

PRINTED: 11/29/2011
FORM APPROVED
OMB NO. 0938-0391

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

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 11/10/2011
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NAME OF PROVIDER OR SUPPLIER NORTHPOINT/LEXINGTON HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1500 TRENT BOULEVARD LEXINGTON, KY 40515
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000 F 241 SS=D	<p>INITIAL COMMENTS</p> <p>A Standard Recertification and an Abbreviated Survey Investigating ARO#KY00017925 was initiated 11/07/11 and concluded 11/10/11. Deficiencies were cited, with the highest scope and severity of an "F". ARO#KY00017925 was substantiated with no deficiencies cited.</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to promote care for residents in a manner and in an environment that maintained or enhanced each residents' dignity and respect in full recognition of his or her individuality as evidenced by observation of the meal serviced revealed unsampled residents waiting twelve (12) minutes for their table to be served after serving another table between trays and observation of one (1) of twenty-four (24) sampled residents, (Resident #6) unable to reach his/her food in the dining room. Further, the facility failed to ensure dignity related to observation of a catheter that was not in a dignity bag for one(1) of twenty-four (24) sampled residents, (Resident #5).</p> <p>The findings include:</p>	F 000 F 241	<p>F241</p> <p>It is the practice of this facility to promote the care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>On 11/8/2011 current residents who chose to eat in the dining room were served their meals by table, ensuring all residents received their meal before proceeding to the next table.</p> <p>Resident # 6 was screened by Occupational Therapy on 11/9/2011 for assistance with positioning with meals. The resident refused therapy services.</p> <p>On 11/8/2011 the catheter dignity bag for Resident#5 was placed by the Charge Nurse. Resident's plan of care has been updated to meet the residents needs.</p> <p>On November 9, 2011 the Director of Nursing observed all current residents who chose to eat in the dining rooms Monitoring included delivery and provision of the meal, observations of delivery by table and seating/positioning adjustments. Meal service delivery and seating/positioning changes were adjusted as indicated.</p> <p>On November 8, 2011 management nurses reviewed current residents with indwelling catheters to determine necessity of dignity bags as well as placement if indicated. Dignity bags were added when indicated.</p> <p>On November 11, 2011 staff participating in preparation and delivery of meals were re-educated by the Staff Development Coordinator on the procedure of delivering meals by table to residents who are seated together at a table</p>	

REGULATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Elizabeth Thornton</i>	TITLE Administrator	(X6) DATE 12/28/11
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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 the 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 241	<p>Continued From page 1.</p> <p>1. Observation of evening meal, on 11/08/11 at 5:00 PM, revealed unsampled residents seated together for meal service were not served table by table. Observation at 5:35 PM revealed, table two (2) was served one (1) tray then table five (5) was served one (1) tray, then table two (2) was served one (1) tray, then table five (5) was served another tray. It was 5:47 PM before table two (2) was served their two(2)additional trays, making the residents at table two (2) wait twelve (12) minutes before they were served, while the other two (2) residents, at table two (2) ate their meal.</p> <p>Interview, on 11/08/11 at 5:48 PM, with State Registered Nursing Assistant (SRNA) #14 revealed, the cards must have been mixed up because the trays normally came out table by table. Further interview revealed, the staff just served the trays as they came available.</p> <p>Interview, on 11/08/11 at 5:50 PM, with Licensed Practical Nurse (LPN) #10 revealed, the trays were suppose to be served table by table. Further interview revealed, staff should have waited before serving another table and all residents were to be served together.</p> <p>2. Observation of the meal service, on 11/9/11 at 11:48 AM, revealed Resident # 6 was unable to reach his/her meal tray from a reclining Geri chair.</p> <p>Interview, on 11/9/11 at 11:51 AM, with the Director Of Nursing (DON) validated that Resident #6's meal was brought to the table and she/he was unable to reach it from the Geri chair while other residents were eating. Further interview with the DON revealed that Resident #6</p>	F 241	<p>F241 cont.</p> <p>On November 11, 2011 the Staff Development Coordinator re-educated all nursing staff to adjustments to resident positioning/seating and placement of dignity bags for resident indwelling catheters. Ongoing, management staff will monitor one meal per day for timely delivery by table and resident positioning for needed intervention. Audits will be conducted (3) times weekly for (1) week, then (2) times weekly for (2) weeks and then (1) time weekly for (1) week and then monthly thereafter.</p> <p>Facility management nurses will conduct daily audits for placement of dignity bags. These audits will continue daily for a month, with review and revision to frequency upon evaluation and recommendation of the QA committee, consisting of the Medical Director, Administrator, Director of Nursing, Assistant Administrator, Pharmacist, Dietary Manager, Unit Managers, Staff Development Coordinator, Social Services Director, and Quality Assurance Nurse. Results of the audits will be reviewed and submitted to the Quality Assurance Committee monthly for review and revision until substantial compliance is achieved. The Administrator and Director of Nursing will be responsible for overall compliance.</p>	12/9/2011

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F 241	<p>Continued From page 2</p> <p>should have been properly position when the tray was served.</p> <p>3. Observation of Resident #5, on 11/09/11 at 2:29 PM, revealed the resident's urinary drainage collection bag was not covered by a dignity bag cover, which was observed from the hallway.</p> <p>Interview, on 11/8/11 at 2:33 PM, with Licensed Practical Nurse (LPN) #7 revealed her understanding of the facility's policy was to ensure urinary drainage collection bags were covered with dignity bag covers at all times.</p> <p>483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to provide housekeeping services necessary to maintain a sanitary, and comfortable interior as evidenced by unclean windows, cracked windows, peeling paint, unpainted areas, the presence cobwebs, and crash carts were stored with visible dust. Further, there were leaking faucets on the Combs Unit and the Geri Chair for one (1) of twenty-four (24) sampled residents (Resident #6) was torn.</p> <p>The findings include:</p>	F 241	<p>F253</p> <p>It is the policy of this facility to ensure necessary housekeeping services to provide and maintain a sanitary and comfortable interior.</p> <p>Areas of concern identified on initial tour were corrected with the following actions:</p> <p>On November 9, 2011 all dining room windows were cleaned and detailed by the Housekeeping Director. The Housekeeping Director also took the following action: A16 the privacy curtain was replaced and laundered, A22 the red stain was removed and mopped, B16 bed 2, the bedspread was replaced and laundered, B23 the bathroom was detailed to ensure odor was eliminated. The stainless steel corner protectant in the service hallway was cleaned and detailed, the vent in the service hallway was cleaned and replaced to ensure lint was not present. Crash carts and rehabilitation areas were detailed and cleaned.</p> <p>On November 9th the following actions were taken by the Maintenance Director: the unpainted area above Amelia doorway was painted and the Hallway One sign was secured, Broken blinds in rooms A3, A7, A20, A24 and A27 were repaired or replaced depending upon condition. The wall behind A9 bed one (1) and A26 bed one (1) was repaired at indicated torn areas. The affected ceiling tile in A11 was replaced. The process of wall patching in A17 was completed with paint touch up and A18 wall color was matched for a more aesthetic flush of the paint. The tape was removed from the identified light switch. The indicated cracked windows were special ordered on 11/14/2011</p>	
F 253 SS=E		F 253		

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F.253	<p>Continued From page 3</p> <p>1. On initial tour of the facility, on 11/08/11 at 8:40 AM, the following observations were made of the Amelia Unit. In the dining area, there were cobwebs over the windows and in the corners, both upper and lower corners of the room. Further observation in the entry area to the unit, the windows facing the back of the building were noted to have brown debris in the window seals. Also, in the entry area, above the first doorway was an unpainted area next to the fire alarm. At the beginning of the first hallway, the sign noted to say, "Hallway One" was peeling away from the wall. Several rooms were noted to have broken blinds (Rooms 3A, 7A, 20A, 24A, 27A). In room A4, observation revealed the bathroom floor was noted to have a sticky substance as the shoes of staff were sticking to the floor. Upon entering Room 9A, the wall behind bed one (1) was scarred and noted to have torn areas on the wall. In Room 11A, a ceiling tile was noted to have a brown-orangish ring. Observation of the spa area revealed, a lift pad was stored on the floor and the linens was stored in the spa area as well. Room A16's privacy curtain, of the first bed, was noted to have a dried brown substance on it. There were three (3) unpainted areas noted in room 17A. Behind bed two (2) in Room 18A the wall paint was noted to be a different color than the rest of the room. Room A22's floor between the beds presented with a red substance stain. The wall behind bed one (1) in Room 28A was noted to be torn and scarred. The light switch next to the entrance door of the Amelia Unit was noted to have tape over the light switches. The windows in the sun area were observed with cracks in them. The first pane of the window was cracked and extended the full length of the window. The second pane was cracked. Also, the</p>	F 253	<p>with anticipated installation by 12/20/2011. The flooring at the nurses station has been repaired to remove the indicated scuffing and scarring to the floor. The extension cord was removed from room 4B. The tiles in the service hallway in front of the dietary dept. were removed and replaced on November 9, 2011. Leaking faucets identified in rooms C25 and C26 were repaired to full working order. Temporary privacy curtains were placed in front of linen in spa until special order cart covers were received on December 7, 2011. On November 9, 2011 the Director of Nursing removed the lift pad from the spa floor. The pad was sent to the facility laundry dept. for laundering/appropriate sanitation. The leg rest of Resident #5 were replaced on November 9, 2011. Beginning on November 11, 2011, the facility Administrator, Housekeeping Director and Maintenance Director completed facility wide environmental rounds to identify any additional areas of concern. Work orders and inspection sheets were initiated with corrective action as indicated for any areas of concern. Cleaning schedules were reviewed by the Administrator, Housekeeping Director and Regional Director of Healthcare Service Group for need of any necessary revision to schedules to ensure all areas are maintained for provision of a sanitary and comfortable environment. Preventative Maintenance programs were reviewed by the Administrator and Maintenance Director to ensure all areas are maintained through routine maintenance programs. Hooks were placed in the areas for</p>	

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F 253	<p>Continued From page 4</p> <p>third pane was cracked the full length of the window. Further observation of the window frame revealed the frame was noted with dried window caulking. The flooring at the nursing station was noted to be scuffed and scarred.</p> <p>During the tour of the Breckinridge Unit, on 11/08/11 at 10:00 AM, revealed in the dining room there were cobwebs noted in the first inset of windows and the windows were noted to have brown substances on them, this included all panes of glass. Upon entering Room 4B, the corner cabinet, second shelf was identified with an extension cord. Room 16B2's bedspread was noted to have dried brown material in the center of the bed. There was an odor noted in room 23B's bathroom.</p> <p>On 11/08/11 at 12:30 PM, during the tour of the Rehab department, observation revealed a spoon with dried food particles on it lying on the sink, cobwebs were hanging from the box on the ledge, and dust balls was noted to be lying on the floor next to the stairs.</p> <p>During a tour on the first floor, on 11/08/11 at 4:00 PM, observation revealed tiles of the flooring outside the dietary receiving door were noted with brown debris and noted to be cracked. The vent outside the men's lounge was noted with brown material and lint. The corner protectant at the corner across the hall from the vending machines was noted to have brown dried material along both sides.</p> <p>Observation during tour of the Combs Unit, on 11/08/11 at 2:30 PM, revealed leaking faucets in Rooms C-25 and C-26. Also, the mechanical lift</p>	F 253	<p>resident lift storage for accessibility, appropriate storage and infection control of lift pads.</p> <p>A full house audit was conducted to review the condition of all resident wheelchairs/gerchairs. Identified concerns were communicated on work orders to the Maintenance Director. Repairs and replacements completed on 12/7/2011.</p> <p>Environmental rounds will be conducted weekly by the Administrator, Maintenance Director, and Housekeeping Director to identify necessary housekeeping and maintenance services. Rounds will include review of appropriate storage of lift pads. Facility crash carts will be reviewed daily (7) days a week by Administrative Nurses and communicate any need for corrective action directly to the Housekeeping Director.</p> <p>Wheelchairs and gerchairs will be audited by the QA Nurse weekly for a month and then monthly thereafter for any torn or damaged areas in need of repair.</p> <p>All identified concerns will be documented with corrective action on work orders and inspection sheets. Results of the audits and rounds will be reviewed in the monthly QA Committee meeting with revision of the plan as deemed necessary by the Committee.</p> <p>The Administrator, Maintenance Director, and Housekeeping Director will be responsible for overall compliance.</p>	12/9/2011

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F 253	<p>Continued From page 5</p> <p>In the Crash Cart/Lift Storage Room had a build up of dust and debris at the base. The Spa Room had linens and gowns stored on open shelves with no closet door.</p> <p>During a tour, on 11/09/11 at 3:30 PM with the Maintenance Director, Assistant Maintenance Director and Environmental Services Director, interview revealed housekeeping was responsible for the cleanliness of the facility, but Maintenance was responsible for the upkeep of the facility.</p> <p>Interview, on 11/09/11 at 3:45 PM, with the Environmental Services Director revealed he was not aware the areas of concern were not being taken care of. Further interview validated all areas of concern were scheduled to be cleaned on a weekly basis. Continued interview confirmed, the housekeeping staff had specific job duties that were assigned to be completed on particular days. The Environmental Services Director explained, he thought the facility had a contract for window cleaning.</p> <p>Interview on 11/09/11 at 4:00 PM with the Maintenance Director confirmed all areas was not in good repair. Further interview revealed, no one had brought these issues to his attention. Continued interview confirmed, he would have all areas of concern written on work orders and repaired.</p> <p>2. Tour of the Combs Unit, on 11/08/11 at 2:30 PM, revealed leaking faucets in Rooms C-25 and C-26. Interview, on 11/09/11 at 5:00 PM, with the Assistant Maintenance Director and the District Training Manager revealed the leaking faucets</p>	F 253		

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F 253	<p>Continued From page 6</p> <p>needed to be fixed and they were unaware of the leaking faucets.</p> <p>3. Observations of Residents #5's room, on 11/08/11 at 2:29 PM, revealed the fabric on the resident's Geri Chair was torn on both sides of the leg rest.</p> <p>Interview with Licensed Practical Nurse (LPN) #11, at 3:30 PM on 11/08/11, revealed it was everyone's responsibility to report damaged or torn resident equipment and log it into the Maintenance log.</p> <p>Review of the Maintenance Log, on 11/8/11 at 3:45 PM, revealed no entries for Resident #5's Geri Chair from 8/28/11 through 11/08/11.</p> <p>4. Observation, on 11/10/11 at 10:03 AM, revealed the crash carts for the facility's three (3) units had a visible build up of dust.</p> <p>Interview, on 11/10/11 at 10:20 AM, with LPN #12 revealed the crash carts were not on the cleaning list.</p> <p>Interview, on 11/10/11 at 10:34 AM, with the Amella Unit Manager revealed she did not know if the crash carts were on the cleaning list.</p> <p>Interview, on 11/10/11 at 5:00 PM, with the Director of Environmental Services revealed there was no one assigned to clean the crash carts.</p>	F 253	<p>F280</p> <p>It is the practice of this facility to revise a residents Comprehensive Care Plan related to changes in care and treatment.</p> <p>On November 10, 2011 the care plan of Resident #15 was reviewed and revised by the facility Unit Manager to reflect interventions to prevent choking.</p> <p>On November 14, 2011 facility management nurses reviewed current residents' care plans for need of interventions. Revisions were completed if applicable.</p> <p>On December 1, 2011 the Staff Development Coordinator re-educated licensed nurses regarding care plan revisions. A review of facility events and physician orders will be completed Monday thru Friday during facility CQI meeting with care plan revisions made as applicable.</p> <p>Audits of care plan revisions will be completed by the facility Unit Managers (3) times weekly for (1) week, then (2) times weekly for (2) weeks, then (1) time weekly for (1) week... Auditing when then continue monthly thereafter by the facility QA nurse. Audits will be reviewed during the monthly Quality Assurance meeting with revisions to the plan as deemed necessary by the QA Committee. The Director of Nursing and Administrator are responsible for overall compliance.</p>	12/9/2011
F 280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be</p>	F 280		

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F 280	<p>Continued From page 7</p> <p>incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's investigation, it was determined the facility failed to ensure the Comprehensive Plan of Care was revised for one (1) of twenty-four (24) sampled residents (Resident #15).</p> <p>The facility failed to ensure the Comprehensive Plan of Care was sufficiently revised with adequate interventions to prevent further choking incidents for Resident #15. On 10/14/11 Resident #15 ingested a peanut butter sandwich which was obtained from Unsampled Resident A while sitting beside the nurse's station. Resident #15 who had Physician's Orders for a puree diet became choked on the peanut butter sandwich, and was cyanotic and unresponsive. Staff provided</p>	F 280		

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F 280	<p>Continued From page 8</p> <p>emergency care performing a finger sweep and the Heimlich Maneuver. Resident #15 was sent to the local hospital emergency room and admitted with a diagnosis of Pneumonia. There was no documented evidence of sufficient interventions placed to prevent cognitively impaired residents from offering the resident unsafe food forms although the resident resided on the locked Dementia Unit.</p> <p>The findings include:</p> <p>Review of Resident #15's medical record revealed diagnoses which included Alzheimer's Disease, and Dysphagia. Review of the Comprehensive Plan of Care dated 02/16/10 revealed the resident was at nutritional risk related to mechanically altered diet and required an altered diet secondary to a diagnosis of Dysphagia. The interventions included monitor for chewing/swallowing difficulties, prefers bedside table at meals in diningroom for comfort in geri-chair, and to be up in the diningroom for all meals; If in room for any meals must be supervised. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 10/05/11 revealed the facility assessed the resident as severely impaired in cognitive skills for decision making, as requiring supervision and set up help for eating, and as having a mechanically altered diet (requiring a change in texture of food or fluids).</p> <p>Review of the Physician's Orders dated 10/11 revealed orders for Mechanical Soft Diet with Regular meat/Small Portions. Further review revealed orders dated 10/01/11 for Speech Therapy to treat seven (7) times a week for eight</p>	F 280		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185197	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ D. WING _____	(X3) DATE SURVEY COMPLETED C 11/10/2011
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NAME OF PROVIDER OR SUPPLIER NORTHPOINT/LEXINGTON HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1500 TRENT BOULEVARD LEXINGTON, KY 40516
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LAC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
F 280	<p>Continued From page 9</p> <p>(8) weeks to target skilled techniques and strategies to included care giver training, and diet consistency.</p> <p>Review of the Condition Change Form dated 10/14/11 at 2:25 PM revealed the resident's airway became obstructed related to another resident giving her/him a peanut butter sandwich and the resident was to receive a puree diet. Continued review revealed the resident became cyanotic and unresponsive, 911 was called and staff performed a finger sweep and the Heimlich Maneuver. The resident aroused, food was removed and the resident's oxygen saturation came up to ninety-five percent (95%). The resident was transferred to the hospital emergency room.</p> <p>Review of the Hospital Discharge Summary dated 10/20/11 revealed the resident's discharge diagnoses included Aspiration Pneumonia, and Dysphagia.</p> <p>Interview, on 11/10/11 at 11:50 AM, with the Speech Therapist, revealed the resident received Speech Therapy from 02/03/10 through 03/26/10 for Dysphagia and was found to be independent with swallowing strategies with no cueing needed and would have been considered safe at the time of discharge to eat without supervision. Further interview revealed the Speech Therapy Evaluation completed on 10/20/11 revealed Resident #15 had severe impairment in the ability to clear regular foods and a puree diet with pudding thick liquids was recommended.</p> <p>Review of the Facility's Investigation related to the 10/14/11 choking incident, revealed another</p>	F 280		

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NAME OF PROVIDER OR SUPPLIER NORTHPOINT/LEXINGTON HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1500 TRENT BOULEVARD LEXINGTON, KY 40516
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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 280	<p>Continued From page 10</p> <p>ambulatory cognitively impaired resident was walking past the resident who was sitting at the nurse's station and gave the resident a peanut butter sandwich before staff could intervene. The conclusion stated, this was an unavoidable mishap between two (2) cognitively impaired residents.</p> <p>Interview with the Unit Manager, on 11/10/11 at 9:30 AM, revealed the resident had behaviors of asking for food, and making repetitive statements. She stated, after the 10/14/11 choking event, the resident's door as well as the bedside curtain was to be left open. She further stated staff did rounds to ensure the resident was not receiving food from cognitively impaired residents. However, staff were not observing the resident at all times and cognitively impaired residents including Unsampled Resident A could enter the resident's room with food without staff's knowledge.</p> <p>Interview, on 11/10/11 at 4:30 PM, with the Director of Nursing (DON), revealed there was an immediate inservice to ensure staff knew to monitor residents to ensure they were eating the appropriate diet at all times when in the hallways, rooms, or common areas after the 10/14/11 choking incident. She stated staff was also inserviced to pass snacks immediately when they came up from the dining room. However, further interview revealed there was still the possibility of a cognitively impaired resident giving Resident #15 something to eat in her/his room without staff knowledge. She stated the Continuous Quality Improvement Meeting held each morning reviewed events such as the choking events and updated the Plans of Care then. However,</p>	F-280		

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NAME OF PROVIDER OR SUPPLIER NORTHPOINT/LEXINGTON HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1600 TRENT BOULEVARD LEXINGTON, KY 40515
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
F 280	Continued From page 11 although the Plan of Care revealed a review date of 10/20/11, there was no documented evidence of any new interventions placed after the 10/14/11 incident to include passing snacks immediately, ensuring staff was attentive to the food or beverage a resident was consuming to ensure it was the correct consistency, or leaving the resident's door and bedside curtain open for increased supervision. In addition, there was no documented evidence of sufficient interventions such as assistive devices to prevent confused residents from entering the resident's room and offering food to this resident without staff knowledge. Interview with the Administrator, on 11/10/11 at 5:15 PM, revealed she agreed cognitively impaired residents could enter the resident's room without staffs knowledge and she was having a motion detector sensor placed on the resident's door at that time.	F 280	F281 It is the practice of this facility to ensure services provided and arranged by the facility meet professional standards of quality. On November 6, 2011 the Foley catheter for resident #12 was discontinued with review to validate all other physician orders with no concerns identified. This action was completed by the Unit Manager. On November 14, 2011 management nurses completed an audit of current residents physician orders to verify orders with intervention as applicable. On November 11, 2011 licensed nurses were re educated regarding following of physician orders. Physician orders will be reviewed (5) days per week during facility CQI clinical review to monitor implementation of physician orders. One time orders will be blocked in on the MAR/TAR to alert a nurse to the necessity of a one-time intervention.	
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 interview and record review, it was determined the facility failed to ensure services provided met professional standards of care. The facility failed to ensure Physician's Orders were followed for one (1) of twenty-four (24) sampled residents, (Resident #12). The facility failed to follow Resident #12's Physician's Order to discontinue (DC) the resident's Foley Catheter (a	F 281	Audits of MARs/TARs/physician order implementation will be completed by the QA Nurse (2) times weekly for (1) week, then once weekly for (1) week and then monthly thereafter. Audit results will be reviewed monthly by the Quality Assurance Committee with revisions to the plan as deemed necessary by the Committee review. The Administrator and Director of Nursing will be responsible for overall compliance	12/9/2011

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NAME OF PROVIDER OR SUPPLIER NORTHPOINT/LEXINGTON HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1600 TRENT BOULEVARD LEXINGTON, KY 40515
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 281	<p>Continued From page 12</p> <p>tube inserted into a person's bladder allowing their urine to flow from the bladder into a bag) when an antibiotic for a urinary infection (UTI) was completed.</p> <p>The findings include:</p> <p>Review of the medical record revealed the facility re-admitted Resident #12, on 09/12/11, with diagnoses which included General Muscle Weakness, Alzheimer's Disease, Psychosis, and Urinary Tract Infection.</p> <p>Record review the Physician's Orders revealed a Physician's Telephone Order, dated 10/05/11, for an antibiotic, Macrobid 100 mg (Milligrams), for a UTI was to be given twice a day for two weeks. Further review of the Physician's Orders revealed a Physician's Telephone Order, dated 10/08/11, to insert a Foley Catheter (FC) and leave in place until the antibiotic (Macrobid) was completed, secondary to the resident having a urinary tract infection with Vancomycin Resistant Enterococcus (VRE) bacteria.</p> <p>Interview, on 11/10/11 at 11:50 AM, with the Licensed Practical Nurse (LPN) #5, who worked as the facility's Infection Control Nurse, regarding the facility's infection control practices revealed a resident with VRE infection in the urine was catheterized (insert a FC) to contain the organism. LPN #5 further stated the FC should be discontinued when the antibiotic was completed.</p> <p>Review of the Treatment Administration Record (TAR), for October 2011, revealed a FC was inserted on 10/08/11 and had an FYI (for your</p>	F 281		
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NAME OF PROVIDER OR SUPPLIER NORTHPOINT/LEXINGTON HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1800 TRENT BOULEVARD LEXINGTON, KY 40515
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	<p>Continued From page 13 Information) note to DC the FC after the antibiotic was completed.</p> <p>Review of the Medication Administration Record (MAR) for October 2011, revealed the antibiotic Macrobld was started on 10/05/11 and was completed on 10/19/11.</p> <p>Review of Resident #12's Physician's Orders revealed a Physician's Telephone Order, dated 11/06/11, for an order clarification to DC the FC related to the order on 10/06/11 for a FC until the antibiotics were completed.</p> <p>Review of the TAR, for November 2011, revealed the FC was removed on 11/08/11.</p> <p>Interview, on 11/08/11 at 4:30 PM, with Registered Nurse (RN) #4 revealed there was a Physician's Order dated 10/06/11 for Resident #12 to have a FC inserted, left in place until the antibiotic was completed and then removed. The antibiotic (Macrobid) was completed on 10/19/11. Further interview revealed the FC should have been removed after the antibiotic was completed on 10/19/11. Further interview with RN #4 revealed the FC was removed on 11/06/11.</p> <p>Interview, on 11/09/11 at 2:45 PM, with the Director of Nursing (DON) revealed Resident #12 had a Physician's Order, dated 10/06/11, for a FC to be inserted and left in place until the antibiotic (Macrobid) was completed (10/19/11). Further interview revealed, based on the order and no other documentation showing otherwise, the FC should have been discontinued after the antibiotic was completed. The DON also stated the treatment record (for October 2011) should have</p>	F 281		

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NAME OF PROVIDER OR SUPPLIER NORTHPOINT/LEXINGTON HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1600 TRENT BOULEVARD LEXINGTON, KY 40515
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F 281 F 323 SS=E	<p>Continued From page 14</p> <p>Included the specific date the FC should have been discontinued instead of writing it as an FYI when the antibiotic was completed.</p> <p>483.26(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview; and record review, it was determined the facility failed to ensure that the environment remains as free of accident hazards as is possible, and each resident receives adequate supervision and assistance devices to prevent accidents for one (1) of twenty-four (24) sampled residents (Resident #15).</p> <p>The facility failed to ensure adequate supervision when Resident #15 ingested unsafe food forms. Resident #15 was ordered a puree diet and received a peanut butter sandwich from Unsampled Resident A causing Resident #15 to become choked, and the resident's airway became obstructed. The resident became cyanotic and unresponsive and staff performed a finger sweep and the Heimlich Maneuver. Resident #15 was sent to the emergency room and admitted to the hospital with a diagnosis of Pneumonia. There was no documented evidence</p>	F 281 F 323	<p>F323</p> <p>It is the practice of this facility to ensure that the resident's environment remains as free of accident hazards as is possible and each resident receives adequate supervision and assistance devices to prevent accidents. On November 10, 2011 the Maintenance Director placed an alarm on the door of Resident # 15 to alert staff of other residents entering the room. On November 8, 2011 the Maintenance Director locked the door to the utility room on the Breckinridge Hall with the addition of a automatic locking device. On November 11, 2011 the Director of Nursing and Unit Managers reviewed current residents receiving mechanically altered diets for need of care plan interventions to prevent choking. Interventions were completed as applicable. On November 8, 2011 utility rooms throughout the facility were checked by the Maintenance Director to monitor and ensure locking of utility rooms. On November 11, 2011 all staff were re-educated by the Staff Development Coordinator regarding supervision of residents who receive altered consistency diets. Re-education also included monitoring that designated doors were secured and locked. Audits will be completed by management staff to monitor that residents receiving altered consistency diets are supervised accordingly (2) times weekly for (2) weeks then (1) time weekly for (1) week and then monthly thereafter. The Maintenance Director will audit designated doors are secured (2) times weekly for (2) weeks, then (1) time weekly</p>	

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NAME OF PROVIDER OR SUPPLIER NORTHPOINT/LEXINGTON HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1600 TRENT BOULEVARD LEXINGTON, KY 40515
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	<p>Continued From page 15</p> <p>of sufficient interventions placed to prevent a subsequent reoccurrence of a choking incident.</p> <p>In addition, the facility failed to ensure the resident environment remained free from accidental hazards as evidenced by observation, on 11/09/11 at 10:00 AM, on the Breckinridge Hall revealed an unlocked door to the utility room with breaker boxes unlocked and exposed wires accessible to the residents.</p> <p>The findings include:</p> <ol style="list-style-type: none"> Review of Resident #15's clinical record revealed diagnoses which included Alzheimer's Disease, and Dysphagia. Review of the Comprehensive Plan of Care dated 02/16/10 revealed the resident was at nutritional risk related to mechanically altered diet and required an altered diet secondary to Dysphagia. The interventions included monitor for chewing/swallowing difficulties and report as needed, prefers bedside table at meals in dining room for comfort in Geri-chair, and to be up in the dining room for all meals; if in room for any meals must be supervised. <p>Review of the Physician's Orders dated 09/11 revealed orders for a Mechanical Soft Diet with Regular Meats, may have regular diet for special occasions up to two (2) times a month.</p> <p>Review of the Nurse's Notes dated 09/24/11 at 6:50 PM revealed a Certified Nursing Assistant (CNA) entered the resident's room and noted the resident was unresponsive, eyes rolled back, mouth noted open, mouth and throat obstructed by a large piece of food. The CNA performed a</p>	F-323	<p>for (1) week and then monthly thereafter. In addition, weekly environmental rounds will be conducted by the Administrator, Housekeeping Director and Maintenance Director to ensure doors are secured. An additional random safety audit will be conducted by the Assistant Administrator in conjunction with facility safety rounds to ensure doors are secure. Audit results will be reviewed in the monthly Quality Assurance Committee Meeting with revisions to the plan as deemed necessary by the QA committee. The Administrator, Assistant Administrator, DON, and Maintenance Director will be responsible for overall compliance</p>	12/9/2011

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NAME OF PROVIDER OR SUPPLIER NORTHPOINT/LEXINGTON HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1500 TRENT BOULEVARD LEXINGTON, KY 40518
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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	<p>Continued From page 16</p> <p>finger sweep and the resident was noted to take breaths and begin to respond. The resident was cyanotic prior to removal of food from the resident's mouth. Afterwards, the resident became very white, was noted to sweat, and oxygen saturation was seventy-one percent (71 %) on room air. According to the Note, the nurse applied oxygen up to eight (8) liters with oxygen saturation at eighty-nine percent (89 %). Further review revealed the resident was transferred to the emergency room.</p> <p>Review of the Hospital Transfer Summary dated 09/30/11 revealed diagnoses including Aspiration Pneumonia, and Dysphagia. Further review revealed a Puree Diet was recommended and the resident was a high-aspiration risk, but resident and family wanted to continue the pleasure it gave to the resident. A Barium Swallow Study was done with no aspirations.</p> <p>Review of the re-admission Physician's Orders dated 09/30/11 revealed orders for a Puree Diet. Review of Orders dated 10/01/11 revealed orders for Speech Therapy to evaluate and treat as indicated.</p> <p>Interview on 11/10/11 at 9:30 AM with Licensed Practical Nurse (LPN) #3/ Unit Manager, revealed after the choking event on 09/24/11, the intervention was added to the Plan of Care to have the resident in the dining room to eat and not to be left in the room eating unsupervised.</p> <p>Review of the Physician's Orders dated 10/11 revealed orders for Mechanical Soft Diet with Regular meat/Small Portions. Further review revealed orders dated 10/01/11 for Speech</p>	F 323		

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NAME OF PROVIDER OR SUPPLIER NORTHPOINT/LEXINGTON HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1600 TRENT BOULEVARD LEXINGTON, KY 40518
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR L8D 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	<p>Continued From page 17</p> <p>Therapy to treat seven (7) times a week for eight (8) weeks to target skilled techniques and strategies to included care giver training, and diet consistency.</p> <p>Review of the Quarterly Minimum Data Set (MDS) Assessment dated 10/05/11 revealed the facility assessed the resident as severely impaired in cognitive skills for decision making. Further review revealed the facility assessed the resident as requiring supervision and set up help for eating, and as having a mechanically altered diet (requiring a change in texture of food or fluids).</p> <p>Review of the Condition Change Form dated 10/14/11 at 2:25 PM revealed the resident's airway became obstructive related to another resident gave her/him a peanut butter sandwich and the resident received a puree diet. Further review revealed the resident became cyanotic and unresponsive, 911 was called and a finger sweep and the Heimlich Maneuver was performed. The resident aroused, food was removed and the resident's oxygen saturation came up to ninety-five percent (95%). The resident was transferred to the emergency room.</p> <p>Review of the Hospital Discharge Summary dated 10/20/11 revealed the resident's discharge diagnoses included Aspiration Pneumonia, and Dysphagia.</p> <p>Interview, on 11/10/11 at 11:50 AM, with the Speech Therapist revealed the resident received Speech Therapy from 02/03/10 through 03/26/10 for Dysphagia and was found to be independent with swallowing strategies with no cueing needed</p>	F 323		

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NAME OF PROVIDER OR SUPPLIER NORTHPOINT/LEXINGTON HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1500 TRENT BOULEVARD LEXINGTON, KY 40516
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F 323	<p>Continued From page 18</p> <p>and would have been considered safe at the time of discharge to sit in the bed and eat without supervision. This was prior to the 09/24/11 choking event. Further interview revealed there was another Speech Therapy Referral on 09/30/11 and the Speech Therapy Evaluation completed on 10/20/11 revealed the resident had severe impairment in the ability to clear regular foods and a puree diet with pudding thick liquids was recommended.</p> <p>Review of the Facility Investigation related to the 10/14/11 choking incident, revealed; on 10/24/11 another ambulatory cognitively impaired resident was walking past the resident who was sitting at the nurses's station and gave the resident a peanut butter sandwich before staff could intervene. Conclusion: this was an unavoidable mishap between two (2) cognitively impaired residents.</p> <p>Further interview with the Unit Manager, on 11/10/11 at 9:30 AM, revealed the resident had behaviors of asking for food, and making repetitive statements. She stated, after the 10/14/11 choking event, the resident's door was to be left open, with the bedside curtain open, and staff were to do rounds to ensure the resident was not receiving food from cognitively impaired residents. However, staff were not observing the resident at all times and cognitively impaired residents including Unsampled Resident A who gave the resident the peanut butter sandwich could enter the resident's room with food without staff's knowledge.</p> <p>Interview; on 11/10/11 at 4:30 PM, with the Director of Nursing (DON), revealed after the</p>	F 323		

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NAME OF PROVIDER OR SUPPLIER NORTHPOINT/LEXINGTON HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1600 TRENT BOULEVARD LEXINGTON, KY 40515
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F 323	<p>Continued From page 19</p> <p>10/14/11 choking event there was an immediate inservice to ensure staff knew to monitor residents to ensure they were eating the appropriate diet at all times when in the hallways, rooms, or common areas. She also stated they were inserviced to pass snacks immediately when they came up from the dining room. However, continued interview revealed there was still the possibility of a cognitively impaired resident giving Resident #15 something to eat in her/his room without staff knowledge. She further stated the Continuous Quality Improvement Meeting held each morning reviewed events such as the choking events and updated the Plans of Care then. Although the Plan of Care had a reviewed date of 10/20/11, there was no documented evidence of any new interventions placed after the 10/14/11 to include passing snacks immediately, ensuring staff was attentive to the food or beverage a resident was consuming to ensure it was the correct consistency, or leaving the resident's bedside curtain and door open. In addition, there was no documented evidence of sufficient interventions to prevent confused residents from entering the resident's room and offering food to this resident.</p> <p>Interview, on 11/10/11 at 5:15 PM, with the Administrator revealed she agreed cognitively impaired residents could enter the resident's room without staffs knowledge and she was having a motion detector sensor placed on the resident's door at that time.</p> <p>2. Observation, on 11/08/11 at 10:00 AM, revealed the utility room (mechanical room) that contained the breaker boxes was unlocked and accessible by residents. In addition to the door</p>	F 323		

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F 323	<p>Continued From page 20 being unlocked, the breaker boxes was also unlocked.</p> <p>Interview with the Director of Nursing (DON), on 11/08/11 at 10:00 AM, revealed the door should have been locked and not accessible to anyone other than those personnel with a key to enter the room. Further interview identified, the utility room being unlocked was a safety risk for all residents. Continued interview validated, the door to the utility room should be locked at all times and if the door was unlocked then the breaker boxes should have been locked.</p> <p>Interview with License Practical Nurse (LPN) # 12, on 11/08/11 at 10:15 AM, revealed the door was normally locked, but she could not explain how and why the door was unlocked. Further interview confirmed, the door being unlocked was a safety hazard for the residents and visitors.</p> <p>Interview with the Maintenance Director, on 11/08/11 at 10:25 AM, revealed the utility room door should never be unlocked and he could not explain how the door was left unlocked. Further interview revealed, the door being unlocked posed a risk for resident accidents.</p>	F 323	<p>F364 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. At meal service on November 11, 2011 all beverages were observed for temperatures and upon solicited feedback of interviewable residents all beverages were at palatable temperatures. At meal service on November 11, 2011 the nectar think juices were chilled and coffee was brewed to palatable temperatures. Interviewable residents confirmed the palatability of the beverages according to resident preference. On November 11, 2011 the Dietary Manager re-educated all staff related to palatability and satisfaction of beverages and food. Audits were initiated to ensure residents are satisfied with temperatures and palatability of food and beverages at meal service. Dining room audits were initiated on November 11, 2011 to solicit feedback from resident to ensure food and beverage palatability. The audits will be conducted daily for (4) weeks. These audits will be reviewed in the monthly Quality Assurance Committee meeting until compliance is achieved. Any identified concern will result in revision to auditing, re-education and monitoring as deemed appropriate by the QA committee.</p>	
F 364 SS=E	<p>483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced</p>	F 364		

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F 364	Continued From page 21 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 dining room between the Combs and Amella units. A test tray revealed the temperature of the nectar thick apple juice was 62 degrees Fahrenheit and the coffee was 108 degrees Fahrenheit. The findings include: Observation of temperatures taken of a test tray on 11/09/11 at 12:30 PM revealed the nectar thick apple juice was 62 degrees Fahrenheit and the coffee was 108 degrees Fahrenheit. Interview with the Dietary Manager on 11/08/11 at 7:00 PM revealed the facility did not have a written policy which defined expected point of service temperatures; however, her expectation was for hot items to be at least 120 degrees Fahrenheit and cold items to be no more than 50 degrees Fahrenheit.	F 364	F364 cont The Administrator, Assistant Administrator, Dietary Director, and Dietician will be responsible for overall compliance F371 It is the practice of this facility to store, prepare, distribute and serve food under sanitary conditions On November 7, 2011 the scoops in the prep table were immediately removed by the Dietary Director, washed and stored per infection control standards. On November 7, 2011 the Dietary Director immediately disposed of all foods identified to be without date and label. On November 9, 2011 the freezer in the Combs unit dining room was cleaned by the Dietary Director with a working thermometer placed. On November 9, 2011 the utensil were	12/9/2011
F 371 SS=F	489.35(l) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of	F 371		

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F 371	<p>Continued From page 22</p> <p>the facility's policy it was determined the facility failed to distribute and serve food under sanitary conditions. The facility failed to ensure scoop utensils were stored properly with their handles all in the same direction and foods were properly stored and labeled. Additionally, the freezer on the Combs Unit was soiled and staff placed used serving utensils in a manner that allowed them to touch. Furthermore, the holding temperatures were not maintained at 140 degrees Fahrenheit or higher.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Observation during initial tour, on 11/07/11 at 11:30 AM, revealed a prep table drawer containing scoop utensils with handles facing multiple directions and the scoop parts not turned upside down. <p>Interview, on 11/07/11 at 11:30 AM, with the Dietary Manager revealed the scoop utensils should be stored with all handles in the same direction and the scoop turned down for infection control purposes.</p> <p>Observation during initial tour, on 11/07/11 at 11:40 AM, of the walk in refrigerator revealed two food items not properly stored and labeled. A container of chicken salad was opened without a label showing when the item was opened and a container of ham salad was opened with a label showing an open date of 11/03/11.</p> <p>Interview, on 11/07/11 at 11:40 AM, with the Dietary Manager revealed the container of chicken salad should have a label showing the date opened and the ham salad container should</p>	F 371	<p>removed and replaced by the Dietary Director, with a clean set for dinner service on this date.</p> <p>On November 8, 2011 the hashbrowns in the freezer were immediately removed and disposed by the Dietary Director.</p> <p>On November 8, 2011 all foods on the steam table were temped for the evening meal service. Initial temperatures upon start of meal service and between second round were held at safe temperature of 140 degrees Fahrenheit or higher.</p> <p>On November 8, 2011 dietary sanitation rounds were conducted by the facility Dietary Director and Assistant Administrator. All areas of concern identified and corrected at time of review.</p> <p>On November 9, 2011 the food temperatures were recorded for each meal service. All temperatures were found to be within safe holding temperatures. Hot foods were above 140 degrees Fahrenheit and cold foods were below 41 degrees Fahrenheit.</p> <p>On November 11, 2011 all dietary staff were re-educated by the Dietary Director on storage methods used for serving utensils, proper labeling and dating of stored foods, change out of utensils between meal service per infection control standards, proper storage of food items in the refrigerator and freezer to prevent condensation from dripping onto stored food items, maintaining sanitation/cleanliness standards in dining room freezers and safe holding temperatures.</p> <p>Dietary sanitation audits will be conducted daily by the Dietary Director and weekly by the ANHA/Designee for (4)</p>	

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F 371	<p>Continued From page 23</p> <p>no longer be stored because it was good for three (3) days only after it was opened.</p> <p>2. Observation of the freezer in the Combs Unit dining room, on 11/08/11 at 5:31 PM, revealed a dried brown substance in the bottom of the freezer. Additionally, there was a broken thermometer in the bottom of the freezer. The freezer was used to hold milk, juices, Ensures, and other fluids for the meal.</p> <p>Additional observation, on 11/09/11 at 11:25 AM, revealed the freezer continued to have a dried brown substance and broken thermometer in the bottom of the freezer.</p> <p>Interview, on 11/09/11 at 12:57 PM, with Dietary Aide #8 revealed the freezer was cleaned when the dietary manager told someone to clean it.</p> <p>3. Observation, on 11/09/11 during the lunch meal on the Combs Unit, revealed the dietary aide place the serving utensils into one steam table well on a plate. The serving utensils were touching each other.</p> <p>Interview, on 11/09/11 at 12:57 PM, with Dietary Aide #8 revealed the utensils should not touch each other. She stated if they touch there is a risk of cross contamination.</p> <p>4. Observation of the walk-in freezer, on 11/08/11 at 10:00 AM, revealed a box of hash browns which was open with individual brown bags, one (1) of these bags was noted to be opened, ice build-up was noted on top of this box and the bags within the box.</p> <p>Interview with the Dietary Manager, on 11/08/11 at 10:10 AM, revealed she would still use the boxes of food as long as the ice/water from the</p>	F 371	<p>weeks to ensure compliance with storage of serving utensils, proper labeling and dating of stored foods, appropriate storage of foods in the freezer and refrigerator and to ensure all foods are within safe holding temperatures.</p> <p>Audits will be conducted of dining services to include the cleanliness of the refrigerator/freezer and change out of utensils between meal service. The audits will be conducted daily by the assigned meal service monitor for (4) weeks to ensure compliance and then monthly thereafter.</p> <p>Results of the 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, Assistant Administrator, Dietary Director and Dietician will be responsible for overall compliance</p>	12/9/2011

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F 371	Continued From page 24 condenser had not penetrated through the box. She further stated she would not use the hash browns where the ice had built up on the bags of hash browns. Observation of tray line, during the evening meal on 11/08/11 at 6:10 PM, revealed Dietary Aide # 5 took the temperatures before the second round of trays were served to residents from the kitchen. Observation revealed the ground tuna was 110 degrees Fahrenheit, the Cauliflower was 120 degrees Fahrenheit, the beef vegetable soup was 122 degrees Fahrenheit and the hamburger patties were 125 degrees Fahrenheit. Interview with the Dietary Manager, on 11/09/11 at 7:00 PM, revealed the temperature of hot food held on the tray line should be 141 degrees Fahrenheit or greater.	F 371	F441 It is the practice of this facility to 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. On November 8, 2011 Residents #5, 20 and 21 catheters tubing and bag were changed and new dignity bags placed on bed and wheelchair. On November 8, 2011 the SRNA caring for Resident #8 provided perineal care per infection control standards with appropriate removal of soiled gloves and handwashing prior to touching other objects. Staff were re-educated on correct technique when performing pericare to reduce risk of infection.	
F 441 SS=F	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. (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	F 441	On November 8, 2011 the Unit Manager cleaned and replaced the boot splints of Resident #18. On November 10, 2011 the Unit Manager cleaned the ice scoop and ice chest, placing the ice scoop in a covered container. On November 7, 2011 linens taken from one room to another were removed by facility nursing staff and laundered. On November 8, 2011 current residents with foley catheters were observed for catheter tubing/drainage bags placement per infection control standard with intervention as applicable by management nursing staff. On November 8, 2011 and ongoing random observation audits of perineal care will be conducted by the Staff Development Coordinator of current applicable residents for appropriate infection control technique with perineal care with interventions as	

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LEXINGTON, KY 40515

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F 441	<p>Continued From page 25</p> <p>determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(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.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, 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 safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>Residents #5, #20 and #21 were observed to have catheter bags and tubing laying on the floor.</p> <p>Observation of perineal care for Resident #8, revealed staff failed to remove soiled gloves and wash hands prior to touching other objects in the room.</p>	F 441	<p>applicable.</p> <p>Facility wide round of all current residents were conducted to observe for resident equipment or devices on the floor. Any concerns were addressed and corrected.</p> <p>On November 8, 2011 resident rooms were monitored for linen placement per infection control standards with interventions as applicable.</p> <p>On November 11, 2011 nursing staff were re-educated by the Staff Development Coordinator of infection control standards in regard to catheter tubing, drainage bags, dignity bags, perineal care technique hand hygiene, placement of assistive devices/splints, ice scoop placement and transport of linen.</p> <p>Audits will be conducted of catheter tubing/drainage bags/dignity placement, perineal care technique, hand hygiene, placement of assistive devices/splints, ice scoop storage and linen transport. These audits will be completed (5) times weekly for (1) week, then (3) times weekly for (1) week and then (2) times weekly for (1) week and then monthly thereafter.</p> <p>Results of the audits will be submitted and reviewed monthly by the facility Quality Assurance Committee for need of revision or re-education until compliance is achieved.</p> <p>The Administrator, Director of Nursing and QA Nurse will be responsible for overall compliance.</p>	12/9/2011

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F 441	<p>Continued From page 26</p> <p>Resident #18's boot splints was observed lying on the floor.</p> <p>The ice scoop was observed inside the ice chest during meal service on the Combs Unit.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Review of the facility's "Handwashing/Hand Hygiene" Policy, undated, revealed employees must wash their hands using anti-microbial or non-microbial soap and water after contact with blood, body fluids, secretions, mucous membranes or non-intact skin or after handling items potentially contaminated with blood, body fluids, secretions, mucous membranes, or non-intact skin. <p>Observation of perineal care, on 11/08/11 at 3:40 PM, revealed Certified Nursing Assistant (CNA) #18 cleansed stool from the perineal area, removed the soiled gloves, and obtained another pair of gloves from the clean box of gloves. She proceeded to don new gloves and cleanse stool from the rectal area, and repeatedly pick up the spray bottle of peri-cleanser to spray wash cloths with the soiled gloves. Using the same soiled gloves she proceeded to pull the resident up in the bed with a draw sheet, pull the resident's covers up, and move the bed against the wall. She then placed the bottle of peri-cleanser on the sink in the room.</p> <p>Interview, on 11/08/11 at 3:50 PM, with Licensed Practical Nurse (LPN) #3/Nurse Manager who was assisting CNA #18 at the time of observation of perineal care, revealed the CNA should have removed the soiled gloves and washed her hand</p>	F 441		

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F 441	<p>Continued From page 27</p> <p>prior to obtaining new gloves from the clean box. Further interview, revealed CNA #18 should have removed her soiled gloves and washed her hands prior to using the spray bottle of peri-cleanser and prior to touching other objects in the room.</p> <p>2. Observation, on 11/07/11 at 3:00 PM revealed State Registered Nursing Assistant (SRNA) #14 was dispensing linens to the residents of the Breckinridge Unit. Further observation revealed, SRNA #14 carried the linens in and out of seven (7) different rooms.</p> <p>Interview, on 11/07/11 at 3:30 PM, with SRNA #14 revealed she should have not taken all the linens in and out of the various rooms. Further interview revealed, she should have only taken what was just for each resident in a particular room. Continued interview validated taking linens from room to room was an infection control issue.</p> <p>Interview, on 11/07/11 at 3:45 PM, with License Practical Nurse (LPN) #13 revealed only the linens that were going to be used for a resident should be taken into the room. Further interview revealed, it was an infection control issues to take linens in and out of rooms.</p> <p>Interview on 11/10/11 at 11:50 AM, with the Infection Control Nurse, revealed the SRNAs were education on proper techniques where linens are concerned. Further interview identified, the SRNA failed to follow proper infection control techniques while dispensing linens. Continued interview revealed, staff were educated initially at orientation and then annually.</p> <p>3. Review of the facility's policy, Ice Machines and Ice Storage Chests (dated Revised</p>	F 441		

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F 441	<p>Continued From page 28</p> <p>December 2008), revealed the ice machines and ice storage containers will be used and maintained to assure a safe and sanitary supply of ice. Item E of the policy stated, "Keep the ice scoop in a covered container when not in use".</p> <p>Observation, on 11/08/11 at 11:50 AM, revealed License Practical Nurse (LPN) # 11 picked up the ice scoop which was in the ice chest and filled a cup up with ice. Further observation revealed the ice scoop was placed in the ice scoop holder after obtaining the ice from the ice chest.</p> <p>Interview, on 11/08/11 at 12:00 PM, with LPN #11 revealed the ice scoop was lying in the ice chest when she opened the ice chest. Further interview revealed the ice scoop should have been placed in the ice scoop holder when it was last used.</p> <p>Interview, on 11/10/11 at 11:50 AM, with the Infection Control Nurse identified the ice scoop should have been taken to the dietary department for sanitation and the ice chest should have been emptied, sanitized, and refilled.</p> <p>4. Record review revealed the facility admitted Resident #18 on 10/02/08, with diagnoses which included Joint Contracture - Ankle. Review of the Aide Care Plan revealed the resident was to have splints applied to ankles six days a week.</p> <p>Observation of Resident #18's room, on 11/09/11 at 9:10 AM, revealed splint boots stored on the floor in the corner of the room.</p> <p>Interview, on 11/09/11 at 9:15 AM, with Licensed Practical Nurse #18 revealed the splint boots should not have been on the floor because of contamination. Further interview revealed the</p>	F 441		

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F 441	<p>Continued From page 29</p> <p>nurse was going to bag the splint boots and report this to restorative so they could be cleaned.</p> <p>Interview about the splint boots, on 11/09/11 at 9:20 AM, with the Unit Coordinator/ Registered Nurse #4, revealed the boots should not be kept on the floor because they could become contaminated and possibly cause an infection.</p> <p>5. Review of the facility's policy on Urinary Catheter and Drainage Bag Care (not dated) revealed the catheter bag and tubing were to be kept off the floor.</p> <p>Observation, on 11/8/11 at 2:29 PM, revealed Resident #5's urinary drainage bag was lying on the floor and was not in a privacy/dignity bag.</p> <p>Interview, on 11/8/11 at 2:33 PM, with License Practical Nurse (LPN) #11, who was performing skin assessment at the time of observation, revealed Resident #5's catheter bag should not have been directly on the floor, per her understanding of facility's policy.</p> <p>6. Observation, on 11/9/11 at 11:31 AM, revealed Resident #21's, who was in a wheel chair in the common area in front of the nursing station, staff urinary drainage bag and tubing were laying the floor.</p> <p>7. Observations, on 11/07/11 at 11:00 AM and 11/09/11 at 1:05 PM, revealed Resident #20's tubing for his/her indwelling catheter was laying on the floor. The resident was sitting in the wheelchair at the nurse's station.</p> <p>Observation, on 11/09/11 at 2:26 PM, revealed Resident #20 was lying in the bed and the</p>	F 441		

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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 11/10/2011
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NAME OF PROVIDER OR SUPPLIER NORTHPOINT/LEXINGTON HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1500 TRENT BOULEVARD LEXINGTON, KY 40515
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F 441	<p>Continued From page 30 catheter drainage bag, with no privacy dignity bag, was laying on the floor.</p> <p>Interview, on 11/09/11 between 11:30 AM and 4:45 PM, with Licensed Practical Nurse #5 and State Registered Nurse Aides (SRNAs) #13 and #14 revealed catheter tubing and collection bags were to be kept off the floor, to prevent possible infection.</p>	F 441		

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NAME OF PROVIDER OR SUPPLIER NORTHPOINT/LEXINGTON HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1500 TRENT BOULEVARD LEXINGTON, KY 40515
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR §483.70 (a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 05/12/87</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type (111) Protected</p> <p>SMOKE COMPARTMENTS: Eight (8) smoke compartments.</p> <p>COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM</p> <p>FULLY SPRINKLED, SUPERVISED (Wet SYSTEM)</p> <p>EMERGENCY POWER: Type II Diesel Generator.</p> <p>A life safety code survey was initiated and concluded on 11/09/11. 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.</p> <p>Deficiencies were cited with the highest</p>	K 000	<p>Submission of this response and plan of correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited, and is also not to be construed as an admission of interest against the facility, the Administrator, employees, agents or other individuals who may be discussed in this response and plan of correction. In addition, preparation and submission of this plan of correction does not constitute an admission of agreement of any kind by the facility or the correctness of any conclusion set forth in this allegation by the survey agency. Accordingly, the facility has prepared and submitted this plan of correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a plan of correction within (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. 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: December 9, 2011</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Cynthia Gorton</i>	TITLE Administrator	(X6) DATE 12/9/2011
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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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K 000 K 062 SS=D	<p>Continued From page 1 deficiency identified at "E" level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>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</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure sprinkler heads were maintained as required. This deficient practice affected one (1) of eight (8) smoke compartments. The facility is licensed for one hundred fifty (150) beds and the census the day of the survey was one hundred forty-six (146).</p> <p>The findings include:</p> <p>Observation during the Life Safety Code survey tour, on 11/09/11, at 1:56 PM, with the Maintenance Director revealed corrosion and paint was noted on four (4) sprinkler heads in the Amelia Hall Spa. Not maintaining sprinkler heads can decrease their ability to react as intended.</p> <p>Interview with the Maintenance Director, on 11/09/11 at 1:56 PM, revealed he was not aware of that requirement.</p> <p>Reference: NFPA 25 (1998 Edition).</p> <p>2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of</p>	K 000 K 062	<p>K062</p> <p>It is the practice of this facility to ensure sprinkler heads are maintained in reliable operating condition and are inspected and tested periodically.</p> <p>Koorsen Fire Protection was contacted on 11/9/2011 to schedule necessary service of identified/affected sprinkler heads.</p> <p>All sprinkler heads in the facility were inspected on November 28, 2011 by the Maintenance Director and representative of Koorsen Fire Protection with recommendation of replacement of sprinkler heads in all (3) spa areas within the facility to total (9) sprinklers. Replacement units were purchased on November 28, 2011 with anticipated installation on December 12, 2011.</p> <p>Weekly Preventative Maintenance audits of sprinkler heads will be conducted by the Maintenance Director with monthly review by the Safety Committee and Quality Assurance Committee. Koorsen Fire Protection will inspect all sprinkler heads quarterly in conjunction with the facility's quarterly sprinkler system inspection.</p> <p>Additional review will be conducted during weekly Environmental Rounds by the Maintenance Director and Administrator.</p>	

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K 062 K 147 SS=E	<p>Continued From page 2</p> <p>corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure wiring was maintained, according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect three (3) smoke compartments, eighty (80) residents, staff and visitors.</p> <p>The findings include:</p> <p>Observation, on 11/09/11 at 11:00 AM, revealed three (3) electrical junction boxes located above the drop ceiling near the smoke barrier in Combs Hall #1, Combs Hall #2 and Breck Hall #2 did not have a cover in place. Electrical junction boxes must have covers in place to prevent risk of electrical shock or fire. The observations were confirmed with the Maintenance Director.</p> <p>Interview, on 11/09/11 at 11:00 AM, with the Maintenance Director, revealed he was unaware of any electrical junction boxes not having covers</p>	K 062 K 147	<p>K147</p> <p>It is the practice of this facility to ensure electrical wiring and equipment is maintained in accordance with NFPA 70, National Electrical Code 9.1.2. All pull boxes, junction boxes, and conduit bodies are provided with covers compatible with the box or conduit body construction of use. Where metal covers are used, all comply with the grounding requirements of Section 250-110. An extension from the cover of an exposed box shall comply with Section 370-22.</p> <p>The (3) identified junction boxes located on Combs Hall #1, Combs Hall #2 and Breck Hall #2 were equipped with UL rated metal electrical conjunction box covers. All junction boxes within the facility meet NFPA Standards.</p> <p>All electrical junction boxes within the facility were inspected on November 9, 2011 by the Maintenance Director and Assistant.</p> <p>All boxes met National Fire Protection Association (NFPA) standards. Monthly the Maintenance Director will conduct an inspection of all electrical piping and junction boxes throughout the facility to ensure ongoing compliance with NFPA standards. This inspection will be added to the facility Preventative Maintenance Program.</p> <p>Results of this inspection will be submitted and reviewed monthly by</p>	

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K 147	<p>Continued From page 3 In place.</p> <p>Reference: NFPA 70 (1999 edition)</p> <p>Refer to NFPA 70 (1999 Edition).</p> <p>370.28(c) Covers.</p> <p>All pull boxes, junction boxes, and conduit bodies shall be provided with covers compatible with the box or conduit body construction and suitable for the conditions of use. Where metal covers are used, they shall comply with the grounding requirements of Section 250-110. An extension from the cover of an exposed box shall comply with Section 370-22,</p>	K 147	<p>facility Safety Committee and monthly Quality Assurance Committees for review and revision until the QA committee has determined compliance is achieved. The Administrator and Maintenance Director will be responsible for overall compliance.</p>	12/9/2011