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

PRINTED: 02/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185197		C 01/24/2013

NAME OF PROVIDER OR SUPPLIER: NORTHPOINT/LEXINGTON HEALTHCARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE: 1500 TRENT BOULEVARD, LEXINGTON, KY 40515

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	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 again 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.	
	An abbreviated survey investigating KY#00019668 was initiated on 01/23/13 and concluded on 01/24/13. KY#00019668 was substantiated with a deficiency cited.			
F 224 SS=D	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN	F 224		
	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 the facility's policy, it was determined the facility failed to prohibit neglect for one (1) of four (4) sampled residents (Resident #1). Resident #1 was transported to dialysis on 01/14/13 with nothing covering his/her toes. Upon arrival at the dialysis center, staff noted the resident's toes to be purple in color.			
	The findings include:			
	Review of the facility's Abuse Policy, undated, revealed neglect is the failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness.			
	Review of Resident #1's record revealed the facility admitted the resident on 01/03/13 with diagnoses which included End Stage Renal			

RECEIVED FEB 12 2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Elizabeth Morrison
TITLE: Administrator
(X6) DATE: 2/12/13

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185197		C 01/24/2013

NAME OF PROVIDER OR SUPPLIER: NORTHPOINT/LEXINGTON HEALTHCARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE: 1500 TRENT BOULEVARD, LEXINGTON, KY 40515

(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 224	Continued From page 1 Disease (ESRD) with Dialysis and Bilateral Heel Ulcers. Review of the admission Nursing Assessment, dated 01/13/13, timed 11:45 AM, revealed the nurse assessed the resident to have unstageable "black" areas to his/her bilateral heels. The Nurse documented Resident #1 was alert and oriented. According to the Nurse's documentation, the resident had dialysis on Mondays, Wednesdays, and Fridays. Additionally, the nurse noted the resident required assist of two (2) for transfers. Review of the Admission Care Plan, dated 01/03/13, revealed an Activities for Daily Living (ADL) Care Plan which noted interventions that included assistance of one (1) for dressing and grooming. Review of the Nurse's Note, dated 01/14/13 and timed 9:50 AM, revealed Resident #1 was leaving the unit to go to dialysis. Further review of the Nurse's Notes revealed a Note dated 01/14/13, timed 10:50 AM, which noted the dialysis center had called stating Resident #1 was unresponsive and was being sent to the hospital. Interview, on 01/24/13 at 3:52 PM, with the van driver who transported Resident #1 to dialysis on 01/14/13 revealed he observed bandages on the resident's feet; however, he could see his/her toes on one foot. He stated it was "really cold" that day. According to the van driver, when Resident #1 arrived at the diatysis center his/her toes had "a little bluish cast to them" like they were cold. Interview, on 01/23/13 at 9:17 AM, with the Dialysis Center Manager revealed when Resident #1 arrived at the dialysis center on 01/14/13 with no socks on his/her feet, his/her toes were	F 224	**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 February 15, 2013** **It is the practice of this facility to develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of residents' property.** **Beginning January 25,2013 the facility management nurses began direct observation of current residents that leave the facility on appointments to ensure appropriate dress for the season, physical needs and dignity. No current residents were found to be negatively affected.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	t85197	A. BUILDING B. WING	C 01/24/2013

NAME OF PROVIDER OR SUPPLIER
NORTHPOINT/LEXINGTON HEALTHCARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
1500 TRENT BOULEVARD
LEXINGTON, KY 40515

(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 224	Continued From page 2 exposed and were purple. She stated the temperature outside on 01/14/t3 was twenty-eight (28) degrees Farenheit. Interview, on 01/23/13 at 3:29 PM, with State Registered Nursing Assistant (SRNA) #1, who was assigned to Resident #1 on 01/14/13, revealed the resident required staff to dress him/her on 01/14/13. She stated she thought she recalled putting socks on the resident's feet that morning. Interview, on 01/23/13 at 3:56 PM, with Physical Therapy Assistant (PTA) #1 revealed she assisted with turning the resident in bed when SRNA #1 dressed Resident #1 the morning of 01/14/13. She stated she observed the resident to have on open toed blue heel boots (a heel pressure off loading device) and socks which had been placed over the dressings on the resident's heels. Interview, on 01/24/13 at 10:35 AM, with Licensed Practical Nurse (LPN) #1, who was assigned to Resident #1 on 01/14/13, revealed when she observed Resident #1 the morning of 01/14/13 prior to leaving for dialysis, she could not recall if the resident had socks on or anything covering his/her feet. Interview, on 01/24/13 at 4:27 PM, with Resident #1's Power of Attorney (POA) revealed she would have expected the resident to have socks on his/her feet as he/she always wore socks. Interview, on 01/24/13 at 4:46 PM, with the Director of Nursing (DON) revealed she had performed an investigation after receiving a	F 224	**On February 8, 2013 the Social Service Director/QA team observed current residents within the facility to monitor provision of goods and services necessary to avoid physical harm, mental anguish and mental illness.** **On February 8, 2013 the Social Services Director interviewed 10 cognitively intact residents related to perception of treatment, services and property with no identified concerns.** **Auditing of resident care and treatment to include observation and interview or residents will be conducted two (2) times a week for 2 weeks, then weekly for four weeks and monthly thereafter to ensure substantial compliance. These audits will be completed by the Social Services Director/QA team .**	

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

PRINTED: 02/07/2013
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 C 01/24/2013
NAME OF PROVIDER OR SUPPLIER NORTHPOINT/LEXINGTON HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1500 TRENT BOULEVARD LEXINGTON, KY 40515	

(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 224	Continued From page 3 phone call from the Dialysis Center Manager. She stated she was informed by the Dialysis Center Manager that Resident #1 had arrived at the dialysis center on 01/14/13 with no shoes or socks on. The DON gave the surveyor a copy of her investigation. Review of the DON's investigation report, dated 01/15/13, revealed SRNA #1, who cared for Resident #1 on 01/14/13, informed her Resident #1 had "bunny" boots on his/her feet when he/she left the facility. Further review revealed the DON had performed "on the spot" education with SRNA #1 to ensure residents had socks on their feet, as well as a blanket if the weather was cold. Continued interview with the DON revealed Resident #1 should have had socks on, or something covering his/her feet, prior to being transported to dialysis. Review of the online local weather channel's report for 12:00 PM on 01/14/13 revealed the temperature was twenty-seven (27) degrees Farenheit.	F 224	**Nursing staff were re-educated on abuse and neglect on 2/15/2013, specifically addressing observation of residents that leave the facility on appointments to ensure appropriate dress for the season, physical needs and dignity. Audit results will be reviewed monthly in the QA & A Meeting with revision to the plan as deemed by the QA & A Committee.** **The Administrator is responsible for overall compliance.**	