

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

PRINTED: 10/16/2012
FORM APPROVED
OMB NO. 0938-0391

Acceptable
ROC 10/25/12

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 C 10/02/2012
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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 Abbreviated Survey to investigate KY#00019080 and KY#00019144 was initiated on 10/01/12 and concluded on 10/02/12. KY#00019080 was unsubstantiated with no deficient practice identified. KY#00019144 was substantiated. An unrelated deficiency was cited at 42 CFR 483.13 Resident Behavior and Facility Practice, F-225 at a scope and severity of a "D".	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.	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ Individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law, or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property, and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.	F 225		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Cynthia Thornton TITLE: Administrator (X6) DATE: 10/25/12

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 225 Continued From page 1

The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

This REQUIREMENT is not met as evidenced by:
Based on interview, record review and review of the facility's policy, it was determined the facility failed to ensure all employees had a thorough background check completed prior to hire. Review of four (4) employee files revealed Employee #1 did not have a criminal background check completed prior to hire and Employee #2 did not have an abuse registry check completed prior to hire.

The findings include:

Review of the policy titled, "Alleged Abuse Reporting/Investigation", undated, revealed "the facility will demonstrate reasonable efforts to determine whether a person being considered for employment has an abuse record".

Review of the facility file for Employee #1 revealed the State Registered Nursing Assistant (SRNA) was hired by the facility on 03/18/09. However, the first documented evidence of an abuse registry check was on 06/21/11.

F 225

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 25, 2012

Facility Administrator reviewed the employee files of named employee #1 and employee #2 with confirmation that each employee's file included a required criminal background check and abuse registry check.

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Review of the facility file for Employee #2 revealed the Licensed Practical Nurse (LPN) was hired by the facility on 08/24/05. Continued review revealed no documented evidence a criminal background check was completed until 11/17/05.

Interview with the Administrator, on 10/02/12 at 5:35 PM, revealed Employee #1 was transferred to the facility from another corporately-owned facility which was no longer operating. She stated she talked to the corporate Human Resources department and learned that there were no hard copies of background checks other than those contained in the current file. Continued interview revealed she did not know why Employee #2 did not have a criminal background check completed until three (3) months after the hire date. The Administrator stated she felt the oversights were identified on employee file audits and appropriate background checks were completed at that time.

F 225 An audit was completed by the facility HR director of all current employee files to confirm completion of a criminal background check and abuse registry check prior to hire. Identified concerns were corrected with completion on October 25, 2012

Re-education to current HR director and Staff Development Coordinator of the necessity of completion of both pre-employment screenings prior to hire.

The Administrator will sign off on all employee's personnel files to verify completion of both New hire files will be reviewed in the facility QA meeting for the next 90 days to ensure ongoing compliance. Ongoing, upon determination of, the Administrator will review a 10% sample as a part of the facility QA process

Corrective Action Completed:
October 25, 2012