

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

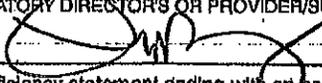
PRINTED: 10/27/2011
FORM APPROVED
OMB NO. 0988-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185160	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/13/2011
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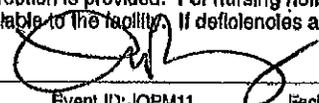
NAME OF PROVIDER OR SUPPLIER LEXINGTON COUNTRY PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 700 MASON HEADLEY ROAD LEXINGTON, KY 40504
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	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		
F 241 SS=E	<p>A Standard Recertification Survey was initiated on 10/11/11 and concluded on 10/13/11. Deficiencies were cited at 42 CFR 483.15 Quality of Life, 42 CFR 483.20 Resident Assessment, 42 CFR 483.25 Quality of Care, 42 CFR 483.35 Dietary Services, 42 CFR 483.65 Infection Control, 42 CFR 483.70 Physical Environment and 42 CFR 483.75 Administration. The highest scope and severity was an "E".</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure care was provided in an environment and in a manner that maintained and enhanced each resident's dignity for two (2) of thirteen (13) sampled residents, (Resident #2 and #9) and (1) unsampled resident (Unsampled Resident B). The facility failed to ensure Resident #2's and Unsampled Resident B's indwelling catheter drainage bags were in dignity bag covers. Observation of meals revealed the facility failed to ensure residents' trays were served in a manner to promote dignity during the meal service.</p> <p>The findings include:</p>	<p>The following constitutes Lexington Country Place's plan of correction for the deficiencies cited and will serve as the facility's credible allegation that substantial compliance will be achieved by November 15, 2011.</p> <p>The submission of this plan of correction is not an admission on the part of the facility that a deficiency exists or that the facility necessarily agrees with the accuracy of the surveyor's findings. Rather, it is being submitted as required by law.</p> <p>Nursing staff were in-serviced by the Director of Nursing (DON) on October 12, 2011, on the proper procedure for serving meal trays and the requirement that all residents seated at the same table are served at the same time. Staff were also instructed to engage residents in conversation while providing assistance during meals.</p> <p>Resident seating arrangements and preferences were reviewed by the nursing unit managers and the dietary staff was notified to ensure that meal trays are arranged on the food carts in table order.</p> <p>To help prevent a reoccurrence, the DON or Unit Coordinators will monitor dining rooms during a meal five (5) times per week for six (6) weeks using an audit tool (Exhibit A) to ensure meals are served at the same time to all residents seated at the same table and</p>	11/15/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	ADMINISTRATOR	11/2/11

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.

AMENDED:  ADMINISTRATOR 11/17/11

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F 241	Continued From page 1 Review of the facility's policy, Personal Privacy and Respect (dated 1/1/07), revealed nonspecific criteria related to dignity. Interview, on 10/12/11 at 4:45 PM, with the Director of Nursing (DON), in the Conference Room, revealed she had requested a policy specific to dignity but no documented evidence was available for review. 1. Observation of the lunch meal, on 10/11/11 at 12:40 PM, revealed residents sitting at the meal tables was not served all together. Further observation revealed table one (1) was served the first two (2) trays, then table two (2) was served one (1) tray, next table three (3) was served one (1) tray and the Speech Therapist assisted him/her with the meal, then a resident sitting in the sitting room was served, then table one (1) was served another tray, then table two (2) was served three (3) trays and finally table three (3) was served three (3) trays. Interview, on 10/11/11 at 12:15 PM, with State Registered Nursing Assistant (SRNA) # 5 in Unit Two (2) dining area, revealed staff was to pass the trays out as they come off the cart. Further interview validated, the trays do not always come out table by table. Interview, on 10/11/11 at 12:25 PM, with SRNA #4 in Unit Two (2) dining area, revealed that nursing assistants normally passed trays by room number as that was the way they were arranged in the server cart from the kitchen. Further interview, validated it could make a resident feel bad if they were not served their tray when other residents at that table received their trays.	F 241	that staff engage residents in conversation while assisting with the meal. The physician for Resident #9 was contacted and instructed to knock and ask residents permission before entering a patient room and check with nursing staff as necessary to preserve privacy and help ensure dignity. Other physicians will be notified of this requirement as well. To ensure ongoing compliance, the Social Services Director (SSD) or Social Services Assistant will interview three (3) residents per week for six (6) weeks using an audit tool (Exhibit B) to determine if privacy needs are being met. The catheter drainage bags for Resident #2 and Unsampled Resident B were placed in dignity bag covers and have been kept in these covers while the resident is in bed or in a wheelchair. Other residents with indwelling catheters were checked for the presence of uncovered catheter bags but none were identified. Nursing staff were in-serviced by the Director of Nursing (DON) on October 12, 2011, on the requirement that catheter bags be covered with dignity bags at all times and that they never touch the floor.		

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F 241	<p>Continued From page 2</p> <p>Interview, on 10/11/11 at 12:45 PM, with SRNA #6 in Unit Two (2) dining area, revealed that staff served the trays as they came up on the tray cart, but the residents did not sit according to room numbers.</p> <p>Interview, on 10/11/11 at 1:00 PM, with SRNA #7 in Unit Two (2) dining area, revealed staff were suppose to serve trays as they came up on the dietary cart. Further interview confirmed residents were not all served, table by table because the trays did not come up that way.</p> <p>Observation of the evening meal, on 10/11/11 at 5:15 PM, revealed table two (2) being served two (2) trays, then table one was served one (1) tray, then a resident sitting alone in the sitting room was served, then table two (2) was served another tray, then table one (1) was served one (1) tray, then table three (3) was served one (1) tray, then back to table one (1) for one (1) tray, next table two (2) was served one (1) tray and the last three (3) trays were served to table three (3).</p> <p>Interview, on 10/12/11 at 5:40 PM, in the Unit Two (2) dining area, with the Dietary Manager, revealed trays on Unit Two (2) came out in room order and were served accordingly.</p> <p>In addition, observation of the evening meal, at 5:05 PM on 11/12/11, revealed State Registered Nurse Aide (SRNA) #9 (restorative aide) only provided cues to residents to eat, no observations were made of any attempts at social conversation.</p> <p>Interview, on 10/12/11 at 6:00 PM, with SRNA #9</p>	F 241	<p>To prevent a reoccurrence, the DON or Unit Coordinators will audit five (5) indwelling catheters per week for six (6) weeks using an audit tool (Exhibit C)</p> <p>Any further deficiencies noted will be referred to the facility Quality Assurance committee for corrective action.</p>	

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F 241	Continued From page 3 revealed that part of her job description as a Restorative Aide included engaging residents in social conversation during meal times. 2. Interview with Resident #9, on 10/13/11 at 10:25 AM, in his/her room, revealed he/she had requested to use the bedpan and was left on the bedpan when his/her physician came for a visit. Further interview revealed Resident #9 confirmed with his/her physician the bedpan was in place and the physician indicated he would take care of the issue. Continued interview with Resident #9 confirmed, "It embarrassed me". Interview, on 10/13/11 at 3:30 PM, with Social Services Director, revealed she was not aware of the bedpan/physician visit issue. 3. Observations during initial tour, on 10/11/11 revealed Unsampled Resident B's indwelling catheter was not in a privacy bag. Interview, on 10/11/11 at 2:15 PM, with Licensed Practical Nurse (LPN) #4 revealed Unsampled Resident B's catheter should have been put in a privacy bag to maintain Unsampled Resident B's dignity. Interview, on 10/11/11 at 2:30 PM, with SRNA #3 revealed that catheters should be in a privacy bag to enhance a residents sense of dignity.	F 241		
F 253 8S=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.	F 253	The therapy department was deep cleaned on October 12, 2011. Dust was removed from the eight exercise machines and the fire extinguisher, and the floor below the seated bicycle was cleaned and the white substance removed.	11/15/11

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F 253	<p>Continued From page 4</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview it was determined the facility failed to maintain the environment in a clean and orderly manner. Observation of the therapy department revealed a visible build up of dust on the exercise equipment and the "Upper Back Machine" had duct tape around the seat cushion.</p> <p>The findings include:</p> <p>Observations of the therapy department, on 10/11/11 at 10:20 AM and 10/12/11 at 12:41 PM, revealed a buildup of visible dust on eight (8) exercise machines and the fire extinguisher. Under the seated bicycle there was a buildup of a white powdery substance.</p> <p>Interview, on 10/11/11 at 4:05 PM, with the Therapy Manager revealed she was aware the equipment was dusty and had requested a "deep clean" the week before. She explained the housekeeping manager was out of the facility that week and the cleaning could not be scheduled.</p> <p>Observation of the "Upper Back Machine", on 10/11/11 at 10:20 AM and 10/12/11 at 12:41 PM, revealed duct tape was around the edge of the seat cushion. The duct tape was tattered and pilling around the edge.</p> <p>Interview, on 10/11/11 at 4:30 PM, with the Outpatient Therapist revealed she did not know why the duct tape was in place. She examined the tape and stated there was a hole in the cushion. She stated she did not know how</p>	F 253	<p>A new seat cushion was installed on the Upper Back Machine on October 19, 2011 and the old cushion with duct tape noted was discarded.</p> <p>A new cleaning schedule for the therapy room was developed by the Director of Environmental Services and the room and its equipment contents will be routinely cleaned weekly.</p> <p>To help ensure ongoing compliance, the therapy room will be audited by the Director of Environmental Services for cleanliness and the presence of taped cushions or equipment weekly for six (6) weeks using an audit tool (Exhibit D).</p> <p>Any further deficiencies noted will be referred to the facility Quality Assurance committee for corrective action.</p>	

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F 253	Continued From page 5 long the tape had been in place.	F 253			
F 323 SS=E	<p>Interview, on 10/11/11 at 12:44 PM, with Therapy Manager revealed the machines were no longer manufactured and it was difficult to get parts. She stated she did not know for sure how long the duct tape had been in place. The Therapy Manager also stated she did not know what maintenance was doing to fix the cushion.</p> <p>Interview, on 10/11/11 at 4:50 PM, with the Maintenance Director revealed he was not aware the duct tape was on the equipment.</p> <p>489.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to provide a resident environment that was free from accident hazards as evidenced by hazardous chemicals not being secured by the facility and some handrails having sharp edges. The following chemicals were found in an unlocked sink cabinet in the resident's shower room: a plastic spray bottle of Ecolab TB Disinfectant and Deodorizer, a plastic bottle of Tile And Grout Rejuvenator, and a plastic spray</p>	F 323	<p>The TB Disinfectant and Deodorizer, Grout Rejuvenator, and Acid Free Restroom Cleaner found in the sink cabinet of the 100 Hall shower room were removed on October 11, 2011 and the cabinet locked. Cabinets and storage units located in the other shower rooms were inspected for the presence of chemicals but none were noted.</p> <p>All staff were in-serviced on October 21, 2011 by the Administrator on the proper storage of hazardous chemicals and the need to keep them locked up and non-accessible by residents at all times.</p> <p>To prevent a reoccurrence, the Maintenance Director or Director of Environmental Services will audit shower rooms for the presence of unlocked chemicals three (3) times per week for six (6) weeks using an audit tool (Exhibit E) and remove them as necessary.</p>	11/15/11	

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F 323	<p>Continued From page 6</p> <p>bottle of AFC Acid Free Restroom Cleaner. In addition the facility failed to ensure handrails in the corridors were free from sharp edges.</p> <p>The findings include:</p> <p>1. Observation, on 10/11/11 at 9:05 AM, of shower room on hallway one-hundred (100), used by multiple residents, revealed the following hazardous chemicals found under an unlocked sink cabinet:</p> <p>Observation revealed a plastic spray bottle of Ecolab TB Disinfectant and Deodorizer. The label noted "Danger: Corrosive causes irreversible eye damage and skin burns".</p> <p>Observation revealed a plastic bottle of Tile and Grout Rejuvenator. The label listed "Caution: May cause eye/skin irritation".</p> <p>Observation revealed a plastic bottle of AFRC Acid Free Restroom Cleaner. The label read "Caution: Harmful if absorbed through the skin. Avoid contact with skin, eyes, and clothing."</p> <p>Interview, on 10/11/11 at 10:00 AM, with Director of Environmental Services regarding the chemicals found under the sink revealed they should have been locked up. He stated the bathroom cabinet should have been locked. When asked about the danger of these chemicals not being secured he stated all chemicals can be dangerous.</p> <p>2. Observation on 10/11/11 at 10:55 AM, revealed some areas of the corridor handrails on Anna's Place had some sharp edges.</p>	F 323	<p>The handrails observed to have sharp edges/ areas in Anna's Place, Greenbriar Crossing (100 Hall) and Magnolia Court were repaired by maintenance staff on October 11, 2011 and the sharp edges removed.</p> <p>Other handrails were inspected by the maintenance staff for sharp edges and firm mounting and repaired as necessary.</p> <p>To prevent a reoccurrence, the Maintenance Director or maintenance staff will audit handrails for sharp edges three (3) times per week for six (6) weeks using an audit tool (Exhibit I) and make repairs as necessary.</p> <p>Any further deficiencies noted will be referred to the facility Quality Assurance committee for corrective action.</p>	

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F 323	Continued From page 7 Observation, on 10/11/11 at 12:45 PM, revealed some areas of the corridor handrails along the one-hundred (100) hall had some sharp edges. Observation, on 10/11/11 at 12:55 PM, revealed some areas of the corridor handrails on Magnolia Wing Hall had some sharp areas. Interview, on 10/11/11 at 3:20 PM, with the Plant Operations Director regarding the sharp areas along the corridor handrails revealed he acknowledged the sharp edges on the handrails and stated the sharp edges could be a hazard to residents.	F 323		
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 This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility's policy it was determined the facility failed to distribute food in a sanitary manner. Observation of the tray line on 10/11/11 during the lunch meal revealed staff moved from task to task without changing gloves or washing hands. In addition the facility failed to ensure staff in the	F 371	The kitchen staff were in- serviced on October 12, 2011 by the Foodservice Director (FSD) on the proper procedures for hand washing, and the wearing of gloves and hair nets. To prevent a reoccurrence and ensure ongoing compliance; the FSD, Dieticians or dietary supervisors will audit the kitchen five (5) times per week for six (6) weeks using an audit tool (Exhibit F) to ensure proper employee sanitation practices. Any further deficiencies noted will be referred to the facility Quality Assurance committee for corrective action.	11/15/11

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F 371	<p>Continued From page 8 kitchen wore hair covering that covered all of the hair.</p> <p>The findings include:</p> <ol style="list-style-type: none"> Review of the facility's policy "Hand Washing" dated 01/01/01 revealed hand washing is to be done after contact with soiled or contaminated articles, such as waste removal and articles that are contaminated with body fluids; after removal of gloves. <p>Observation of kitchen during the lunch meal, beginning at 11:00 AM on 10/11/11, revealed two (2) staff members were putting away supplies. One (1) staff member rubbed her nose with the palm of her hand and proceeded into the walk-in refrigerator/freezer without washing her hands.</p> <p>Additional observations, on 10/11/11 at 11:10 AM, of the Dietary Manager during the lunch meal preparation revealed he checked the temperature of the ribs, put the ribs into the oven and proceeded to take the temperature of the cauliflower, alternate meat, mashed potatoes, melted cheese and pureed carrots without changing his gloves and washing his hands.</p> <p>Interview, on 10/11/11 at 1:03 PM, with the Dietary Manager revealed gloves are changed between each task.</p> <p>Observation, on 10/11/11 during the lunch meal service, of Cook #3 revealed she removed plastic from the steam table and proceeded to serve food. The cook checked the book for serving size and put a new glove on her left hand without washing her hands. Cook #3 reset a timer,</p>	F 371		

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F 371	<p>Continued From page 9</p> <p>removed the glove from her right hand and placed a new glove on the right hand. The cook did not wash her hands when she changed gloves.</p> <p>Interview, on 10/11/11 at 12:56 PM, with Cook #3 revealed she washed her hands a lot. The cook was not aware she should have washed her hands when changing gloves.</p> <p>Further observation of the kitchen, during the lunch meal on 10/11/11, revealed Cook#4 preparing peanut butter and jelly sandwiches. The cook put on gloves obtained the bread and peanut butter from the dry storage area and began making sandwiches without changing her gloves. The cook obtained a can of jelly from the dry storage area and continued to make sandwiches. Cook #4 then took bread and cheese to the stove to make a grilled cheese sandwich. The cook was wearing the same pair of gloves which was donned when she began to make the peanut and butter sandwich. The cook did not change her gloves and wash her hand prior to moving to a new task.</p> <p>Additional observation of Cook #4, on 10/11/11 at 11:55 AM, revealed she put away her sandwich making supplies and washed her hands. She obtained bacon from the walk-in refrigerator and put on gloves. She asked a male dietary aide to hand her a can of non-stick spray. The male employee did not have gloves on his hands. Cook #4 proceeded to spray a pan and place strips of bacon onto the pan with her gloved hand which had touch the can of non-stick spray handled by the male aide who was putting away supplies. The cook did not change her gloves or</p>	F 371			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105180	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/13/2011
NAME OF PROVIDER OR SUPPLIER LEXINGTON COUNTRY PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 700 MASON HEADLEY ROAD LEXINGTON, KY 40604	
(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 371	<p>Continued From page 10</p> <p>wash her hands after touching the can of spray. Interview, on 10/11/11 at 12:59 PM, with Cook #4 revealed gloves were to be changed each time she switched foods and tasks. She stated the male aide had given her the can of non-stick spray and she did not know if he was wearing gloves and was putting away stock.</p> <p>Observation of Dietary Aide #2, on 10/11/11 beginning at 11:00 AM, revealed she was on the serving line placing plates on the trays and placing the trays into carts. The aide was observed to leave the serving line, enter the walk-in refrigerator to obtain a sandwich and resumed placing items on trays. The aide did not change her gloves or wash her hands. The aide dropped a lid onto the floor and picked the lid up with her gloved hands and placed the lid on top of the plate warmer. The aide did not change her gloves or wash her hands. Additional observation revealed Aide #2 took a bowl from a staff member in the dining room and placed the bowl on the serving line, next to the pureed foods. The aide did not wash her hands or change gloves.</p> <p>Interview, on 10/11/11 at 12:52 PM, with Dietary Aide #2 revealed she was to change gloves and wash her hands when she changed tasks. She stated she should have changed her gloves when going to the walk-in, after picking up the lid and after taking the bowl from the dining room. She stated the bowl from the dining room was contaminated and should have gone to the dish room, not the serving line.</p> <p>2. Observation of the kitchen area, on 10/11/11 beginning at 11:00 AM, revealed the Dietary Manager and three (3) other dietary staff's hair</p>	F 371		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185160	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/13/2011
NAME OF PROVIDER OR SUPPLIER LEXINGTON COUNTRY PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 700 MASON HEADLEY ROAD LEXINGTON, KY 40504		
(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 371	Continued From page 11 covering did not cover all the hair.	F 371			
F 441 88=D	<p>Interview, on 10/11/11 at 12:52 PM, with Dietary Aide #2 revealed hair covering was to cover all the hair line.</p> <p>In an interview, on 10/11/11 at 12:56 PM, with Cook #3 revealed hair coverings were worn to prevent hair from getting into food and should cover the entire hairline.</p> <p>Interview, on 10/11/11 at 1:03 PM, with the Dietary Manager revealed hair covering was worn to prevent hair falling into food and spreading microorganisms.</p> <p>488.65 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 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 - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (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</p>	F 441	<p>Nursing staff were in- serviced by the DON on October 13, 2011 on the proper procedure for administering medications and the prohibition against placing medications in bare hands.</p> <p>To ensure compliance, the DON or Unit Coordinators will perform three (3) medication pass audits of LPN's and/ or KMA's per week for six (6) weeks using an audit tool (Exhibit G).</p> <p>Nursing staff were in- serviced by the DON on October 12, 2011 on other infection control practices including the requirement that resident's food not be touched by staff with their bare hands.</p> <p>The therapy department staff were in- serviced by the Rehabilitation Director on October 24, 2011 on the requirement that resident's food not be touched by</p>	11/15/11	

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NAME OF PROVIDER OR SUPPLIER LEXINGTON COUNTRY PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 700 MASON HEADLEY ROAD LEXINGTON, KY 40504		
(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 12 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 review of facility's policy and procedures it was determined the facility failed to maintain effective infection control. Observations and interviews revealed two (2) staff pushed medications from blister packs into their hands, contaminating the medication. Additional observation revealed two (2) staff State Registered Nursing assistant (SRNA) #9 and the Speech Therapist handled residents' food with bare hands. In addition, an indwelling catheter drainage bag was observed laying on the floor.</p> <p>The findings include: Review of the facility's "Specific Medication Administration Procedures" policy dated 02/01/10, revealed medications were to be</p>	F 441	<p>staff with their bare hands</p> <p>To ensure ongoing compliance, the DON or Unit Coordinators will monitor dining rooms during a meal five (5) times per week for six (6) weeks using an audit tool (Exhibit H) to ensure that staff do not improperly touch food.</p> <p>The catheter bag for resident #2 was repositioned on October 12, 2011, placed in a cover and secured to prevent it from touching the floor. Other residents were checked for the presence of indwelling catheter bags touching the floor but none were identified.</p> <p>Nursing staff were in-serviced by the Director of Nursing (DON) on October 12, 2011, on the requirement that catheter bags be covered with dignity bags at all times and that they never touch the floor.</p> <p>To prevent a reoccurrence and ensure ongoing compliance, the DON or Unit Coordinators will complete an audit three (3) times per week for six (6) weeks using an audit tool (Exhibit C)</p> <p>Any further deficiencies noted will be referred to the facility Quality Assurance committee for corrective action.</p>		

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NAME OF PROVIDER OR SUPPLIER LEXINGTON COUNTRY PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 700 MASON HEADLEY ROAD LEXINGTON, KY 40504		
(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	Continued From page 13 poured into souffle cups.	F 441			
	<p>1. Observation, on 10/12/11 at 8:05 AM, revealed Kentucky Medication Aide (KMA) #2 pushed a medication into her bare hand. Observation, on 10/12/11 at 8:50 AM, revealed Licensed Practical Nurse (LPN) #1 pushed a medication into her ungloved hand. Observation, on 10/12/11 at 9:47 AM, revealed KMA #2 dropped several medications from her ungloved hand into a medication cup.</p> <p>Interview, on 10/12/11 at 10:00 AM, with LPN #1 revealed she had pushed a resident's medication into her bare hand. She stated that was wrong and she should have pushed it out into a cup.</p> <p>In interview, on 10/12/11 at 10:15 AM, with KMA #2 she stated she had medications in her hand when observed giving medications at 9:47 AM. The KMA stated medications were to be pushed out over a cup or gloved hand.</p> <p>Interview, on 10/12/11 at 11:30 AM, with the Director of Nursing (DON) revealed staff was to push medications from the blister packs into cups and not their hands.</p> <p>In an interview, on 10/12/11 at 1:11 PM, with LPN #2 revealed medications were to be pushed out of blister packs into a cup. She explained touching medications was an infection control issue.</p> <p>Interview, on 10/12/11 at 1:11 PM, with KMA #1 revealed medications should be put out into cups, to prevent contaminating the medication.</p>				

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NAME OF PROVIDER OR SUPPLIER LEXINGTON COUNTRY PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 700 MASON HEADLEY ROAD LEXINGTON, KY 40504
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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
F 441	<p>Continued From page 14</p> <p>Interview, on 10/12/11 at 4:13 PM, with LPN #3 revealed medications were pushed out of blister packs into cups, due to infection control.</p> <p>Interview, on 10/12/11 at 4:29 PM, with LPN #4 revealed the rationale for pushing medications into cups was to prevent contamination of the medication.</p> <p>2. Observation during the evening meal service, on 10/12/11 at 5:05 PM, revealed SRNA #9 was feeding residents at the Restorative Dining table with bare hands. Observation revealed SRNA #9 took a sandwich out of a baggie with bare hands, out it with a knife and handed the resident half of the sandwich, handed another resident at the Restorative table a sandwich with bare hands, touched her face and a resident's face then gave that resident a drink and assisted another resident to get a drink from the water fountain before sanitizing hands.</p> <p>Interview with SRNA #9, on 10/12/11 at 6:00 PM, revealed she should not have touched resident food with bare hands.</p> <p>Interview with LPN #6, Restorative Aide Charge Nurse, on 10/13/11 at 2:35 PM, revealed SRNA #9 should not have used her bare hands to feed residents. LPN #6 further stated SRNA #9 should have used Standard Infection Control procedures when assisting or feeding residents.</p> <p>3. Observation, on 10/11/11 at 12:43 PM, in the Unit Two (2) dining area, revealed the Speech Therapist (ST) was assisting Resident #2 with eating. Further observation revealed the ST removed a grilled cheese sandwich from Resident #2's plate with her bare hands and</p>	F 441		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185160	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/13/2011
NAME OF PROVIDER OR SUPPLIER LEXINGTON COUNTRY PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 700 MASON HEADLEY ROAD LEXINGTON, KY 40504		
(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 441	Continued From page 15 began feeding the resident.	F 441			
F 468 SS-E	<p>Interview, on 10/13/11 at 2:55 PM, in the Conference room, with the ST revealed she normally wore glove when feeding residents. Further interview validated she should have had a glove or some barrier on her hands prior to touching the sandwich.</p> <p>4. Review of the facility's policy on Urinary Catheter and Drainage Bag Care (dated 10/1/09) revealed "Do not allow the catheter bag holder, tubing, or splot to touch the floor. Further review of policy on Care of Patient with Foley Catheters (dated 1/07) on 10/12/11 at 4:45 PM, confirmed in 3.0 Procedure, first bulleted item states, "Bags are hung on the frames of beds, sides of wheelchairs, and stretchers, so that they do not touch the floor."</p> <p>Observation, on 10/12/11 at 9:00 AM, revealed Resident #2's urinary drainage bag was lying on the floor and was not in a privacy/dignity bag.</p> <p>Interview, on 10/12/11 at 3:20 PM, with License Practical Nurse (LPN) #2, on Unit Two (2), revealed Resident #2's catheter bag should not have been directly on the floor.</p> <p>Interview, on 10/12/11 at 3:25 PM, with the Director of Nursing (DON), revealed per policy catheter bags were to be kept off the floor.</p> <p>489.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS</p> <p>The facility must equip corridors with firmly secured handrails on each side.</p>	F 468	<p>The end segments of the handrails located in Anna's Place, the handrails along the glass corridors leading into Greenbriar Crossing, and the handrail outside of Room 204 were all tightened</p>	11/15/11	

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NAME OF PROVIDER OR SUPPLIER LEXINGTON COUNTRY PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 700 MASON HEADLEY ROAD LEXINGTON, KY 40504	
(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 468	<p>Continued From page 16</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to provide firmly secured handrails in the corridors. The handrails along various corridors of the facility were not firmly secured to the wall and one corridor did not have handrails available.</p> <p>The findings include:</p> <p>Observation, on 10/11/11 at 12:15 PM, of the handrail on both sides of the glass corridor going from the dining area to Anna's Wing revealed they were not firmly secured to the wall on both end segments of each handrail.</p> <p>Observation, on 10/11/11 at 12:40 PM, of the handrails along the glass side of the corridor going from the dining area to the Greenbrier Crossing Wing revealed the handrail was not firmly secured to the wall at the both end segments of the handrail.</p> <p>Observation, on 10/11/11 at 12:50 PM, of the handrails on both sides of the glass corridor going from the dining area to the Magnolia Wing revealed they had no handrails along the glass corridor. Further observation revealed there were holes along the corridor's structure indicating where a handrail had been secured.</p> <p>Observation, on 10/11/11 at 12:55 PM, of the hallway handrail outside of room 204 revealed it was not firmly secured to the wall.</p> <p>Interview, on 10/11/11 at 3:20 PM, with the Plant</p>	F 468	<p>by maintenance staff on October 11, 2011 and are firmly secured to the wall. Handrails were installed on both sides of the glass corridor leading into Magnolia Court by maintenance staff on October 12, 2011.</p> <p>To prevent a recurrence, the Maintenance Director or maintenance staff will complete an audit three (3) times per week for six (6) weeks using an audit tool (Exhibit I).</p> <p>Any further deficiencies noted will be referred to the facility Quality Assurance committee for corrective action.</p>	

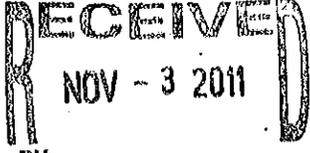
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185180	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/19/2011
NAME OF PROVIDER OR SUPPLIER LEXINGTON COUNTRY PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 700 MASON HEADLEY ROAD LEXINGTON, KY 40504		
(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 468	Continued From page 17 Operations Director confirmed the loose handrails in the observed areas. He acknowledged that the loose handrails could possibly give way if a resident leaned against them. He also stated they should have a handrails on the corridor between the Dining Room and the Magnolia Wing.	F 468			

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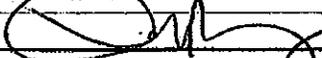
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185160	(X2) MULTIPLE CONSTRUCTION: A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/12/2011
NAME OF PROVIDER OR SUPPLIER LEXINGTON COUNTRY PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 700 MASON HEADLEY ROAD LEXINGTON, KY 40504	
(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
K 000	INITIAL COMMENTS CFR: 42 CFR 483.70(a) Building: 01 Plan Approval: 1980 Survey under: NFPA 101 (2000 edition) Facility type: SNF/NF Type of structure: Smoke Compartment: Seven (7) Fire Alarm: Complete fire alarm with smoke detectors in resident rooms and at smoke barriers. Sprinkler System: Complete sprinkler system Generator: 300KW diesel installed in 1986 A standard Life Safety Code survey was conducted on 10/12/2011. Lexington Country Place was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The census the day of the survey was eighty nine (89). The facility is licensed for one hundred eleven (111). The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire) with the highest scope and severity (S/S) of an "F".	K 000	The following constitutes Lexington Country Place's plan of correction for the deficiencies cited and will serve as the facility's credible allegation that substantial compliance will be achieved by November 15, 2011. The submission of this plan of correction is not an admission on the part of the facility that a deficiency exists or that the facility necessarily agrees with the accuracy of the surveyor's findings. Rather, it is being submitted as required by law.  BY: _____	
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4	K 025	The conduit and ductwork penetrations found in the Station 1 smoke compartment, the smoke barrier next to Room 219, and smoke barrier for Station 2 were filled using an approved fire rated patching compound on October 31, 2011. Other above- ceiling smoke barrier walls were inspected by the maintenance staff on October 12, 2011 for the presence of holes/ penetrations, but none were identified.	11/15/11

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

TITLE

(X6) DATE



ADMINISTRATOR

11/2/11

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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NAME OF PROVIDER OR SUPPLIER LEXINGTON COUNTRY PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 700 MASON HEADLEY ROAD LEXINGTON, KY 40504	
(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
K 025	<p>Continued From page 1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure smoke barriers were maintained according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect two (2) of seven (7) smoke compartments, seventy four (74) residents, staff and residents.</p> <p>The findings include:-</p> <p>Observation on 10/12/2011 at 9:21 AM, revealed the smoke compartment for Station One (1) has three (3) penetrations from conduit and one (1) from duct work. Further observation revealed three (3) penetrations from conduit in the smoke barrier next to room 219. Penetrations were as observed in the smoke barrier for Station two (2) by two (2) pieces of conduit. The observation was confirmed with the Maintenance Director.</p> <p>Interview on 10/12/2011 at 9:21 AM, with the Maintenance Director, revealed the facility checks smoke barriers approximately ever three (3) months and he was unaware the smoke barriers were penetrated.</p> <p>Reference: NFPA 101 (2000 edition) 8.2.4.4.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through smoke partitions shall be protected as</p>	K 025	<p>To prevent a reoccurrence, the Maintenance Director or designee will inspect smoke barrier walls monthly for 6 months using an audit tool (Exhibit J) and make repairs as necessary. Any further deficiencies noted will be referred to the facility Quality Assurance committee for corrective action.</p>	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185160	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/12/2011
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NAME OF PROVIDER OR SUPPLIER LEXINGTON COUNTRY PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 700 MASON HEADLEY ROAD LEXINGTON, KY 40504
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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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K 025	Continued From page 2 follows: (1) The space between the penetrating item and the smoke partition shall meet one of the following conditions: a. It shall be filled with a material that is capable of limiting the transfer of smoke. b. It shall be protected by an approved device that is designed for the specific purpose. (2) Where the penetrating item uses a sleeve to penetrate the smoke partition, the sleeve shall be solidly set in the smoke partition, and the space between the item and the sleeve shall meet one of the following conditions: a. It shall be filled with a material that is capable of limiting the transfer of smoke. b. It shall be protected by an approved device that is designed for the specific purpose. (3) Where designs take transmission of vibrations into consideration, any vibration isolation shall meet one of the following conditions: a. It shall be made on either side of the smoke partitions. b. It shall be made by an approved device that is designed for the specific purpose.	K 025		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25,	K 062	New sprinkler heads have been ordered to replace the corroded sprinkler heads located under the front entrance canopy and are scheduled to be installed on or before November 15, 2011.	11/15/11

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K 062	<p>Continued From page 3 9.7.5</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the sprinkler system components were maintained according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect two (2) smoke compartments, thirty two (32) residents, staff and visitors.</p> <p>The findings include:</p> <p>Observation, on 10/12/2011 at 1:21 PM, revealed seven (7) of eight (8) sprinklers head located at the front canopy was corroded. Sprinkler heads must remain free of corrosion to ensure the sprinkler heads activated during a fire. The observation was confirmed with the Maintenance Director.</p> <p>Interview on 10/12/2011 at 1:21 PM, with the Maintenance Director, revealed he was unaware that the sprinkler heads were corroded.</p> <p>Observation on 10/12/2011 at 9:34 AM, revealed sprinkler piping located in the attic (near room 219) was being used to support duct work. Further observation revealed sprinkler piping in the attic above Station Three and the Station Three connector was being used to support various cables and wires. The observation was confirmed with the Maintenance Director.</p> <p>Interview on 10/12/2011 at 9:34 AM, with the Maintenance Director, revealed he was unaware</p>	K 062	<p>Other sprinkler heads were inspected by the maintenance staff on October 12, 2011 but none were identified.</p> <p>To prevent a reoccurrence, the Maintenance Director or designee will inspect outdoor sprinkler heads monthly for 6 months using an audit tool (Exhibit K) and replace them as necessary.</p> <p>The wires being supported by the sprinkler piping located in the attic near Room 219 and the attic located above Station 3 and the Station 3 connector have been secured with wire hangers and suspended above the piping.</p> <p>Other attic areas were inspected by the maintenance staff on October 13, 2011 for the presence of wiring being supported by sprinkler piping and those found have been suspended above the pipes using wire hangers.</p> <p>To prevent a reoccurrence, the Maintenance Director or designee will inspect attic areas monthly for 6 months using an audit tool (Exhibit L) and make repairs as necessary.</p> <p>Any further deficiencies noted will be referred to the facility Quality Assurance committee for corrective action.</p>		

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K 062	<p>Continued From page 4</p> <p>the sprinkler piping was being used to support the wires and cables.</p> <p>Reference: NFPA 25 (1998 edition) 2-2.1 Sprinklers. 2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation. Exception No. 1:* Sprinklers installed in concealed spaces such as above suspended ceilings shall not require inspection. Exception No. 2: Sprinklers installed in areas that are inaccessible for safety considerations due to process operations shall be inspected during each scheduled shutdown. 2-2.2* Pipe and Fittings. Sprinkler pipe and fittings shall be inspected annually from the floor level. Pipe and fittings shall be in good condition and free of mechanical damage, leakage, corrosion, and misalignment. Sprinkler piping shall not be subjected to external loads by materials either resting on the pipe or hung from the pipe. Exception No. 1:* Pipe and fittings installed in concealed spaces</p>	K 062		

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K 062	Continued From page 5 such as above suspended ceilings shall not require inspection. Exception No. 2: Pipe installed in areas that are inaccessible for safety considerations due to process operations shall be inspected during each scheduled shutdown.	K 062		
K 072 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD 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 This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure exits were maintained free and clear of obstructions according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) smoke compartment, one hundred and eleven (111) residents, staff and visitors. The findings include: Observation on 10/12/2011 at 11:12 AM, revealed an exit corridor leading from the basement area was being used to store various items (bed, mattresses, wheelchairs). Corridors must be kept free and clear of obstruction for their instant use. The basement area contained the beauty shops and physical therapy. All residents had	K 072	The exit corridor leading from the basement area will be cleared of the beds, mattresses, wheelchairs and other items on or before November 15, 2011 in order to be free of obstructions. This corridor will no longer be used for any type of storage, including temporary storage. Other exit corridors were inspected by the maintenance staff for the presence of stored items but none were identified. To prevent a reoccurrence, the Maintenance Director or designee will inspect exit corridors weekly for 6 months using an audit tool (Exhibit M) and remove any items found as necessary. Any further deficiencies noted will be referred to the facility Quality Assurance committee for corrective action.	11/15/11

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K 072	<p>Continued From page 6</p> <p>customary access to the area. The observation was confirmed with the Maintenance Director. Interview on 10/12/2011 at 11:12 AM, with the Maintenance Director, revealed the area was used to store the items before being transferred to another storage area. Further interview revealed the items may stay in the corridor for up to three (3) days before being moved to storage.</p> <p>Reference: NFPA 101 (2000 edition) 7.1.10.1* Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.</p>	K 072		