

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

PRINTED: 04/07/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185069	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/25/2010
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NAME OF PROVIDER OR SUPPLIER MAYFAIR MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 3300 TATES CREEK ROAD LEXINGTON, KY 40502
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F 000	INITIAL COMMENTS A Recertification/Abbreviated Survey for AROs KY00014209 and KY00014211 was conducted 03/23-25/10, and a Life Safety Code Survey was conducted 03/25/10. Deficiencies were cited, with the highest scope and severity of a "F". ARO KY00014211 was unsubstantiated. ARO KY00014209 was substantiated with deficiencies cited.	F 000	F 246 1. All dietary staff was counseled on resident #4 and #10 regarding food preferences by the dietary manager on 4-09-2010. Resident fruit preferences have been reviewed and updated by the dietary manager to include fresh fruit	
F 246 SS=E	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to accommodate residents' food preferences for two (2) of eleven (11) sampled residents (Residents #4 and #10). In addition the facility failed to provide fresh fruits to residents as evidenced by group and individual interviews and the lack of fresh fruits available in the kitchen and not included on the facility's menus. The findings include: 1. Review of Resident #4's record revealed the resident was admitted to the facility for rehabilitation on 02/08/10. Review of the Admission Minimum Data Set (MDS)	F 246	2. Dietary Manager Audit's of all individual resident food preferences and dietary requirements will be adjusted to resident requirements and preferences by 4-30-2010. On admission and during quarterly care plans the Dietary Manager will interview residents/family members on resident food preferences to include fresh fruit. Preferences will be placed in the computer system and printed on daily diet cards by the dietary manager. 3. The Dietary Manager in-serviced the dietary staff 4-09-2010 on the check system, to insure the resident food preferences are honored each meal. The check system is as follows: The dietary assistant that heads up the tray line will call their residents name at the beginning of the tray line, calling out the food dislikes and or food preferences, placing the silver ware across the plate heat pellet passing on to the second dietary assistant, the dietary assist will also call out the same dislike, then the cook who is placing the food on the	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Gene H. Martin</i>	TITLE <i>Administrator</i>	(X6) DATE <i>4/18/10</i>
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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 MAYFAIR MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 3300 TATES CREEK ROAD LEXINGTON, KY 40602	

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F 248	<p>Continued From page 1</p> <p>assessment, dated 02/15/10, revealed the facility assessed the resident as being alert and oriented and independent in decision making abilities.</p> <p>Observation, on 03/23/10 at 12:05 PM, revealed Resident #4 was served turkey with gravy and rice, squash and zucchini mix, a roll, and pudding. Observation further revealed Resident #4 consumed 100% of the meal except for the squash and zucchini mix.</p> <p>Review of the diet card on Resident #4's tray revealed squash as a dislike. Interview with Resident #4, on 03/23/10 at 12:05 PM, revealed she had informed the facility of her dislikes upon admission. The resident stated that he/she wished another vegetable had been served. Interview further revealed the facility rarely served fruit and never served fresh fruit at meals. Resident #4 stated he/she ate fresh fruit everyday prior to admission.</p> <p>2. Observation, on 3/24/2010 at 12:30 PM, revealed Resident #10 was served ham with sauce, spinach, sweet potato fries, blueberry cake, and vanilla ice cream. Review of the diet card on Resident #10 tray revealed ice cream as a dislike and ice cream as a supplement. The resident stated that she was served vanilla ice cream with her lunch every day although she had informed the facility she did not like vanilla ice cream. Interview further revealed that she requested fresh fruit and that the facility did not serve fresh fruit with meals or snacks.</p> <p>3. Group interview, on 03/23/10 at 3:15 PM, revealed residents rarely received fresh fruits. Residents stated they received canned fruits but would prefer to have fresh fruit more frequently.</p>	F 246	<p>plate, will call out the food dislikes, the plate is then passed to the tray loader to verify the diet card. The Tray loader will then verify the dislikes for the final check point. On 4/13/10 an in-service was given to the nursing staff by the Director of Nursing on the purpose of the dietary tray card and their responsibility for ensuring the resident food preferences to include fresh fruit are honored. The resident council will review the fruit options for the month. Likes and dislikes will be updated on the tray cards monthly by the dietary manager.</p> <p>4. The Dietary Manager/RD will observe the tray line for accuracy five times per week for four weeks, for food preferences, likes and dislikes. The weekly monitoring results by the dietary manger will be taken to the weekly standards of care for review by the IDT for four weeks. If at the end of the four weeks monitoring of the food preferences likes and dislikes continued monitoring is needed, the dietary manager will continue the (5) times / week audit until 100% compliance is obtained... If individual food preference compliance is met, the dietary manager will audit weekly and report to the IDT, The IDT committee will monitor the tray line audit results on a weekly basis in standards of care meeting. Unit manager/ ADON will review 10% tray card weekly for four weeks. The SRNA's will review tray cards for accuracy prior to tray delivery to each resident to insure resident preferences are honored. All audit results will be presented to the quarterly QA meeting for follow up.</p>	5/01/10

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F 246

Continued From page 2

Interview with the Dietary Manager, on 03/25/10 at 9:45 AM, revealed everyone on the tray line was to review the tray card and ensure residents' food preferences were honored. In additional interview, the Dietary Manager stated the facility was currently on the Winter Menu which primarily used canned fruits. She stated the residents had expressed a desire for more fresh fruits; however, when she tried to identify which fruits the residents wanted they were unable to state preferences.

F 246

F 281
SS=D

Interview, on 03/24/10 at 12:55 with Dietary Aide #6, revealed she was to identify food preferences and make sure the residents did not receive foods listed as a dislike. The Dietary Aide was unable to explain how Residents #4 and #10 received foods listed as dislikes.

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 that the facility failed to meet professional standards of quality for two (2) of eleven (11) sampled residents (Residents #4 and #11 and Unsampled Resident #1).

The findings include:

1. Observation of the medication cart, during the initial tour on 03/23/10 at 9:10 AM, revealed medication cups containing packets of medication

F 281

F 281

1. On 3-25-2010, KMA #1 and LPN #3 were counseled by the DON on appropriate procedures for medication administration. KMA#1 and LPN#3 were then in serviced on proper administration of medications. The medication cart audit was completed 3-25-2010 by the DON/ SDC/ RN to determine if any medications were pre set.

2. Training will be completed by the DON on 4-18-2010 for all Nurses and KMA's regarding proper Medication Administration including the five "R". All staff is aware that presetting of medications is prohibited at this facility

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F 281	Continued From page 3 with 11:00 AM and 2:00 PM written on them, were in the medication drawer for Resident #4 and the Unsampled Resident #1. Further observation of the Medication Administration Record (MAR) revealed that the medications predisensed in the cups for these residents were signed out as given. Interview with State Registered Nurse Aide/Kentucky Medication Aide (SRNA/KMA) #1 revealed she had set the medications up because she had not administered medications for a few months and felt pressured and was afraid she might forget something. SRNA/KMA #1 stated "if residents refused meds then I would circle my initial and document the reason on the back of the MAR. I know I'm not supposed to set meds up early". 2. Interview on 03/25/10, at 10:30 AM with LPN #3, revealed that on the evening of 12/02/09, she was the Nurse assigned to care for Resident #11. LPN # 3 stated Resident #11 had refused to take the meds and that she had placed the resident's meds back in the med cart in the cup. LPN #3 further revealed that the predisensed medication in the cup in the med oart were given to Resident #11 when the resident's family questioned if the resident had gotten their medication. Review of the facility's Medication Administration Polloy and Procedure revealed that medication should be administered when dispensed using the five (5) rights and signed off after administration of the medication.	F 281	3. The DON will perform a medication pass and a cart audit weekly for four weeks. The Consulting Pharmacist will conduct monthly medication pass audits for concerns related to Medication Administration following the 5 "R's". Medication carts will be monitored for pre set medications by the DON/unit manager weekly. Non compliance results will be reported to DON/ Administrator immediately for corrective action. 4. The Medication Administration Audits will be presented to the monthly safety meeting and forwarded to the quarterly QA meeting for follow up.	
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident	F 323		5/1/10

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F 323	<p>Continued From page 4</p> <p>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, interview, and record review it was determined the facility failed to ensure residents were free from hazards as evidenced by the unlocked housekeeping closet on the 100 Unit on 03/24/10 and 03/25/10 in which hazardous chemicals were stored.</p> <p>The findings include:</p> <p>Observations on 03/24/10 at 9:00 AM, 12:15 PM, and 3:00 PM and on 03/25/10 at 9:00 AM, revealed the housekeeping closet across from the Nurse's station, in a common resident area, was found to be unlocked. Observation further revealed two (2) cleaning agents were stored in the closet that contained hazardous warning labels. Observation revealed a spray bottle of Tilex and a spray can of Clean-Sweep.</p> <p>Review of the Material Safety Data Sheet (MSDS) for the Tilex Spray revealed health hazard data which included: Eye irritant, respiratory risk, and harmful if swallowed. Review of the MSDS for the Clean-Sweep revealed health hazard data which included: Eye irritant, skin irritant, irritant to the respiratory system, and harmful if swallowed.</p> <p>Interview with Housekeeping staff, on 03/25/10 at 8:45 AM, revealed the door was not always</p>	F 323	<p>F 323</p> <p>1. The housekeeping door was locked immediately by maintenance. The area was assessed immediately for any health hazards. An auto door lock was installed 3-26-2010 to prevent any further occurrence. The housekeeping staff on North Wing was counseled regarding the door lock policy on 3-26, 2010 by the housekeeping director.</p> <p>2. All housekeeping doors have been assessed for automatic door locks on 4-16-2010 by the maintenance director. All housekeeping staff was in serviced by the housekeeping supervisor by 4-30-2010 to ensure the housekeeping doors are locked at all times. The Housekeeping Supervisor in-serviced the Housekeeping Staff 3-26-2010 regarding hazards and concerns of housekeeping closets.</p>	
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F 323 F 372 SS=D	<p>Continued From page 5</p> <p>locked and she was unaware that the chemicals were in the closet. Interview with the Maintenance Director and the facility Cooperate Nurse, on 03/25/10 at 9:35 AM, revealed the closet should be locked at all times.</p> <p>483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY</p> <p>The facility must dispose of garbage and refuse properly.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to properly dispose of old furniture.</p> <p>The findings include:</p> <p>Observations, on 03/23/10 at 9:00 AM and 3:00 PM and on 03/24/10 at 2:30 PM, revealed a facility bed located outside the facility by the first exit door on the 100 Unit. Observation revealed the bed was uncovered, the frame was rusted, and the mattress was faded, saturated with water and ripped down the middle. Further observation revealed an old brown chair located outside the second exit at the end of the 100 Unit under a covered porch.</p> <p>Interview with the Maintenance Director, on 03/25/10 at 9:15 AM, revealed the bed had been set outside the exit door when it was replaced by a new bed. Interview revealed he was not sure how long it had been sitting outside the exit door. He further stated both furniture items should have been disposed of when they were removed from the facility.</p>	F 323 F 372	<p>3. The housekeeping supervisor will monitor the housekeeping doors (5) times per week for the function and compliance of the auto door locks. Audits will be reported to the monthly safety committee meeting.</p> <p>4. The monthly Safety Committee will report any noncompliance of closing doors to the quarterly QA committee for follow up.</p> <p>F 372</p> <p>1. The facility disposed of all garbage and refuse properly. The bed and chair were disposed of 3/25/10 by the maintenance director. The maintenance director was counseled on 3-25-2010 by the administrator regarding the proper disposal of garbage and refuse property.</p> <p>2. The facility was evaluated on 4-8-2010 by the Maintenance director for any other areas of garbage and refuse property. The maintenance staff was in-serviced by the Administrator on 3/26/10 concerning disposing of furniture/items properly.</p>	5/1/10

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F 465 SS=F	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to provide a safe, functional, sanitary, and comfortable environment as evidenced by scuffed paint on walls, resident room heaters, doors, and baseboards throughout the facility.</p> <p>The findings include:</p> <p>Observation of the interior of the facility on 03/23/10 and 03/24/10 revealed paint was scuffed on the heating units in residents' rooms throughout the facility. Observations further revealed the interior of residents' bathroom doors exhibited scuffed paint throughout the facility. Continued observations revealed baseboards and door casings throughout the facility were nicked and scuffed.</p> <p>Observation of the door casing on room 223 revealed the bottom piece of the door casing was missing therefore leaving a rough edge. Observation of the mailbox in front of room 215 revealed the mailbox was pulled away from the wall. Observation of the door casing of room 216 revealed a three (3) inch piece of wood that was splintered and taped back to the door casing.</p> <p>Interview with the Maintenance Director, on</p>	F 465	<p>3. The building exterior will be monitored during weekly rounds by the Maintenance Director and Administrator/Designee. Areas of concern will be addressed immediately by the administrator and or safety committee.</p> <p>4. All findings will be reviewed by the facility management staff in morning meeting. All areas of concern will be sent to the monthly Safety Committee for follow up and reported to quarterly QA meeting for further follow up.</p> <p>F 465</p> <p>1. The following items were repaired on 3/26/10: door casing on room 223; mailbox at 215. The door casing for room 216 was ordered and will be installed upon arrival by the maintenance staff.</p> <p>2. The interior building was evaluated 4-8-2010 by the maintenance director for resident: walls, bathroom doors, room heaters, baseboards and door casings. Areas were assessed and a plan for painting and repairs has been developed.</p>	5/1/10

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F 465 SS=F	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to provide a safe, functional, sanitary, and comfortable environment as evidenced by scuffed paint on walls, resident room heaters, doors, and baseboards throughout the facility.</p> <p>The findings include:</p> <p>Observation of the interior of the facility on 03/23/10 and 03/24/10 revealed paint was scuffed on the heating units in residents' rooms throughout the facility. Observations further revealed the interior of residents' bathroom doors exhibited scuffed paint throughout the facility. Continued observations revealed baseboards and door casings throughout the facility were nicked and scuffed.</p> <p>Observation of the door casing on room 223 revealed the bottom piece of the door casing was missing therefore leaving a rough edge. Observation of the mailbox in front of room 215 revealed the mailbox was pulled away from the wall. Observation of the door casing of room 216 revealed a three (3) inch piece of wood that was splintered and taped back to the door casing.</p> <p>Interview with the Maintenance Director, on</p>	F 465	<p>3. A painting schedule has been put in place to ensure that the facility will provide a safe, functional, sanitary, and comfortable environment. The Maintenance Assistant has scheduled painting days of Monday, Thursday and Friday which will ensure the interior of the facility is repainted every six months.</p> <p>The Maintenance Director and Housekeeping Director will make weekly rounds to identify areas of concern and scuffed paint to ensure that painting and repairs are maintained timely per maintenance repair log.</p> <p>4. All Areas of concern will be reviewed by the monthly safety committee and forward to the quarterly QA committee for follow up.</p> <p>Date 4-18-2010</p>	4/18/10

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<p>F 465</p> <p>F 514 88=D</p>	<p>Continued From page 7</p> <p>03/25/10 at 9:15 AM, revealed he was aware that some areas needed painting. He stated that his assistant usually painted two (2) times per week but that he would be having him paint daily.</p> <p>483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to maintain clinical records in accordance with accepted professional standards and practices that were complete, accurate, and readily accessible for two (2) of eleven (11) sampled residents (Resident #7 and Resident #11). The Physician's Orders and Medication Administration Record (MAR) for Resident #7 indicated medications were to be given by mouth; however, Resident #7 could only receive medications via Gastrostomy Tube (G-tube). The facility was unable to provide the November 2009 MAR and the December 2009 MAR for "as needed" (prn) medications for Resident #11.</p>	<p>F 465</p> <p>F 514</p>	<p>F 514</p> <p>1. On 3/25/10 Resident #7's MAR and Physician Order was reviewed by the DON/unit manager. The Physician orders for resident #7 were clarified with the physician to reflect the accurate route of medication administration. The MAR was updated to reflect the correct order clarification. The Nov. and Dec. (MAR) Medication administration record for resident #11 is available for review in the residents closed record.</p>	
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F 514	<p>Continued From page 8</p> <p>The findings include:</p> <p>1. Review of Resident #7's medical record revealed the resident was readmitted to the facility on 02/09/10 with diagnoses which included Dysphagia. Review of the admission Physician's Orders revealed Resident #7 had a Gastrostomy Tube (G-tube), was NPO (nothing by mouth), and was to receive all medications per G-tube.</p> <p>Observation during a medication administration, on 03/24/10 at 2:10 PM, revealed Licensed Practical Nurse (LPN) #2 pulled an Acidophilus Capsule and opened the capsule to mix with water and pulled a Flexeril 5 milligram (mg) tablet and crushed the tablet to mix with water. Interview with LPN #2 revealed these medications were to be given per G-tube.</p> <p>Review of the March 2010 MAR revealed the two (2) medications were to be given per mouth. Further review of the March 2010 MAR revealed all of the medications for Resident #7 were ordered to be given per mouth. Review of the Monthly Physician's Orders for March 2010 revealed all of the Medications were to be given per mouth.</p> <p>Interview with LPN #1 and LPN #2, nurses assigned to Resident #7's unit, on 03/24/10 at 2:30 PM revealed Resident #7 was to have nothing by mouth and all nutrition and medication was administered per G-tube.</p> <p>Interview with the Admissions Coordinator, assigned to check the monthly change over orders and MAR's, on 03/25/10 at 11:00 AM, revealed the "by mouth" should have been "per</p>	F 514	<p>2. A Physician's Order and MAR audit was completed for 100% of the residents in house on 3/25/10 by the DON and Restorative Nurse for accuracy of the administration of medication route. The clinical records audit of 100% of the in house residents was completed to include accuracy within the documentation of the record, that each clinical records is accessible in the records department and is in a systematically organized filing system to ensure sufficient information to identify the resident details of the resident assessments, the plan of care for the resident and the results of an preadmission screening conducted by the state and the clinical medical progress notes. An audit of all Residents receiving tube feedings was completed by the DON/ RN to determine all MAR's and Physicians Orders accurately reflect the correct route of administration. A comprehensive audit has been completed for closed records to ensure there are no missing documents.</p>	

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

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FORM APPROVED
OMB NO. 0938-0991

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186069	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/25/2010	
NAME OF PROVIDER OR SUPPLIER MAYFAIR MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 3300 TATES CREEK ROAD LEXINGTON, KY 40502		
(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 514	<p>Continued From page 9</p> <p>G-tube" for Resident #7. She further stated that she had missed this mistake when she reviewed the monthly change over records.</p> <p>2. Review of Resident # 11's medical record revealed the resident was admitted 11/25/09, and discharged on 12/2/09. Further review revealed no November 2009 Medication Administration Record (MAR) and no December 2009 MAR for "as needed" (prn) medications.</p> <p>Interview with Medical Records staff, on 03/25/10, at 1:35 PM revealed that these MARs could not be located for Resident #11.</p>	F 514	<p>3. An audit of 100% of the in house clinical records will be conducted by the RN weekly. The clinical records audit will include accuracy within the documentation of the record, that each clinical records is accessible and is in a systematically organized filing system to ensure sufficient information to identify the resident details of the resident assessments, the plan of care for the resident and the results of an preadmission screening conducted by the state and the clinical medical progress note A comprehensive audit of closed records will be completed by the medical records director within seven days of resident discharge to ensure completion and accuracy of the record prior to being closed and filed.</p> <p>4. Results of the audit will be taken to the clinical meeting for review and forwarded to the IDT for evaluation and follow up. DON will forward clinical record review results to the Medical Records director monthly for review. Any area of concern identified will be reported to the facility Administrator, DON and regional SCC nurse for review and plan of action. The director of medical records will forward all audit results to the quarterly QA meeting for follow up.</p> <p>DATE: 5-1-2010</p>	5-1-10

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

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185068	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 03/25/2010
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NAME OF PROVIDER OR SUPPLIER MAYFAIR MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 3300 TATES CREEK ROAD LEXINGTON, KY 40502
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K 000	<p>INITIAL COMMENTS</p> <p>A Life Safety Code survey was initiated and concluded on March 25, 2010 for compliance with Title 42, Code of Federal Regulations, 483.70 and found the facility not in compliance with NFPA 101 Life Safety Code, 2000 Edition.</p> <p>Deficiencies were cited with the highest deficiency identified at a " F "</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure exit doors were readily accessible at all times and had the proper signage.</p> <p>The findings include:</p> <p>During the Life Safety Code tour on March 25, 2010 at 10:15 a.m., with the Director of Maintenance, an exit door with a magnetic locking device located near the laundry room was noted not to release within fifteen (15) seconds. The door did not have the proper signage indicating the door would release in fifteen (15) seconds. The Director of Maintenance stated a corporate employee installed the magnetic locks in the facility and the Director of Maintenance was not</p>	K 000	<p>K 038</p> <p>1. The maintenance director has reviewed the life safety code K 038 regarding exit doors. The exit door located near the laundry room was evaluated and was corrected to release within 15 sec. The 15 second signage was posted on the door immediately by the maintenance director. All exit doors have been reviewed and have the proper signage posted and have been corrected to release within 15 sec code.</p> <p>2. All facility exit doors (nine) have been reviewed. All doors meet the code of an irreversible process that shall release the lock within 15 sec. upon application of a force to the release device with magnetic locking devices and have the proper 15 second egress signage.</p>	
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APR 19 2010
BY: _____

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Glenn H. Martin</i>	TITLE <i>Administrator</i>	(X6) DATE <i>4/18/10</i>
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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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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165089	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 03/25/2010
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NAME OF PROVIDER OR SUPPLIER MAYFAIR MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 3300 TATES CREEK ROAD LEXINGTON, KY 40502
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K 038	<p>Continued From page 1</p> <p>aware the door should open within fifteen (15) seconds and have the proper signage. During the survey six (6) exit doors were noted not to release or have the proper signage. Three (3) exit doors were noted to release within fifteen (15) seconds however, failed to have the proper signage.</p> <p>Reference: NFPA 101 2000 edition</p> <p>7.2.1.6.1 Delayed-Egress Locks. Approved, listed, delayed-egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met.</p> <p>(a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6.</p> <p>(b) The doors shall unlock upon loss of power controlling the lock or locking mechanism.</p> <p>(c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority</p>	K 038	<p>3. All facility exit doors will be checked five times a week during maintenance rounds for egress compliance and proper signage. Maintenance will correct immediately any non compliance issues.</p> <p>4. Facility exit door audits will be reported to the monthly Safety Committee and reported quarterly to the QA committee for follow up.</p> <p>DATE: 4-18-2010</p>	
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NAME OF PROVIDER OR SUPPLIER MAYFAIR MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 3300 TATES CREEK ROAD LEXINGTON, KY 40502
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K 038 K 072 SS=F	<p>Continued From page 2</p> <p>having jurisdiction, a delay not exceeding 30 seconds shall be permitted.</p> <p>(d) * On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>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</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure corridors were maintained free from obstructions related to full instant use in the case of fire or other emergencies.</p> <p>The findings include:</p> <p>During the Life Safety Code tour on March 25, 2010 at 9:45 a.m., with the Director of Maintenance, a linen cart was noted to be not in use and unattended on the south wing short hall corridor. An interview with the Director of Maintenance revealed linen carts were routinely left unattended to one side of the corridor. Corridors are intended for means of egress, internal traffic and emergency use, not storage spaces. The Life Safety Code has specific</p>	K 038 K 072	<p>K 072</p> <p>1. The linen cart was removed from south unit short hall corridor immediately. Four other hallways were assessed and the linen carts were removed to ensure means of egress and full instant use in case of fire or other emergency.</p> <p>2. Laundry and Nursing Staff in service completed by 4-18-10 regarding life safety code K072. Regarding linen carts. Means of egress are to be continuously maintained free of obstruction or impediments for use in case of fire and or other emergency.</p> <p>3. The DON/ clinical staff will ensure the linen cart moves freely down the corridor room to room during resident care. The housekeeping laundry director will follow up with a weekly audit to ensure the linen carts are not impeding the egress for fire and other emergency. Any non compliance will be reported to the DON/ Unit manager for immediate correction. All exits will be monitored by the</p>	
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NAME OF PROVIDER OR SUPPLIER MAYFAIR MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 3800 TATES CREEK ROAD LEXINGTON, KY 40502
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K 072	Continued From page 3 requirements for storage spaces. These items would also limit the use of the hand rails by residents, when needed. Four other corridors were also noted during the survey to have linen carts stored in the corridor.	K 072	maintenance staff to ensure the hallways and the corridors are free from obstruction.	
K 076 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure oxygen cylinders were stored according to NFPA standards. The findings include: During the Life Safety Code tour on March 25, 2010 at 8:55 a.m., with the Director of Maintenance, twenty seven (27) E size oxygen cylinder tanks were noted to be stored in an accessible small closet in the corridor area. These tanks were within five (5) feet of combustible storage. Oxygen storage rooms must be secured against unauthorized entry and cylinders must be kept five (5) feet from combustibles. During an interview with the Director of Maintenance, during the tour, the</p>	K 076	<p>4. The weekly linen cart audit will be reviewed on a monthly basis by the DON/ Safety committee and forwarded to quarterly QA committee for follow up.</p> <p>K 076</p> <p>1. The area was assessed for proper storage of oxygen tanks on 4-16-2010. CMS guidelines states that (12 E sized cylinders) associated with patient care can be located outside of an enclosure at locations to the corridor. The O2 storage area has (12 E cylinders).</p> <p>2. The facility does not have but the one storage area for oxygen. The oxygen storage area is in compliance with the CMS guideline. Maintenance and clinical staff will be in serviced regarding the proper storage and maximum capacity by the DON. 4-18-2010</p>	

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NAME OF PROVIDER OR SUPPLIER MAYFAIR MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 3900 TATES CREEK ROAD LEXINGTON, KY 40502
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K 078	<p>Continued From page 4</p> <p>Director Indicated not being aware of this requirement. Refer to S&C-07-10. Reference: NFPA 99 1999 edition 8-3.1.11.2</p> <p>Storage for nonflammable gases greater than 8.5 m³ (300 ft³) but less than 85 m³ (3000 ft³)</p> <p>(A) Storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited-combustible construction, with doors (or gates outdoors) that can be secured against unauthorized entry.</p> <p>(B) Oxidizing gases, such as oxygen and nitrous oxide, shall not be stored with any flammable gas, liquid, or vapor.</p> <p>(C) Oxidizing gases such as oxygen and nitrous oxide shall be separated from combustibles or materials by one of the following:</p> <p>(1) A minimum distance of 6.1 m (20 ft)</p> <p>(2) A minimum distance of 1.5 m (5 ft) if the entire storage location is protected by an automatic sprinkler system designed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems</p> <p>(3) An enclosed cabinet of noncombustible construction having a minimum fire protection rating of ¼ hour. An approved flammable liquid storage cabinet shall be permitted to be used for cylinder storage.</p>	K 078	<p>3. The DON /ADON will audit the area 3 times weekly for four weeks to ensure the staff is maintaining compliance. The O2 vendor will report weekly visit compliance to the DON.</p> <p>4. All audits will be reported in the weekly standards of care meeting and forwarded to the monthly Safety committee. Staff will be monitored and counseled for non compliance of the policy. All results of the audits will be followed in the quarterly QA meeting. 4-18-2010</p>	
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