	F 226	further investigation and/or reporting. All incidents will be reviewed daily by the IDT in CQI to identify any events requiring further investigation or necessity of reporting. The facility Administrator will report any concerns to OIG/APS for discretionary discussion with the Intake coordinator to ensure timely reporting standards by this facility. The Administrator will be responsible for overall compliance. Corrective action completed: October 16, 2013	