

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

PRINTED: 02/14/2012
FORM APPROVED
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 188069 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 02/02/2012 |
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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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| (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) | (X8) COMPLETION DATE |
|--------------------|---|---------------|---|----------------------|
| F 000 | INITIAL COMMENTS | F 000 | 1. On February 3, 2012 the facility director of nursing and administrator reviewed resident #1 record for any other incidents or accidents that resulted in injury and or had the potential for requiring a physician intervention. No other deficient practice was identified. | 3/15/12 |
| F 157 SS=D | <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> | F 167 | <p>2. On February 9, 2012 the facility administrator and director of nursing reviewed, the past thirty days, all accidents that resulted in an injury to ensure each resident's legal representative was notified immediately of an accident which resulted in an injury and or had the potential for requiring a physician intervention. No other deficient practice was identified.</p> <p>3. All licensed staff and the clinical team will be educated on March 5, 2012 by the director of nursing and staff development director regarding the facility policy and procedures for notification of change and or injury and the guidelines 483.10, Resident Rights regarding the notification of change and KAR 20:300-3(2). The resident rights education will consist of each licensed staff member understanding that each resident's legal representative must be notified immediately of an accident which resulted in an injury and or had the potential for requiring a physician intervention. The director of nursing and/or administrator will perform a 100% review of charts listed on the twenty four hour report, for notification to the legal representative of all incidents and or accidents and or change that required a physician intervention. Any identified incidents and or accidents that are not reported to the legal representative immediately will be reported immediately to the administrator for follow up action and medical director review.</p> | |

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Genevieve H. Martin</i> | TITLE <i>Administrator</i> | (X8) DATE <i>3/2/12</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 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 157 | <p>Continued From page 1</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined the facility failed to ensure the resident's legal representative was notified immediately of an accident which resulted in injury and had the potential for requiring physician intervention for one (1) of six (6) sampled residents (Resident #1).</p> <p>The findings include:</p> <p>Record review revealed the facility admitted Resident #1 on 12/09/11 with diagnoses which included Degenerative Joint Disease and Dementia. Continued review of the Nurses' Notes revealed the resident sustained a fall on 01/18/12 which resulted in an ankle fracture. Continued review revealed the resident was sent out to the hospital and underwent surgery to repair the fracture.</p> <p>Interview with the Ombudsman, on 01/30/12 at 4:40 PM, revealed she was aware the resident had been out to the hospital but did not know of the fall and fracture.</p> <p>Interview with the nephew of Resident #1, on 02/02/11 at 9:05 AM, revealed he was Power of Attorney (POA) for the resident. He stated the resident fell at the nursing home and was sent out to the hospital without notification of the POA. Continued interview revealed the family had gone</p> | F 157 | <p>4. 100% of the daily chart reviews, by the director of nursing, for the compliance of reporting any injury and or, accident, will be reported to the administrator daily. Any deficient practice will be re-educated immediately, and or before the staff member is allowed to perform further duties, by the Director of nursing and or the staff development educator of the facility. Any deficient practice will be reported in the daily clinical meeting by the director of nursing and a quality assurance committee meeting will be held by the administrator within seven days for review and evaluation by the medical director and quality assurance committee. The medical director will be informed immediately, by the administrator, of any future deficient practice. The compliance audits will be forwarded quarterly to the quarterly quality assurance committee for evaluation and follow up by the administrator, facility medical director and the quality assurance committee. Quarterly the quality assurance committee will review the process effectiveness for notification to the legal representative regarding any accident which resulted in injury and or had the potential for requiring the physician intervention for effectiveness.</p> | |

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| F 157 | <p>Continued From page 2</p> <p>to the facility on 01/18/12 to visit and discovered the resident was not there. He stated he had talked to the resident's nurse, who reported the resident had fallen and been sent to the hospital. He further stated the nurse apologized and said she just didn't think about calling the family. The POA was unable to recall the nurse's name. He stated the family went to the hospital and located the resident in the emergency room.</p> <p>Interview with the Director of Nursing, on 02/02/12 at 11:36 AM, revealed she had learned Licensed Practical Nurse (LPN) #1 failed to notify the family of Resident #1's fall and transfer to the hospital. She stated it was wrong of the nurse not to call the POA. She further stated there was so much going on, the nurse "just forgot". Continued interview revealed it was an unfortunate oversight and against facility practice, but "it just happened".</p> <p>Interview with the Administrator, on 02/02/12 at 12:35 PM, revealed she was aware LPN #1 failed to notify the family of the incident. She stated it was forgotten in the commotion of caring for the resident, calling the physician, and making ambulance arrangements. She further stated the family arrived about one and one-half hours after the fall and the resident was already at the hospital.</p> | F 157 | | |