STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185197	A. BUILDING _____ B. WING _____	01/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHPOINT/LEXINGTON HEALTHCARE CENTER	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	The PM programs will be revlewed and submitted to the monthly QA committee to ensure compliance is met as determined by the QA Committee. Any identified area of concern will result in revision to auditing, re-education and monitoring as deemed appropriate by the QA Committee. The Administrator is responsible for overall compliance.	2/8/2013
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview with staff, record review, and review of the facility's policy, it was determined the facility failed to promote care for residents in a manner and in an environment that maintained or enhanced each resident's dignity and respect for two (2) of twenty-four (24) sampled residents (Resident #5 and #6), and two (2) unsample residents. The facility failed to ensure staff knocked on residents' doors prior to entry or failed to ask permission to enter, after knocking, when appropriate before entering residents' rooms. The findings include: Review of the facility's policy titled, "Resident's Rights", revised on 02/08/11, revealed the facility would make every effort to assist each resident in exercising his/her rights to assure that the resident was always treated with respect, kindness, and dignity. Further review of the policy revealed each employee had a duty to read and learn the residents' rights.	F 241	F241 The doors for residents #5 and #6 have been knocked upon by staff, including CNAs #2, #5 and RN #1, and the staff waited for permission to enter the room from the residents on 1/28/2013. The residents were interviewed by the Social Worker on 1/28/2013 and they validated that staff was knocking on their doors and awaiting permission to enter prior to entry. They further stated they felt their dignity is upheld and respected by the facility staff.	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Cheryl Beth Thornton	Administrator	2/1/2013

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 000	INITIAL COMMENTS A Standard Recertification Survey was conducted 01/08/13 through 01/11/13 with deficiencies cited, with the highest Scope and Severity of an "E".	F 000	**The PM programs will be reviewed and submitted to the monthly QA committee to ensure compliance is met as determined by the QA Committee.**	
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview with staff, record review, and review of the facility's policy, it was determined the facility failed to promote care for residents in a manner and in an environment that maintained or enhanced each resident's dignity and respect for two (2) of twenty-four (24) sampled residents (Resident #5 and #6), and two (2) unsample residents. The facility failed to ensure staff knocked on residents' doors prior to entry or failed to ask permission to enter, after knocking, when appropriate before entering residents' rooms. The findings include: Review of the facility's policy titled, "Resident's Rights", revised on 02/08/11, revealed the facility would make every effort to assist each resident in exercising his/her rights to assure that the resident was always treated with respect, kindness, and dignity. Further review of the policy revealed each employee had a duty to read and learn the residents' rights.	F 241	**Any identified area of concern will result in revision to auditing, re-education and monitoring as deemed appropriate by the QA Committee.** **The Administrator is responsible for overall compliance.** **F241** **The doors for residents #5 and #6 have been knocked upon by staff, including CNAs #2, #5 and RN #1, and the staff waited for permission to enter the room from the residents on 1/28/2013. The residents were interviewed by the Social Worker on 1/28/2013 and they validated that staff was knocking on their doors and awaiting permission to enter prior to entry. They further stated they felt their dignity is upheld and respected by the facility staff.**	2/8/2013

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BY:

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F 241	Continued From page 1 1. Review of Resident #5's medical record revealed the facility admitted the resident on 02/06/12 with diagnoses which included Aspiration Pneumonia, Bipolar Disorder, and Alzheimer's Disease. Review of the quarterly Minimum Data Set (MDS) Assessment, completed 11/14/12, revealed Resident #5 had a Brief Interview for Mental Status (BIMS) score of fifteen (15) out of fifteen (15) which indicated Resident #5 was cognitively intact. Observation, on 01/10/13 at 2:00 PM, revealed Certified Nursing Assistant (CNA) #5 entered Resident #5's room while she was knocking and did not wait for Resident #5 to give his/her permission for her to enter. Interview with Resident #5, on 01/10/13 at 2:10 PM, revealed staff entered his/her room a lot without knocking. He/she further stated "they are going to do what they are going to do". Interview with CNA #5, on 01/10/13 at 2:15 PM, revealed she had been answering Resident #5's call light; therefore, she did not wait for Resident #5 to give his/her permission for her to enter his/her room. Further interview revealed even though she was answering a call light, she should not have entered the room before the resident gave his/her permission for her to enter the room. 2. Review of Resident #6's medical record revealed the facility admitted the resident on 11/28/12 with diagnoses which included Pneumonia, Anxiety, Pain in Joints, and Dysphagia. Review of the quarterly MDS Assessment, completed on 12/05/12, revealed	F 241	**10 cognitively intact residents were interviewed by the Social Worker on 1/28/2013 regarding maintenance of dignity and respect in full recognition of each resident's individuality. No cognitively intact residents expressed any concerns. Facility residents with cognitive deficits were observed by the Social Worker on 1/28/2013 for signs that their individual dignity and respect were not being observed and no symptoms were identified.** **Facility staff were re-educated by the SDC and/or department managers on 1/10/2013 regarding resident's rights and dignity and promoting that each resident is always treated with respect, kindness and dignity regardless of cognitive status.** **The facility management team will complete audits to monitor that dignity and respect are being maintained. The audits will be completed Daily x 1 week, Weekly x 4 weeks then Monthly until compliance met.**	

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F 241	Continued From page 2 Resident #5 had a BIMS of eleven (11) out of fifteen (15) which identified the resident as being cognitively intact. Observation during initial tour, on 01/08/13 at 6:20 AM, revealed CNA #2 entered Resident #6's room without knocking or introducing themselves. Interview, on 01/08/13 at 6:40 AM, with CNA #2 revealed she had been checking on the resident and forgot to knock and introduce herself before she entered the resident's room. She further stated she should have knocked and introduced herself to the resident before she entered the room. 3. Observation, on 01/10/13 at 9:10 AM, revealed Registered Nurse (RN) #1 walked into two (2) unsampled residents' rooms without knocking or waiting for the residents to give their permission for her to enter their rooms. Interview with RN #1, on 01/10/13 at 9:40 AM, revealed she should not have entered the residents' rooms without first knocking. She further stated staff was not to enter a resident's room without the resident's permission. Interview with the Director of Nursing (DON), on 01/11/13 at 11:00 AM, revealed staff should always knock before entering a resident's room and wait for the resident to give their permission before they enter the resident's room. She further stated even if staff had been answering a resident's call light, they should still wait for the resident to give their permission before they entered the resident's room. Further interview revealed if a resident was cognitively impaired,	F 241	**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.**	2/8/2013

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F 241	Continued From page 3 staff was to still knock and identify themselves before they entered the resident's room. She further stated all residents should be treated with dignity and respect and if staff failed to knock before they entered a resident's room or failed to wait for the resident to give them permission to enter the resident's room; this would be a violation of the resident's right to be treated with dignity and respect.	F 241	**F281** **The order for TED hose for resident #8 was discontinued on 1/8/2013.** **Resident #5 had a skin assessment completed on 1/15/2013 by RN which included the resident being undressed and the assessment included visualization of the the entire body including the perineal area, thighs, ears and between her fingers.** **Current facility residents have had their physician orders and care plans reviewed by administrative nurses by 1/31/2013 for accuracy with observation by the administrative nurses that ordered interventions are implemented for applicable residents. MARs and TARs were reviewed by administrative nurses on 1/31/2013 for validating documentation that physician orders are followed. Current facility residents have received a skin assessment by**	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure the services provided meet professional standards. The facility failed to ensure Physician's Orders were followed as evidence by one (1) of twenty-four (24) sampled residents (Resident #8) did not have TED hose applied as indicated by the Physician's Order. Additionally, the facility failed to ensure a thorough assessment was performed for one (1) of twenty-four (24) sampled residents (Resident #5) when Registered Nurse (RN) #1 failed to undress the resident when performing a skin assessment. The findings include:			

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F 281	Continued From page 4 1. Interview with the Director of Nursing (DON), on 01/11/13 at 10:40 AM, revealed the facility did not have a policy that addressed following of Physician's Orders. In addition, she stated the standard of practice followed by the facility did not address following Physician Orders. Record Review revealed the facility admitted Resident #8 11/07/11 with diagnoses which included Alzheimer's Dementia, Anemia, Diabetes Melitis, Depression, Anxiety, Hypertension, Hearing Loss, and Hyperlipidemia. Review of the most recent annual Minimal Data Set (MDS) Assessment, dated 11/08/12, revealed Resident #8 was assessed as being severely cognitively impaired. Review of Resident #8's current careplan addressing Activities of Daily Living (ADLs), revealed an intervention of TED hose to be applied every morning and taken off at night. Further review of this plan of care revealed, it was last revised January 2013. Review of Resident #8's Physician's Orders revealed on order, dated 01/30/12, which stated to apply TED hose every morning and remove the TED hose at bedtime. In addition, the order stated to notify the Physician of any significant change in edema. Review of Resident #8's Treatment Administration Record (TAR), for 01/01/13 through 01/31/13, revealed a treatment for TED hose to be applied every morning and taken off at bedtime daily. Beside this treatment order was an area designated to be initialed by the person	F 281	licensed nurses which visualizes the entire body by 1/19/2013. Nurses were re-educated on 1/25/2013 by the SDC regarding validating that interventions/orders which are signed as being present by licensed staff are implemented and present. Re-education of all nurses was completed by the SDC on 1/25/2013 regarding professional standards of practice. This re-education included, but was not limited to, following physician orders, implementation of care plan interventions, validating that orders/treatments are utilized prior to placing initials on the MAR/TAR, and technique for completing a thorough skin assessment. The QA Nurse will complete audits for professional standards of practice to include following physician orders, implementation of care plan interventions, documentation on the MAR/TAR of validated orders prior to placing initials, and accuracy of	

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F 281	Continued From page 5 administering the treatment. Initials were present in all columns, thus, indicating the treatment had been applied. Observations, on 01/08/13 at 1:15 PM, 01/09/13 at 9:00 AM, 01/09/13 at 10:15 AM, 01/09/13 at 2:58 PM, revealed Resident #8 did not have TED hose applied as indicated per the Physician's Order. Interview with State Registered Nursing Assistant (SRNA) #1, who was assigned to care for Resident #8, on 01/09/13 at 3:00 PM, revealed Resident #3 was supposed to wear TED hose during the day. She reported the hose were placed on when he/she got up for breakfast. Although, she was unsure why the TED hose had not been applied on 01/08/13 or 01/09/13. Interview with Licensed Practical Nurse (LPN) #1, on 01/09/13 at 3:05 PM, who was assigned to Resident #8 on 01/08/13 to 01/09/13, revealed he forgot to ensure Resident #8 was wearing TED hose both days. Also, he admitted that he did sign Resident #8's TAR indicating the hose were in place on both 01/08/13 and 01/09/13. However, he stated this was an oversight and he had signed the TAR, but actually forgot to ensure the TED hose were in place. Interview with Registered Nurse (RN) #1 (Acting Unit Manager), on 01/09/13 at 3:10 PM, revealed she was not familiar with Resident #8's treatment orders. She stated if there was a Physician's Order in place as well as a careplan indicating Resident #8 was to have TED hose applied, then LPN #1 should have made sure it was done.	F 281	**completing skin assessments. These audits will be completed 2 times weekly for 2 weeks, weekly for 4 weeks then monthly.** **Audit results will be reviewed monthly in the QA&A meeting with revision to the plan as deemed by the QA&A Committee.** **The Director of Nursing is responsible for overall compliance.**	2/8/2013

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F 281	Continued From page 6 Interview with the Director of Nursing (DON), on 01/09/13 at 3:19 PM, revealed if Resident #8's Physician's Order and careplan indicated TED hose were to be applied, then it should have been followed. Furthermore, she added, the nurses signing the TAR should ensure the TED hose were applied before initiating the record. 2. Interview with the DON, on 01/11/13 at 10:40 AM, revealed the facility did not have a policy that addressed the technique for performing a skin assessment. In addition, she stated the standard of practice followed by the facility did not address the technique to be used when performing a skin assessment. Record review revealed the facility admitted Resident #5 on 02/06/12 with diagnoses which included Pneumonia-Aspiration, Schizophrenia, Dysphagia, and Alzheimer Disease. Review of the most recent Minimum Data Set (MDS) Assessment, dated 11/14/12, revealed Resident #5 was assessed as being cognitively intact, with a Brief Interview of Mental Status (BIMS) of fifteen (15) out of fifteen (15). Observation, on 01/10/13 at 9:20 AM, revealed RN #1 performed Resident #5's skin assessment while Resident #5 was still fully dressed. She pulled back Resident #5's pants and brief to assess the perineal area, revealing only the top portion of the perineal area. Further observation revealed RN #1 did not assess behind Resident #5's ears or between his/her fingers. Interview, on 01/10/13 at 9:40 AM, revealed she felt she had done a thorough skin assessment	F 281		

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F 281	Continued From page 7 and was able to visualize the entire perineal area. She further stated she could not see Resident #5's inner thigh area nor could she see Resident #5's entire upper thigh since the pants remained on the resident during the entire skin assessment. Further interview revealed she had not assessed behind Resident #5's ears or between Resident #5's fingers. She further stated she should have assessed these areas. Interview with the DON, on 01/11/13 at 11:00 AM, revealed she did not feel that the entire perineal area could be visualized with the resident's brief and pants still on. She further stated in order to perform a thorough skin assessment of the perineal area, the brief and pants should have been removed while the perineal area was being assessed. Further interview revealed RN #1 should have assessed behind Resident #5's ears and between his/her fingers.	F 281	**F323** **The disinfectant cleaner(quat) has been secured in a locked cabinet in each facility shower room. The disposable razors have been disposed of in a sharps container in the facility shower room. Actions were completed by Director of Nursing on 1/8/2013.** **Facility Mangers observed all facility areas on 1/8/2013 for the presence of accident hazards.** **Facility staff were re-educated by the SDC/Department Managers on 1/11/2013 regarding accident hazards, supervision and assistive devices to prevent accidents.** **The management team will complete audits to monitor for accident hazards, supervision and assistive devices. These audits will be completed daily x1 week, and then weekly x 4 weeks then monthly x 3 months or compliance met.**	
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of the facility's policy, and the facility's Material Safely Data Sheet, it was delermined the facility failed to	F 323		

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F 323	Continued From page 8 ensure the resident environment was free from accidents and hazards over which the facility had control. The facility failed to identify Quant (a disinfectant chemical), stored in the resident shower rooms in an unlocked cabinet, available to unsupervised residents, as potentially harmful. The facility failed to identify disposable razors stored in the resident shower rooms in an unlocked drawer available to unsupervised residents, as potentially harmful. The facility failed to identify and implement interventions to reduce hazards to the facility's residents. The findings include: Review of the facility's policy related to needles and sharp items titled "Sharps, Disposal of" (undated), revealed the purpose of the policy was to provide storage of potentially hazardous supplies and to minimize potential risk. Further review of the facility's policy revealed all used sharps should be placed in a needles/sharps disposable container after use. Observation during the initial tour, on 01/08/13 at 6:00 AM, revealed an unlocked cabinet in the Hall A shower room to contain three (3) disposable razors. Two (2) disposable razors were un-opened in a plastic sleeve and one (1) disposable razors was opened and used with a white residue on the blades. The unlocked cabinet also contained a spray bottle of Quat Disinfectant Cleaner. Additional observations during the initial tour revealed the Amelia shower room as well as the Hall B shower room to both have an unlocked cabinet containing one (1) bottle of Quat Disinfectant Cleaner spray.	F 323	**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.**	2/8/2013

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F 323	Continued From page 9 Review of the Material Safety Data Sheet (MSDS) for the chemical used in the facility, 3M Quat Disinfectant Cleaner, revealed this chemical to be an immediate health, physical, and environmental hazard. Further review revealed it may cause chemical eye burns, chemical skin burns, chemical gastrointestinal burns and may be fatal if ingested. Additionally, the MSDS revealed the chemical may cause cancer. The first aid procedures recommended by the manufacturer were to seek immediate medical attention with a note to treating physicians that measures against circulatory shock, respiratory depression, and convulsions may be needed. Interview with the House Keeping Supervisor, on 01/08/13 at 12:35 PM, revealed the Quat Disinfectant Cleaner spray was stored in the shower rooms for the nursing staff to use as needed on the equipment in the shower rooms. Interview with Certified Nursing Assistant (CNA) #8, on 01/08/13 at 12:50 PM, revealed the cabinet where the razors and Quat Cleaner were located should have been locked and not available to the residents. Further interview revealed the used razor should have been disposed of in the sharps container. Additionally, CNA # 8 revealed this to be a potentially hazardous safety issue for the facility's residents. Interview with the Director of Nursing (DON), on 01/08/13 at 12:55 PM, revealed the cabinet containing the razors and the Quat Cleaner should have been locked. Further interview revealed the chemical and the razors were a potential safety hazard to the facility's residents. Additionally, the DON revealed the Maintenance	F 323		

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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 323	Continued From page 10 Department had been notified to correct the issues and lock the cabinets.	F 323	F364	
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutrilive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure food was served at a proper temperature to ensure palatability for residents in the Breckenridge/Combs dining room. A test tray revealed the turkey was one hundred and twelve (112) degrees Fahrenheit and the sweet potatoes were one hundred and seventeen (117) degrees Fahrenheit. The findings include: A Group Interview conducted with residents on the morning of 01/08/13 at 9:50 AM revealed residents in the Breckenridge/Combs dining room felt food served was too cold by the time it reached the tables. A test tray was obtained on 01/09/13, the last tray served delivered to the dining room after all residents to the dining room had been served, at 12:25 PM. Temperatures were taken and food was tested by survey staff for palatability. Turkey and sweet potatoes were determined to be	F 364	It is the practice of this facility to ensure 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. The Management /QA team audited meal service on January 14,2013 with feedback of interview able resident of all foods and beverages served at palatable temperatures. No concerns identified on this date. On January 14, 2013 a test tray was monitored with compliance of foods at palatable temperatures On January 14, 2013 the Dietary Manager re-educated all staff related to palatability and satisfaction of beverages and foods.	

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	185197	A. BUILDING _____ B. WING _____	01/11/2013

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F 364	Continued From page 11 lukewarm, 112 degrees Fahrenheit and 117 degrees Fahrenheit respectively. An interview with the Registered Dietician (RD), on 01/10/13 at 3:10 PM, revealed there was no rule or regulation regarding the temperatures of foods at the point of service; however, foods should be palatable to the residents. The RD further revealed steam tables were usually used in the Breckenridge/Combs dining room, although they had not been for the past couple of weeks due to resident illness. The RD further stated items would have been more palatable had they been warmer.	F 364	**Audits of dining room services and hall trays were initiated on January 14, 2013 to ensure residents are satisfied with temperatures and palatability of food and beverages at meal services. This audit includes a test tray for one meal by an assigned QA team member.** **On December 20, 2012 the facility purchased an Aladdin on Demand heat base and dome tray system with anticipated delivery of this system on February 1, 2013. Implementation of this system with facility meal service will assist with maintaining palatable temperatures.** **Results of these audits will be reviewed and submitted to the monthly QA committee for review and revision as deemed necessary until compliance is met as determined by the QA Committee.** **Any identified area of concern will result in revision to auditing, re-education and monitoring as deemed appropriate by the QA Committee.**	
F 371 SS=D	483.35(i) 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 and interview, it was determined the facility failed to store food under sanitary conditions. A quart of half-and-half with a use by date of 12/09/12, as well as an eight (8) pound container of macaroni salad with a use by date of 12/30/12, were both in the refrigerator on initial tour on 01/08/13 as well as on 01/09/13.	F 371		

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F 371	Continued From page 12 The findings include: Review of the facility Food Receiving and Storage policy, revised 03/16/11, revealed all food stored in the refrigeralor will be checked by the cook for a "use by" or expiration date prior to being used. Observation on the initial kitchen tour, on 01/08/13 at 6:00 AM, revealed an unopened quart container of half-and-half with a use by date of 12/09/12 sitting on a shelf in front of an unopended box of containers of half-and-half. The quart container was bulging from spoilage. On a higher shelf, just behind another food item, was an eight (8) pound container of macaroni salad with a use by date of 12/30/12. A tour the following day, 01/09/13 at 8:30 AM, with the Kitchen Manager, revealed the aforementioned items remained in the refrigerator. Interview with the Kitchen Manager at that time revealed items in the refrigerator should be checked every day by staff for outdated items. Interview with the Registered Dietician, on 01/10/13 at 3:10 PM, revealed the expired products should not have been left in the refrigerator, and that staff should have pulled it off the shelf on or shortly after the expiration date.	F 371	**The Administrator is responsible for overall compliance.** **F371** **It is the practice of this facility to store, prepare, distribute and serve food under sanitary conditions. On January 10, 2013, The Dietary Manager disposed of the macaroni salad and half-and-half.** **An audit was conducted by the Dietary Manager to ensure all foods were stored, prepared, distributed and served under sanitary conditions on January 10,2013 with no concerns identified.** **The Dietary Director re-educated all Dietary staff to facility practice of sanitary conditions with emphasis on expiration dates of foods and disposal of these items as indicated by printed expiration dates or "use by" dates. Food storage guidelines for reference have been inserviced and posted on 1/31/2013**	2/8/2013
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS 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.	F 441		

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F 441	Continued From page 13 (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. (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. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to maintain an Infection Control Program designed to provide a	F 441	Audits were initiated on January 10, 2013 with review of sanitary conditions of the dietary department to include the storage, preparation, distribution and service of foods under sanitary conditions. These audits will be conducted by the Management/QA team daily for a week, weekly for a monthly and then monthly thereafter to ensure compliance. Results of audits will be reviewed and submitted to the monthly QA committee for review and revision as deemed necessary until compliance is met as determined by the QA Committee. Any identified area of concern will result in revision to auditing, re-education and monitoring as deemed appropriate by the QA committee. The Administrator is responsible for overall compliance.	2/8/2013

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F 441	Continued From page 14 safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection as evidenced by four (4) nurses during six (6) skin assessments, assessing the residents' perineal area and buttocks, then assessing other areas of the residents' bodies without washing their hands or changing their gloves. Additionally, observation revealed an uncovered bedpan in a resident's bathroom, and dried brown material on a resident's raised toilet seat. The findings include: 1. Observation, on 01/09/13 at 9:38 AM, during Resident #3's skin assessment revealed Licensed Practical Nurse (LPN) #5 assessed the resident's buttocks, then assisted to turn Resident #3 without changing gloves or washing her hands. Observation revealed LPN #5 assessed the resident's upper body then perineal area and continued assessing the rest of Resident #3's body without changing gloves or washing her hands. After completion of the skin assessment, LPN #5 was observed to adjust Resident #3's pillow and gown prior to removal of the contaminated gloves. Interview, on 01/10/13 at 1:12 PM, with LPN #5 revealed she shoutd have washed her hands and changed her gloves after assessing the resident's perineal area and after assessing Resident #3's buttocks. 2. Observation, on 01/09/13 at 10:00 AM, during Resident #1's skin assessment revealed LPN #3 assessed the resident's perineal area, then assisted with turning the resident without	F 441	**F441** **The uncovered bedpan in the resident's bathroom has been cleaned and covered by Unit manager on 1/8/2013.** **The resident's raised toilet seat was cleaned and disinfected by housekeeping on 1/9/2013.** **Residents #s 3, 1, 11, 8, 4 and 9 received skin assessments by 1/12/2013 by licensed staff during which they changed their gloves and washed their hands between assessing clean and dirty areas and before touching linens or clean areas in the resident environment.** **Current facility residents had their environment observed by management team on 1/9/2013 for a safe, sanitary and comfortable environment and to observe for measures to help prevent the development and transmission of disease and infection.**	

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F 441	Continued From page 15 changing gloves or washing her hands. Continued observation revealed LPN #4 assessed the resident's buttocks and anal area then assisted with turning the resident back over without changing gloves or washing her hands. Further observation revealed both nurses continued and finished the resident's skin assessment before removing the contaminated gloves and washing their hands. Interview, on 01/11/13 at 10:28 AM, with LPN #3 revealed hands should be washed and gloves should be changed anytime a "dirty" area on a resident's body is touched. LPN #3 stated a "dirty" area was the perineal area or buttocks. She stated she should have changed her gloves after assessing these areas. Interview, on 01/11/13 at 10:37 AM, with LPN #4 revealed she should have changed her gloves after assessing the resident's buttocks and anal area. 3. Observation, on 01/09/13 at 10:25 AM, during Resident #11's skin assessment revealed LPN #1 assessed the resident's perineal area, then continued with the skin assessment without changing gloves or washing his hands. The LPN was observed to remove the contaminated gloves after completion of the skin assessment. 4. Observation, on 01/09/13 at 10:35 AM, during Resident #8's skin assessment revealed LPN #1 assessed the resident's buttocks then continued to assessment of Resident #8's back without changing gloves or washing his hands. Interview, on 01/11/13 at 10:43 AM, with LPN #1	F 441	**Nursing staff were re-educated by SDC by 2/6/2013 regarding infection control practices including, but not limited to, maintaining a safe, sanitary and comfortable environment, preventing the development and transmission of diseases and infections, preventing cross-contamination during resident care and hand-washing. Audits will be completed by the Infection Control nurse/ management nurses to monitor infection control practices including maintaining a safe, sanitary and comfortable environment, preventing the development and transmission of diseases/infections, preventing cross-contamination during resident care and hand-washing. Audits will be completed 4x weekly x 2 weeks, 2x weekly x 1 week and monthly thereafter by IC nurse.**	

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F 441	Continued From page 16 revealed when performing a skin assessment hands should be washed and new gloves donned after assessing residents' perineal area or buttocks. 5. Observation, on 01/09/13 at 11:35 AM, during Resident #4's skin assessment revealed LPN #3 performed the entire skin assessment including assessing the perineal area and buttocks without changing gloves or washing her hands. The LPN was observed to remove the contaminated gloves after completion of the skin assessment. 6. Observation, on 01/10/13 at 3:55 PM, during Resident #9's skin assessment revealed LPN #2 assessed the resident's buttocks, adjusted the covers, and placed her stethoscope in her ears and auscultated Resident #9's lung sounds without changing her gloves or washing her hands. Interview, on 01/10/13 at 4:15 PM, with LPN #2 revealed she should have removed her gloves and washed her hands prior to adjusting the covers and auscultating for lung sounds. Interview, on 01/11/13 at 11:16 AM, with the Director of Nursing (DON) revealed skin assessments were usually scheduled for shower days. She stated hands should be washed and new gloves donned between "dirty" sites. She stated a "dirty" site would be the perineal area. Interview, on 01/11/13 at 2:30 PM, with the Infection Control Nurse revealed staff should always wash their hands any time they change their gloves. She further stated hands should be washed and new gloves donned between "dirty"	F 441	**Audits results will be reviewed monthly in the QA&A meeting with revision to the plan as deemed by the QA&A Committee.** **The Director of Nursing is responsible for overall compliance.**	2/8/2013

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F 441	Continued From page 17 sites which would be considered the buttocks and the perineal area. Further interview revealed staff should have washed their hands and changed their gloves after assessing the "dirty" areas, before they moved to a clean area. 7. Observation during initial tour, on 01/08/13 at 6:15 AM, on the Breckinridge Unit, revealed a bedpan uncovered sitting on the safety grab bar in residents' bathroom between rooms B10 and B12. This was a shared bathroom between the rooms. Interview, on 1/8/13 at 6:15 AM, with Registered Nurse (RN) #2 revealed bedpans should be cleaned and placed in a bag in the residents' bathroom after use. Interview, on 1/11/13 at 11:45 PM, with the DON revealed bedpans should be labeled with the resident's name, covered with a plastic bag and cleaned after use and only used for that resident. Interview, on 01/11/13 at 2:30 PM, with the Infection Control Nurse revealed bedpans should be labeled with the resident's name, covered with a plastic bag and cleaned after each use. She further stated the bed pan should only be used for that resident. 8. Observation during the initial tour, on 01/08/13 at 6:20 AM, on the Breckinridge Unit, revealed a dried dark brown material on the back and on the sides of a white plastic toilet seat cover in a resident's bathroom between rooms B30 and B28. This was a shared bathroom between the rooms. Interview with CNA #2, on 01/08/13 at 6:30 AM, revealed she was not aware of the dried dark brown material on the plastic toilet seat cover.	F 441		

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F 441	Continued From page 18	F 441		

She further stated the resident in room B30 would take him/her self to the bathroom without staff and would sometimes leave feces on the toilet seat. Further interview revealed staff was to clean the bathrooms if they observed they were dirty.

Observation, on 01/09/13 at 9:00 AM, 10:00 AM and 1:00 PM, revealed in the bathroom between rooms B30 and B28, the white plastic toilet seat cover had a dark brown dried material on the back right corner.

Interview with CNA #3, on 01/09/13 at 1:30 PM, revealed she was not aware of the dried dark brown material on the toilet seat cover. Further interview revealed she had taken the resident to use the bathroom at 11:30 AM and she had not noticed the toilet seat cover had anything on it. She further stated housekeeping cleans the bathrooms at least one (1) time a day; however, any staff who assist a resident to the bathroom was responsible to clean the bathroom after each use.

Interview with the DON, on 01/11/13 at 11:00 AM, revealed it was the responsibility of the staff who took the resident to the bathroom to clean anything that was on the toilet seat and then they were to page housekeeping who were to disinfect the toilet seat.

Interview with the Infection Control Nurse, on 01/11/13 at 2:30 PM, revealed staff was to always clean the toilet seat after the resident was done using the bathroom and then page the housekeeper so they could disinfect the toilet seat. Further interview revealed staff should

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F 441	Continued From page 19 have checked the bathroom and cleaned the plastic toilet seat cover.	F 441		

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

PRINTED: 01/25/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185197	A. BUILDING 01 - MAIN BUILDING 01 B. WING	01/08/2013

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K 000	INITIAL COMMENTS CFR: 42 CFR §483.70 (a) BUILDING: 01 PLAN APPROVAL: 05/12/87 SURVEY UNDER: 2000 Existing FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: One (1) story, Type II (111) Protected SMOKE COMPARTMENTS: Eight (8) smoke compartments. COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM FULLY SPRINKLED, SUPERVISED (Wet SYSTEM) EMERGENCY POWER: Type II Diesel Generator. A life safety code survey was initiated and concluded on 01/08/13. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility was found not in substantial compliance with the Requirements for Participation for Medicare and Medicaid. The facility is licensed for one hundred fifty (150) beds and the census was one hundred forty-six (146) the day of the survey. Deficiencies were cited with the highest	K 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.**	

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FEB 11 2013
BY:

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Elizabeth Thornton	Administrator	2/1/2013

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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K 000	Continued From page 1 deficiency identified at "F" level.	K 000	**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**	
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, 9.7.5 This STANDARD is not met as evidenced by: Based on record review and interview, it was determined the facility failed to have sprinkler system gauges replaced or recalibrated every five years according to National Fire Protection (NFPA) standards. The deficiency had the potential to affect the entire facility, all residents, staff, and visitors. The findings include: Record review on, 01/08/13 at 1:30 PM, with the Maintenance Director revealed the facility did not have documentation for gauges being replaced or recalibrated in the past five years of the fire sprinkler system. The Fire Sprinkler system gauges shall be replaced or recalibrated every five years per NFPA requirements. Interview, on 01/08/13, at 1:30 PM, with the Maintenance Director revealed he remembered the sprinkler company stating that the gauges needed to be replaced but it was not documented on the inspection sheet. Reference: NFPA 25 (1998 Edition).	K 062	**Corrective action completed by February 8, 2013**	2/8/2013

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NORTHPOINT/LEXINGTON HEALTHCARE CENTER	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
K 062	Continued From page 2 2-1 General. This chapter provides the minimum requirements for the routine inspection, testing, and maintenance of sprinkler systems. Table 2-1 shall be used to determine the minimum required frequencies for inspection, testing, and maintenance. Exception: Valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 9. Table 2-1 Summary of Sprinkler System Inspection, Testing, and Maintenance Item Activity Frequency Reference Gauges (dry, preaction deluge systems) Inspection Weekly/monthly 2-2.4.2 Control valves Inspection Weekly/monthly Table 9-1 Alarm devices Inspection Quarterly 2-2.6 Gauges (wet pipe systems) Inspection Monthly 2-2.4.1 Hydraulic nameplate Inspection Quarterly 2-2.7 Buildings Inspection Annually (prior to freezing weather) 2-2.5 Hanger/seismic bracing Inspection Annually 2-2.3 Pipe and fittings Inspection Annually 2-2.2 Sprinklers Inspection Annually 2-2.1.1 Spare sprinklers Inspection Annually 2-2.1.3 Fire department connections Inspection Table 9-1	K 062	**K062** **Koorsen Fire Protection replaced the existing sprinkler pressure gauges on January 9, 2013. The sprinkler system was verified by Koorsen to meet the standard of installation, testing and maintainance in accordance with NFPA 13.** **All preventative maintenance programs were reviewed for compliance and timely completion with no concerns identified.** **The PM program was updated to initiate change out of sprinkler pressure gauges every five (5)years** **The facility PM programs will be reviewed by the Administrator monthly in the QA Committee for timely completion and compliance.**	