



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

PRINTED: 06/29/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185197</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C.</b> <b>06/15/2012</b>
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NAME OF PROVIDER OR SUPPLIER  <b>NORTHPOINT/LEXINGTON HEALTHCARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1500 TRENT BOULEVARD LEXINGTON, KY 40515</b>
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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 282	<p>Continued From page 1</p> <p>Clinical record review revealed the facility admitted Resident #4 on 08/21/07 with diagnoses which included Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, Hypertension, Schizophrenia and Difficulty Walking.</p> <p>Review of the Significant Change Minimum Data Set (MDS) Assessment, dated 05/04/12, revealed Resident #4 required limited assistance of one (1) staff for transfers, and supervision for ambulation. Continued review revealed the resident scored 05 on the Brief Interview for Mental Status (BIMS), indicating severe cognitive impairment.</p> <p>Review of nursing documentation, dated 05/24/12, revealed Resident #4 had a witnessed fall with a fracture when the resident attempted to rise from the wheelchair unassisted.</p> <p>Review of the Comprehensive Care Plan revealed it was updated on 05/24/12 to include interventions for bed and chair alarms. Review of the Certified Nursing Assistant (CNA) Care Plans for the months of May and June 2012, revealed the resident was to have bed and chair alarms in place.</p> <p>During the initial facility tour, on 06/12/12 at 11:50 AM, observation revealed Resident #4 was walking in the hall outside his/her room. No alarm was sounding. Continued observation revealed CNA #1 approached and redirected Resident #4 back to bed. Because Resident #4 was noted to be short of breath, CNA #1 called out for Licensed Practical Nurse (LPN) #1 to assist. The resident's oxygen was reapplied; however no alarm was noted to the bed and none was applied.</p>	F 282	<p>Current resident care plans were reviewed by administrative nurses to ensure that interventions are effective for residents current assessed care needs with updates to plan of care as indicated. This action was completed on July 6, 2012</p> <p>Observation audits were completed by the QA Nurse and House Supervisors to ensure care provided to current residents was in accordance with their current comprehensive care plan.</p> <p>On July 3, 2012 the Director of Nursing re-educated the Interdisciplinary Team (IDT) regarding care plan interventions with revisions when applicable related to incidents or change in resident's assessed needs.</p>	

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F 282	<p>Continued From page 2</p> <p>Observation, on 06/12/12 at 3:30 PM, revealed Resident #4 was not in the room. No bed alarm was present. Subsequent observations, on 06/13/12 at 9:30 AM, 9:42 AM, and 11:00 AM, revealed Resident #4 was in bed; however, no alarm was in place.</p> <p>Interview with CNA #1, on 06/13/12 at 2:00 PM, revealed Resident #4 was very non-compliant. He stated he had just placed a new alarm on the bed. He further stated the resident had a history of pulling the wire out of the alarm and throwing the box across the room. He confirmed no bed alarm was in place, as per the Comprehensive Care Plan, on 06/12/12 when the resident was out in the hall. When asked why the resident did not have an alarm at that time, he repeated the resident "pulls the wire out".</p> <p>Interview with LPN #1, on 06/14/12 at 10:07 AM, revealed she was the Unit Manager for the Breckenridge Unit, where Resident #4 resided. She confirmed no alarm was sounding on 06/12/12 when she entered the room after the resident had been found walking in the hall. She stated the resident was non-compliant and took everything off. She further stated Resident #4 had been known to throw the alarm in the trash. Continued interview revealed the aides were supposed to check the alarms at the beginning of each shift. She stated they documented the checks on an "internal document" which she reviewed daily. On further interview, the Unit Manager stated it was not facility practice for the nurses to do narrative documentation regarding the alarms. The Unit Manager could not explain why the resident did not have an alarm on</p>	F 282	<p>The facility's Continuous Quality Improvement (CQI) committee meets Monday through Friday and will review all changes of resident conditions to ensure interventions consistent with assessed needs are initiated with appropriate care plan revisions as applicable.</p> <p>Provision of care audits will be completed by the QA Nurse/Administrative Nurses to monitor that provision of resident care is congruent with the care plan interventions based on the resident's current/assessed needs. The audits will be completed 3 times weekly for 2 weeks, then weekly for 2 weeks and then monthly thereafter.</p> <p>On July 3, 2012 the Staff Development Coordinator re-educated nursing staff related to following interventions on residents comprehensive care plans.</p>	

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F 282	<p>Continued From page 3</p> <p>06/12/12 or on 06/13/12 prior to 2:00 PM, per the Comprehensive Care Plan.</p> <p>Interview with the Director of Nursing (DON), on 06/15/12 at 4:44 PM, revealed Resident #4's alarm was moved from bed to chair as needed, depending on the resident's activity. She explained Resident #4 had a history of removing the alarm, and had been known to shove it under the mattress, or in the closet, where it could not be heard from out in the hall. She stated the aides documented alarm checks on a form that was not part of the medical record. She confirmed the form was an internal document. The DON further stated the Unit Manager audited the forms and disciplinary action was initiated if checks were not done. She could not explain why Resident #4 did not have an alarm on 06/12/12 or 06/13/12 prior to 2:00 PM, per the Care Plan interventions in place.</p>	F 282	<p>Review of care planned interventions will occur during the daily CQI review, weekly standards of care review and QA Committee meetings with revisions to the plan as indicated by the QA Committee. CQI committee is composed of Administrator, DON, Administrative Nurses, Social Services, Activities, and Dietician. The QA committee is composed of the Medical Director, Administrator, DON, Administrative Nurses, Social Service Director, Activities, Maintenance, Pharmacist and Dietician.</p>	
F 323 SS=D	<p>483.25(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 observation, interview, record review and review of the facility's policy, it was determined the facility failed to ensure each</p>	F 323	<p>Audits results of provision of care will be reviewed monthly by the QA committee with revision of the plan/monitoring as deemed necessary by the QA Committee</p> <p>The Administrator and Director of Nursing will be responsible for overall compliance.</p> <p>Corrective action completed: July 20, 2012</p>	

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F 323	<p>Continued From page 4</p> <p>resident received adequate supervision and assistive devices to prevent accidents for one (1) of seven (7) sampled residents (Resident #4). The facility failed to ensure Resident #4 received adequate assistive devices to prevent accident when he/she was observed walking in the hall outside his/her room. No alarm was sounding. Staff returned the resident to bed and did not apply an alarm. According to the Comprehensive Care Plan, the resident was to have a bed alarm.</p> <p>The findings include:</p> <p>Review of facility's policy titled "Falling Star Program", effective 07/16/10, revealed "appropriate interventions with care plan updates will be implemented to prevent falls".</p> <p>Clinical record review revealed the facility admitted Resident #4 on 08/21/07 with diagnoses which included Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, Hypertension, Schizophrenia and Difficulty Walking.</p> <p>Review of the Significant Change Minimum Data Set (MDS) Assessment, dated 05/04/12, revealed Resident #4 scored 05 on the Brief Interview for Mental Status (BIMS), indicating severe cognitive impairment. Continued review revealed the resident required limited assistance of one (1) staff for transfers, and supervision for ambulation.</p> <p>Review of nursing documentation, dated 05/24/12, revealed Resident #4 had a witnessed fall with a fracture when the resident attempted to rise from the wheelchair unassisted.</p> <p>Review of the Comprehensive Care Plan</p>	F 323	<p>It is the practice of this facility to ensure residents receive adequate supervision and assistive devices to prevent accidents.</p> <p>Resident # 4 fall interventions were reviewed and revised by the unit manager on June 16, 2012 with revision of the plan of care to include an alarming floor mat at bedside. On June 16, 2012 the unit manager placed an alarming floor mat at resident bedside as a fall prevention intervention.</p>	

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F 323	<p>Continued From page 5</p> <p>revealed It was updated on 05/24/12 to include interventions for bed and chair alarms. Review of the Certified Nursing Assistant (CNA) Care Plans for May and June 2012 revealed the resident was to have bed and chair alarms.</p> <p>Observation during the initial tour, on 06/12/12 at 11:50 AM, revealed Resident #4 was walking in the hall outside his/her room. The resident's left arm had Ace wrap unwound and hanging. No alarm was sounding. Continued observation revealed CNA #1 approached and redirected Resident #4 back to bed. CNA #1 called for Licensed Practical Nurse (LPN) #1 to assist. The resident's oxygen was reapplied and the arm was rewrapped. No alarm was noted to the bed and none was applied.</p> <p>Observation, on 06/12/12 at 3:30 PM, revealed Resident #4 was not in the room. No bed alarm was present. Observations, on 06/13/12 at 9:30 AM, 9:42 AM, and 11:00 AM, revealed Resident #4 was in bed; however, no alarm was in place.</p> <p>Interview with LPN #1, on 06/12/12 at 11:55 AM, revealed Resident #4 was non-compliant with wearing oxygen and the Ace wrap. She stated the resident was "one we have to watch real close".</p> <p>Interview with CNA #1, on 06/13/12 at 2:00 PM, revealed Resident #4 was very non-compliant. He stated he had just put a new alarm on the bed. He further stated the resident pulled the wire out of the alarm and threw the box across the room. He confirmed no bed alarm was in place on 06/12/12 when the resident was out in the hall. When asked why the resident did not</p>	F 323	<p>Current residents were reviewed by administrative nurses for need/revisions to assistive devices to ensure that current interventions are appropriate and implemented for residents current care needs. Updates to plan of care were completed by administrative nurses as indicated. This action was completed on July 6, 2012.</p> <p>On July 3, 2012 the Director of Nursing re-educated the IDT regarding supervision of residents, compliance with assistive device and preventive interventions with revisions to those interventions as applicable</p> <p>On July 3, 2012 the Staff Development Coordinator re-educated nursing staff related to following care plans and ensuring assistive devices are in place and functional in accordance with each resident's established plan of care.</p>	

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F 323	<p>Continued From page 6</p> <p>have an alarm at that time, he repeated the resident "pulls the wire out".</p> <p>Follow-up interview with LPN #1, on 06/14/12 at 10:07 AM, revealed she was the Unit Manager for the Breckenridge Unit, where Resident #4 resided. She confirmed no alarm was sounding on 06/12/12 when she entered the resident's room after he/she was observed out in the hall. She stated the resident was non-compliant and took everything off. She further stated Resident #4 had been known to throw the alarm in the trash. Continued interview revealed the aides did an alarm check at the beginning of each shift. She stated they documented on an internal document and she reviewed the documentation daily. On further interview, the Unit Manager stated it was not facility practice for the nurses to do narrative documentation regarding the alarms. She could not explain why the resident did not have an alarm on 06/12/12 or on 06/13/12 prior to 2:00 PM.</p> <p>Interview with the Director of Nursing (DON), on 06/15/12 at 4:44 PM, revealed Resident #4's alarm was moved from bed to chair as needed. She explained the resident shoved the alarm under the mattress, or in the closet, and it could not be heard from out in the hall. She stated the aides documented alarm checks on a form that was not part of the medical record. She confirmed the form was an internal document. The DON further stated the Unit Manager audited the forms and disciplinary action was initiated if checks were not done. She could not explain why Resident #4 did not have an alarm on 06/12/12 or 06/13/12 prior to 2:00 PM.</p>	F 323	<p>Provision of care audits will be completed by the QA Nurse/Administrative Nurses to monitor that provision of resident care is congruent with the care plan interventions based on the resident's current/assessed needs and that all assistive devices are in place and functional in accordance with each resident's plan of care.</p> <p>Audits will be completed 3 times weekly for 2 weeks, then weekly for 2 weeks and then monthly thereafter by the QA Nurse/administrative nurses.</p> <p>Audits of assistive devices results will be reviewed monthly by the QA committee with revision of the plan/monitoring as deemed by the QA Committee. The QA committee is composed of the Medical Director, Administrator, DON, Administrative Nurses, Social Service Director, Activities, Maintenance, Pharmacist and Dietician.</p> <p>The Administrator and Director of Nursing will be responsible for overall compliance.</p> <p>Corrective action completed: July 20, 2012</p>	