

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

PRINTED: 12/08/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185160	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  11/20/2014
NAME OF PROVIDER OR SUPPLIER  LEXINGTON COUNTRY PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 700 MASON HEADLEY ROAD LEXINGTON, KY 40504	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS  A Recertification Survey was initiated on 11/18/14 and concluded on 11/20/14. Deficiencies were cited with the highest Scope and Severity of an "E".	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)  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).  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.  The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	F 157	DEC 17 2014  F157  What corrective action will be accomplished for those residents found to have been affected by the deficient practice?  Resident #6 was reassessed, to include a blood glucose finger stick, by the licensed nurse on 11/19/14. The ARNP was notified of assessment findings with new orders received & noted.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

*[Handwritten Signature]*

DSS, NHA

12-18-14

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.

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

PRINTED: 12/08/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185160	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  11/20/2014
NAME OF PROVIDER OR SUPPLIER  LEXINGTON COUNTRY PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 700 MASON HEADLEY ROAD LEXINGTON, KY 40504		
(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 157	Continued From page 1  This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's guidelines, it was determined the facility failed to ensure the Physician was notified when there was a significant change or need to potentially alter treatment for one (1) of eighteen (18) sampled residents (Resident #6).  Resident #6 had a Physician's Order to check his/her Fingerstick Blood Sugar (FSBS) four (4) times a day and staff to call the Physician if the resident's FSBS result was greater than two-hundred and fifty (250). Review of the November 2014 FSBS results revealed documentation of the resident's FSBS results being greater than two-hundred and fifty (250); however, staff interview and record review revealed the Physician was not notified by the facility.  The findings include:  Review of the facility's Guidelines titled, "Resident Condition Changes that Require Physician Notification", revised date 12/19/12, revealed the facility's expectations was for licensed nurses to recognize resident situations/conditions which required Physician notification and document the notification. Additional review revealed the Physician was to be notified if there were significant changes of a chronic condition, such as, blood sugars which exceeded the parameters determined by the Physician.  Review of Resident #6's medical record revealed the facility admitted the resident on 10/13/14, with	F 157	How will the facility identify other residents having the potential to be affected by the same deficient practice?  Residents with orders for blood glucose finger sticks would have the potential to be affected. An audit of current residents with physician ordered blood glucose finger sticks was completed using an audit tool (EXHIBIT H) on 11/19/2014 by Unit Coordinators to identify that any parameters for notification of MD were followed as ordered, No other residents were found to be affected.  Staff will continue to notify the Physician when there is a significant change or need to potentially alter treatment, including when blood glucose results fall outside of ordered parameters.		

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

PRINTED: 12/08/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185160	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  11/20/2014
NAME OF PROVIDER OR SUPPLIER  LEXINGTON COUNTRY PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 700 MASON HEADLEY ROAD LEXINGTON, KY 40504	
(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)

F 157 Continued From page 2  
diagnoses which included Diabetes Mellitus Type II and Chronic Kidney Disease Stage IV. Review of the Admission Minimum Data Set (MDS) dated 10/20/14, revealed the facility assessed Resident #6 as having a Brief Interview for Mental Status (BIMS) score of eleven (11) out of fifteen (15), which indicated moderate cognitive impairment.

Review of Resident #6's November 2014 Monthly Physician's Orders revealed an order for Accuchecks (FSBS) four (4) times a day, and if the results were greater than two-hundred and fifty (250) staff were to call the Physician. Continued review of the Monthly Physician's Orders revealed no documented evidence Resident #6 had routine diabetes medicine ordered or sliding scale insulin ordered.

Review of the November 2014 documentation of Resident #6's FSBS results revealed multiple episodes when the FSBS was greater than 250: on 11/03/14 at 9:30 PM the result was 309; on 11/04/14 at 9:30 PM the result was 273; on 11/10/14 at 9:30 PM the result was 259; on 11/11/14 at 9:30 PM the result was 278; on 11/12/14 at 9:30 PM the result was 344; on 11/13/14 at 4:30 PM the result was 265; on 11/14/14 at 4:30 the result was 304, and at 9:30 PM the result was 284; and on 11/17/14 at 4:30 PM the result was 270.

Continued record review of the November 2014 Nurse's Notes revealed no documented evidence the Physician or the Advanced Practice Registered Nurse (APRN) were notified as ordered when the FSBS results were greater than 250.

Interview with Licensed Practical Nurse (LPN) #2

F 157 **What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?**

DON re-educated the Unit Coordinators and House Supervisors on 11/25/14 in ensuring Physician notification is completed when there is a significant change in condition or an identified need to potentially alter treatment, including blood sugars which exceed the parameters determined by the physician. The Unit Coordinators and House Supervisors initiated re-education on 11/25/14 with facility RNs & LPN's, including LPN #2 & LPN #6, on ensuring Physician notification is completed when there is a significant change in condition or need to potentially alter treatment, including blood sugars which exceed the parameters determined by the physician. This re-education will continue until all LPNs & RNs have received this re-education.

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

PRINTED: 12/08/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185160	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  11/20/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  LEXINGTON COUNTRY PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 700 MASON HEADLEY ROAD LEXINGTON, KY 40504
---	--

(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 157 Continued From page 3

on 11/19/14 at 4:35 PM, revealed she had not always contacted the Physician or APRN when Resident #6's FSBS was above 250 as ordered. LPN #2 revealed the times she had notified them, she had not documented this. Continued interview with LPN #2 revealed sometimes when Resident #6's FSBS was high she monitored the resident for signs of Hyperglycemia and waited an hour to re-check the blood sugar. Per interview, if the FSBS was below 250 when she re-checked, she didn't feel like she needed to contact the Physician, as ordered. However, the LPN stated she had not documented the FSBS re-check results or her assessments, for Hyperglycemia, and stated it was poor documentation on her part. LPN #2 revealed the APRN was aware Resident #6 had high blood sugars, and was contacted that day of the prior FSBS results above 250. She stated the APRN had written a clarification order to call the APRN or Physician now if Resident #6's FSBS results were above 350. LPN #2 further revealed the facility should have gotten a clarification order earlier.

Interview with LPN #6 on 11/19/14 at 5:02 PM, revealed she had done the FSBS on 11/11/14 and had obtained a reading of 278, but didn't notify the Physician as ordered. The LPN stated it was important to check the Physician's Orders. Per interview, she had not routinely taken care of Resident #6 and had not known there was an order for her to contact the Physician when the result was above 250. LPN #6 further stated if the Physician had been notified of the result a treatment might have been ordered and the concern was possible Hyperglycemia.

Interview with the Director of Nursing (DON) on 11/20/14 at 4:55 PM, revealed it was her

F 157 A Finger Stick Blood Sugar Parameter audit tool was implemented by the DON (EXHIBIT A) on 12/1/14 to be used by the Unit Coordinators & House Supervisors to conduct a daily, including weekends, audit to verify that the physician has been notified of any finger stick blood sugars that fall out of ordered parameters. Any identified concerns will be addressed immediately as indicated & reported to the DON.

**How will the facility monitor its performance to ensure solutions are sustained?**

The completed Finger Stick Blood Sugar Parameter audit tool (EXHIBIT A) will be reviewed by the DON weekly for a minimum of six weeks to ensure appropriate follow up has been implemented as indicated based on audit findings. The results of these

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

PRINTED: 12/08/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185160	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  11/20/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  LEXINGTON COUNTRY PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 700 MASON HEADLEY ROAD LEXINGTON, KY 40504
---	--

(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 157	Continued From page 4 expectation staff notified the Physician of the FSBS results as ordered. The DON stated the Physician was to be notified if Resident #6's FSBS results were above 250 to determine if any treatment changes were needed.	F 157	weekly audits will be reported by the DON to the QAPI Committee monthly, which includes but is not limited to the Administrator, Director of Nursing, Medical Director and Pharmacy Consultant monthly. Further action and or education will be implemented based on identified trends & Committee direction.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.  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.  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 the Comprehensive Care Plan was revised for one (1) of eighteen (18) sampled residents (Resident	F 280	Completion Date: 12/19/14  <b>F280</b>  <b>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</b>  On 11/25/14 the licensed nurse discussed skin breakdown prevention interventions with resident & family member. MD was notified & the care plan was updated to reflect newly ordered intervention.	

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

PRINTED: 12/08/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185160	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  11/20/2014
NAME OF PROVIDER OR SUPPLIER  LEXINGTON COUNTRY PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 700 MASON HEADLEY ROAD LEXINGTON, KY 40504	
(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	Continued From page 5 #5).  Resident #5's Comprehensive Care Plan contained a care plan for alteration in skin integrity related to a Right Heel Diabetic Ulcer. The care plan included an intervention to provide pressure redistribution products as ordered, and an order for Resident #5 to wear heel protector boots at all times. Observation and interview revealed however, the resident routinely refused to wear the heel protector boots at all times. Further review of the Comprehensive Care Plan revealed no documented evidence it was updated/revised to include Resident #5's refusals to wear the heel protector boots at all times.  The findings include:  Review of the facility's policy titled, "Process for Plan of Care Development and Communication", revised 07/01/10, revealed the purpose of the care plan was to ensure the effective delivery of care in an organized manner designed to meet the individualized needs of the residents. The Policy revealed the plans of care were to identify residents' needs, problems, strengths, risk factors, and was a work in progress with changes made as the residents' needs changed. Further review of the Policy revealed care plan goals, approaches, and interventions were reviewed and updated as needed at care plan meetings, and by direct care nurses as residents' needs changed.  Review of Resident #5's medical record revealed the facility admitted the resident initially on 04/01/14 and re-admitted the resident on 07/03/14, with diagnoses which included Diabetes Mellitus Type II, Severe Diabetic Neuropathy (peripheral nerve damage), Peripheral Vascular	F 280	<b>How will the facility identify other residents having the potential to be affected by the same deficient practice?</b>  An audit was performed by the Unit Coordinators on current residents care planned for pressure reduction devices, using a QI tool ( <b>EXHIBIT I</b> ) on 12/01/2014 to ensure that all pressure reduction devices are care planned and being implemented as ordered unless otherwise care planned for refusals. Any identified concerns were corrected at the time of the audit.  Residents will continue to have care plans developed by the Interdisciplinary Team, which may include but is not limited to the MDS nurse, Social Worker, Activities, Dietary & Therapy department; and revisions, including non-compliance of interventions, will be made as appropriate and/or indicated based on resident's individualized needs &/or preferences.	

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

PRINTED: 12/08/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135160	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  11/20/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  LEXINGTON COUNTRY PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 700 MASON HEADLEY ROAD LEXINGTON, KY 40504
---	--

(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: Continued From page 6

Disease (narrowing or occlusion of arteries/veins outside of the heart and brain), Renal Failure, Congestive Heart Failure, and was admitted to hospice on 08/08/14. Review of the Significant Change Minimum Data Set (MDS), dated 08/21/14, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of twelve (12) out of fifteen (15) which indicated moderate cognitive impairment.

Continued medical record review revealed Resident #5 had a Diabetic Foot Ulcer identified on 10/03/14, and a November 2014 monthly Physician Order to wear heel protector boots at all times related to a history of ulcers. Review of Resident #5's Comprehensive Care Plan revealed a skin integrity care plan related to the right heel diabetic ulcer and an intervention to provide redistribution products as ordered.

Observations of Resident #5 on: 11/18/14 at 12:28 PM and 5:36 PM; and on 11/19/14 at 10:51 AM, 11:11 AM, and 2:10 PM revealed the resident not wearing heel protector boots.

Interview with Resident #5 on 11/19/14 at 11:11 AM, revealed he/she wore the heel protector boots occasionally, but didn't like to wear the boots when in bed because he/she was unable to turn independently in bed when they were on. Resident #5 reported staff had encouraged him/her to wear the heel protector boots however.

Interview with Registered Nurse (RN) #4 on 11/19/14 at 2:32 PM, revealed Resident #5 was supposed to wear the heel protector boots at all times and the aides knew the resident's care needs per the care plan. Further interview with

F 280: What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?

RNs & LPN's, including RN #4, LPN #6, LPN #4, RN #1, were re-educated in the importance of documentation regarding resident non-compliance and the use of the facility's "Stop and Watch" forms as an effective communication tool by the DON, Unit Coordinators, House Supervisors &/or Staff Educator. This education also included that any type of non-compliance/refusals by residents must be care planned and MD notified. Education began on 11/25/2014 & will continue until current RNs & LPNs have received this education. Newly hired RNs & LPNs will continue to be provided this education during the orientation process.

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

PRINTED: 12/08/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185160	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  11/20/2014
NAME OF PROVIDER OR SUPPLIER  LEXINGTON COUNTRY PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 700 MASON HEADLEY ROAD LEXINGTON, KY 40504		
(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 7</p> <p>the RN revealed, she had talked to Resident #5 "earlier" about putting on the heel protector boots; however, the resident refused to comply.</p> <p>Interview with Licensed Practical Nurse (LPN) #6 on 11/19/14 at 5:02 PM, revealed Resident #5 had not always worn the heel protector boots. Per interview, Resident #5 was supposed to wear them because of the heel wound and risk of the ulcer worsening or the development of another heel ulcer.</p> <p>Interview with the Wound Treatment Nurse/LPN #4 on 11/19/14 at 5:45 PM, revealed Resident #5 had a long standing history of not wearing the heel protector boots, and she had tried different products but the resident felt they were too bulky. The Wound Treatment Nurse/LPN #4 stated the resident had "terrible" circulation and the Physician recommended he/she not be up in the electric wheelchair because it caused weight bearing on his/her heels. Per interview, the Physician wanted Resident #5 to wear the heel protector boots at all times; however, the resident was under Hospice and had refused because he/she felt his/her quality of life was limited when the boots were worn.</p> <p>Interview with RN #1 on 11/20/14 at 12:16 PM, revealed she routinely cared for Resident #6 and the resident wore the heel protector boots only about fifty percent of the time when he/she was up. RN #1 stated Resident #5 usually agreed to wear the heel protector boots when staff requested at the start of the shift, but the problem was the resident chose not wear them all the time. Per interview, however, the care plan was not revised/updated to include Resident #5's heel protector boot non-compliance and for related</p>	F 280	<p>Facility Staff, including nursing, dietary, housekeeping, maintenance &amp; therapy services, received additional re-education by the Administrator on the Stop and Watch Program at Monthly Town Hall Meetings 11/30/2014 and 12/01/2014. This re-education included the importance of completion, assessment, documentation &amp; follow up of the forms. Newly hired employees will continue to receive education on the Stop &amp; Watch Program during the orientation process.</p> <p>A Pressure Device Compliance Audit Tool (EXHIBIT I) was implemented by the DON on 12/1/14 &amp; will be used by the Unit Coordinators &amp; House Supervisors to complete a QI audit daily, including weekends to ensure care plan pressure deduction devices are in place. Any issues identified in these audits will be corrected with any further education implemented as indicated.</p>	

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

PRINTED: 12/08/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185160	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  11/20/2014
NAME OF PROVIDER OR SUPPLIER  LEXINGTON COUNTRY PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 700 MASON HEADLEY ROAD LEXINGTON, KY 40504	
(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)

F 280 | Continued From page 8  
interventions, such as, educating the resident or encouraging him/her to use the boots.

Interview with MDS Coordinator #1 on 11/20/14 at 2:44 PM, revealed residents' care plans were updated appropriately to the situation. Per interview, Resident #5's non-compliance with wearing the heel protector boots had not been discussed at the Interdisciplinary Team (IDT) Meetings and, therefore she was unaware of Resident #5's non-compliance with wearing the boots. The MDS Coordinator revealed Resident #5's care plan should have been updated based on the non-compliance cause and appropriate interventions implemented.

Interview with the Director of Nursing (DON) on 11/20/14 at 4:55 PM, revealed Resident #5's care plan should have been revised to address the resident's heel boot non-compliance and interventions put in place. The DON stated she thought the non-compliance issue was previously addressed; however, could not provide documented evidence of this. She stated nurses were responsible for updating the resident's care plan.

F 371 | 483.35(i) FOOD PROCURE,  
SS=E | 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

F 280 | **How will the facility monitor its performance to ensure solutions are sustained?**

Director of Nursing will review the completed Pressure Device Compliance Audit tools (**EXHIBIT I**) completed by the Unit Coordinators & House Supervisors & their accompanying corrective action weekly for a minimum of 6 weeks to ensure appropriate follow up has been implemented as indicated based on audit findings. The results of these weekly audits will be reported by the DON to the QAPI Committee monthly, which includes but is not limited to the Administrator, Director of Nursing, Medical Director and Pharmacy Consultant monthly. Further action and or education will be implemented based on identified trends & Committee direction.

Completion Date: 12/19/14

F 371

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

PRINTED: 12/08/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185160	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  11/20/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  LEXINGTON COUNTRY PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 700 MASON HEADLEY ROAD LEXINGTON, KY 40504
---	--

(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 371	<p>Continued From page 9</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's policy, it was determined the facility failed to ensure food items were stored, prepared, distributed and served under sanitary conditions as evidenced by observations of food products not labeled, not dated after being opened, and returned to dry storage shelves.</p> <p>Further observations revealed the ceiling vent, over the food preparation area and tray line, had an approximately half inch gap to a one (1) inch gap on three (3) sides. In addition, the light cover next to the vent contained a dried light yellow substance.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Review of the facility's policy titled, "Food Safety", dated 01/01/01 with a revision date of 08/06/12, revealed all potentially hazardous foods have a seven (7) day shelf life when opened and stored food items were to have a product identifier (label) and a use by date documented.</li> </ol> <p>Observation, on 11/18/14 at 9:45 AM, during the initial kitchen tour of the dry storage area revealed: opened powdered sugar; an opened bag of gravy mix not dated; and approximately three fourths (3/4) of an opened bag of pasta not labeled and not dated, wrapped in plastic wrap and returned to the dry storage shelves.</p> <p>Continued observation, on 11/19/14 at 8:35 AM, of the dry storage shelves revealed two (2) opened gravy mix packages; the opened</p>	F 371	<p><b>F371</b></p> <p><b>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <p>The open food items including powdered sugar, bag of gravy mix, &amp; pasta were discarded on 11/19/14 by the Food &amp; Beverage Director.</p> <p>The Maintenance team repaired the gap around the ceiling vent &amp; cleaned the kitchen light cover on 11/20/2014.</p> <p><b>How will the facility identify other residents having the potential to be affected by the same deficient practice?</b></p> <p>All residents have the potential to be affected.</p>	
-------	--	-------	---	--

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

PRINTED: 12/08/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185160	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  11/20/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  LEXINGTON COUNTRY PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 700 MASON HEADLEY ROAD LEXINGTON, KY 40504
---	--

(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 371 Continued From page 10

powdered sugar not dated; and the approximately three fourths (3/4) bag of pasta not labeled and not dated wrapped in plastic film.

Interview, on 11/19/14 at 3:53 PM, Cook #1 revealed dietary staff were to label and date every food item when opened. Cook #1 stated food items were to be dated for a three (3) day expiration date.

Interview, on 11/20/14 at 10:40 AM, with Cook #2 revealed food products were to be wrapped with an opened date. Per interview, food could stay on the dry storage shelves for three (3) to five (5) days after being opened; however, if foods were past the due date the food was "tossed out". He revealed if food items were not dated, after he found out who prepared the food from the day before, he would date the food item based on that date.

Interview, on 11/20/14 at 11:00 PM, with the Dietary Director revealed all food items should be labeled and dated with the opened date and a three (3) day expiration date. The Dietary Director stated if foods were found without a label and not dated the food should be thrown out. Per interview, food would not have good quality, contain moisture, and not be safe for residents if this was not done. Further interview revealed the Policy stated for opened foods there was seven (7) days before food item was thrown out; however, they practiced three (3) days from the day the food item was opened.

2. Continued observation, on 11/19/14 at 8:35 AM, revealed the ceiling vent with an approximate half inch to one (1) inch gap around three (3) sides of the vent, and the light covering next to

F 371

**What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?**

The Food and Beverage Director completed re-education with dietary staff on 11/19/14, regarding the proper storage of food products based on facility policy & protocols, including but not limited to, dating & labeling all opened food products & when to dispose of the products to promote food safety & quality of food for residents. Newly hired dietary staff will continue to receive this education during the orientation process.

Dietary Staff were re-educated by the Administrator on 12/17/2014 initiating the facility's work order process through the TELS system for identified maintenance issues including openings or gaps around ceiling vents, & dirty light fixtures.

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

PRINTED: 12/08/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185160	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  11/20/2014
NAME OF PROVIDER OR SUPPLIER  LEXINGTON COUNTRY PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 700 MASON HEADLEY ROAD LEXINGTON, KY 40504	

(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 371	Continued From page 11 the ceiling vent contained a dried light yellow substance on it.  Interview, on 11/19/14 at 4:40 PM, with the Director of Maintenance revealed there was an old leak from a Heating, Ventilation and Air Conditioning (HVAC) system draining into the ceiling above the kitchen which had drained into the fluorescent light shade and had been repaired.  Continued interview, on 11/20/14 at 11:00 PM, with the Dietary Director revealed the vent in the ceiling was open and dust or particles from the ceiling could have fallen on employees and into the residents' food which would have to be discarded. The Dietary Director stated the light covering contained a stain from a past leak which had not been cleaned up; however, should have been.	F 371	A Food Storage Audit ( <b>Exhibit J</b> ) was initiated by the Food & Beverage Director on 12/15/14. An assigned dietary staff member will complete the audit tool daily, including weekends, for a minimum of 6 weeks. Food storage will continue to be reviewed & noted ongoing monthly during the facility's Registered Dietitian review. Any concerns identified during the audits & during the Dietitian's review will be corrected & reported to the Food & Beverage Director.	
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (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.	F 441	A Mock Survey/Site Visit Dietary Audit tool ( <b>Exhibit K</b> ) will be completed monthly by the Registered Dietitian to identify sanitation & cleanliness concerns, including that light fixtures & the ceiling vents are clean & in good repair. This completed audit tool will be given to the Food & Beverage Director for follow up & correction of identified areas, including initiating of a maintenance work order as indicated.	

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

PRINTED: 12/08/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185160	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  11/20/2014
NAME OF PROVIDER OR SUPPLIER  LEXINGTON COUNTRY PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 700 MASON HEADLEY ROAD LEXINGTON, KY 40504	
(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 441	Continued From page 12  (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.  (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.  This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's policy, it was determined the facility failed to ensure infection control practices were maintained related to disinfection of blood glucose monitoring equipment and proper hand hygiene was performed during resident care.  The findings include:  1. Review of the facility's policy titled, "Blood Glucose Monitoring" dated 02/03/10, revealed blood glucose meters should be assigned to a individual resident if possible to prevent transmission of bloodborne pathogens. Further review revealed, should a glucose meter used for	F 441	<b>How will the facility monitor its performance to ensure solutions are sustained?</b>  The Administrator will review the Food Storage Audits (Exhibit J) weekly to ensure that concerns are addressed & product is discarded if applicable. The Administrator will review the Mock Survey/Site Visit Dietary Audit tool (Exhibit K) & its accompanying corrective action monthly to ensure appropriate follow up has been implemented as indicated based on audit findings.  The results of these audits tools, the monthly Dietitian's report & their accompanying actions will be reported by the Administrator monthly to the QAPI Committee, which includes but is not limited to, the Administrator, DON, Medical Director, & Pharmacy Consultant. Further action &/or education will be implemented based on identified trends & Committee direction.  Completion Date: 12/19/2014	

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

PRINTED: 12/08/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185160	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  11/20/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  LEXINGTON COUNTRY PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 700 MASON HEADLEY ROAD LEXINGTON, KY 40504
---	--

(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 441 Continued From page 13  
one resident be reused for another resident, the device must be cleaned and disinfected with a bleach preparation or an approved designated cleaner.

Review of the product label instructions for the facility's disinfectant wipes, Sani-Cloth Bleach Germicidal Disposable Wipes, revealed the treated surface must remain visibly wet for a full four (4) minutes. Further review revealed to use an additional wipe if needed to assure continuous four (4) minute wet contact time, then allow to air dry.

Observation on 11/19/14 at 4:02 PM, during a resident's blood glucose monitoring procedure, revealed staff wiped the blood glucose meter with a Sani-Cloth Bleach Wipe, and placed the meter on a paper towel to air dry for four (4) minutes. However, further observation revealed the nurse did not ensure the blood glucose meter remained visibly wet for the full four (4) minutes indicated on the product label.

Interview with Licensed Practical Nurse (LPN) #6 on 11/19/14 at 4:25 PM, revealed she was aware the machine had a four (4) minute drying time, but was unaware the machine should stay visibly wet for four (4) minutes and then air dry.

Interview with LPN #7 on 11/19/14 at 5:35 PM, revealed the facility's procedure was to wipe the blood glucose meter off and allow to dry for four (4) minutes. Further interview revealed LPN #7 was not aware the product manufacturer of the disinfectant wipes recommended the product remain visibly wet on the surface for four (4) minutes.

F 441 F441

**What corrective action will be accomplished for those residents found to have been affected by the deficient practice?**

Residents with physician ordered finger stick blood glucose monitoring were re-assessed by the licensed nurse to identify any signs or symptoms of potential infection related to cross contamination on 11/19/2014. (Exhibit L). No signs or symptoms of current infection were identified.

Resident #5 was re-assessed by the licensed nurse to identify any signs or symptoms of potential infection related to possible cross contamination on 12/15/2014. No signs or symptoms of current infection were identified.

**How will the facility identify other residents having the potential to be affected by the same deficient practice?**

All residents have the potential to be affected.

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

PRINTED: 12/08/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185160	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  11/20/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  LEXINGTON COUNTRY PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 700 MASON HEADLEY ROAD LEXINGTON, KY 40504
---	--

(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 441 Continued From page 14

Interview with LPN #1 on 11/19/14 at 5:40 PM, revealed the facility's procedure was to wipe the glucose meter off and allow the meter to air dry for four (4) minutes. Further interview revealed LPN #1 did not know how long the machine was to stay visibly wet after wiping it down. Per interview, LPN #1 was not aware disinfection of the machine required a visibly wet contact time of four (4) minutes.

Interview with Registered Nurse (RN) #3 on 11/19/14 at 5:47 PM, revealed the facility's procedure was to wipe the glucose meter off and allow it to air dry for four (4) minutes. Per interview, RN #3 was not aware the disinfectant wipe's product manufacturer recommended surfaces remain visibly wet for four (4) minutes to ensure disinfection of the surface.

Interview with the Director of Nursing, who was also the Infection Control Nurse, on 11/20/14 at 11:05 AM, revealed the facility's procedure for disinfection of the blood glucose meters was for staff to wipe the device with a Sani-Cloth Bleach wipe and allow it to air dry for four (4) minutes. Continued interview revealed she was unaware the manufacturer recommended a four (4) minute visibly wet "kill time". Per interview, the disinfectant product killed most organisms with a wet surface time of one (1) minute and the DON felt sure the facility's procedures accomplished the one (1) minute time. Further interview revealed she had not identified an increase in infections related to inappropriate disinfection practices.

2. Review of the facility's policy titled, "Hand Washing", revised date 10/15/14, revealed hand washing was the most important component to

F 441 **What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?**

On 11/19/2014 The Executive Director, DON and Administrator attached a laminated copy of the proper procedure for disinfecting glucometers, including the 4 minute contact time as instructed by the product label, on each finger stick blood glucose caddy so that nurses would have easy access to proper procedure readily available.

Re-education of licensed & registered nursing staff, including licensed nurse #6 and #7 began on 11/19/2014 by DON, Unit Coordinator and House Supervisor regarding the proper procedure for disinfecting glucose machines, including the 4 minute contact time as instructed by the product label. See (Exhibit M) for details.

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

PRINTED: 12/08/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185160	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  11/20/2014
NAME OF PROVIDER OR SUPPLIER  LEXINGTON COUNTRY PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 700 MASON HEADLEY ROAD LEXINGTON, KY 40504	

(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 441 Continued From page 15

manage the spread of infection. Review of the policy's procedures revealed hand washing was performed during care when staff moved from an area where there was a concentration of microorganisms, such as an area where there were body fluids, or a contaminated body site to a clean body site.

Review of the facility's policy titled, "Infection Control Policy and Isolation Guidelines", revised date 11/15/10, revealed gloves were to be changed when the gloves went from a contaminated body site to a clean body site.

Review of Resident #5's medical record revealed the facility re-admitted the resident on 07/03/14, with diagnoses which included Congestive Heart Failure, Diabetes Mellitus Type II and Renal Failure. Review of the Significant Change Minimum Data Set (MDS), dated 08/21/14, revealed the facility assessed Resident #5 as having a Brief Interview for Mental Status (BIMS) score of twelve (12) indicating he/she was moderately cognitively impaired.

Observation on 11/20/14 at 9:35 AM, of Resident #5's skin assessment performed by LPN #4/Wound Treatment Nurse revealed the nurse assessed the resident's perineal area, and then moved on to assess the resident's upper front chest area without removing the soiled gloves, washing his hands and donning clean gloves.

Interview with LPN #4/Wound Treatment Nurse on 11/20/14 at 10:46 AM, revealed he routinely performed wound treatments, but did not routinely perform residents' skin assessments. LPN #4/Wound Treatment Nurse stated he realized, after the fact, he had moved from the perineal

F 441 The facility's Clinical Competency Review tool for blood glucose testing was reviewed & updated by the DON on 11/19/14 to include the 4 minute contact time as instructed by the product label. This competency tool will be completed by the Staff

Development Coordinator or DON on newly hired nurses during the orientation process.

Re-education of facility nursing staff, including LPN # 4 began on 11/25/2014 by the DON, Unit Coordinator, & House Supervisor regarding use of proper hand hygiene techniques during resident care, including removing soiled gloves, washing hands & donning clean gloves when moving from an area where there is a concentration of microorganisms, such as an area where there are body fluids, or a contaminated body site to a clean body site.

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

PRINTED: 12/08/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185160	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  11/20/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  LEXINGTON COUNTRY PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 700 MASON HEADLEY ROAD LEXINGTON, KY 40504
---	--

(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 441 Continued From page 16  
area to Resident #5's arm pit and breast area during the skin assessment without changing gloves and washing his hands. Per interview, he was supposed to remove the soiled gloves after assessing the perineal area, and wash his hands and don new gloves before he went to clean areas of Resident #5's body.

Further interview with the DON/Infection Control Nurse on 11/20/14 at 2:48 PM, revealed the nurse performing Resident #5's skin assessment should have removed his gloves when he went from a dirty area, his/her perineal area, and washed his hands and donned new gloves prior to assessing the resident's upper chest which was a clean area. She revealed the reason for this was to decrease the risk of cross contamination from moving from a dirty area to a clean area.

F 520 SS=E 483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS

A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.

The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.

A State or the Secretary may not require disclosure of the records of such committee

F 441 New hires will continue to receive information & education on proper hand hygiene during resident care, that also includes removing soiled gloves, washing hands & donning clean gloves when moving from an area where there is a concentration of microorganisms, such as an area where there are body fluids, or a contaminated body site to a clean body site during resident care & will have a Handwashing Procedure Checklist (**Exhibit N**) completed by the Staff Development Coordinator or a licensed nurse during the orientation process.

F 520 Department Managers, including but not limited to Social Services, DON, Unit Coordinators, Dietary, House Supervisors, Maintenance, Housekeeping supervisor, Admission Coordinator, Activity Director, & MDS Nurses were re-educated by the facility's RN Infection Control Preventionist on 12/16/2014. This

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

PRINTED: 12/08/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185160	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  11/20/2014
NAME OF PROVIDER OR SUPPLIER  LEXINGTON COUNTRY PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 700 MASON HEADLEY ROAD LEXINGTON, KY 40504	

(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 520 Continued From page 17  
except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.

Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.

This REQUIREMENT is not met as evidenced by:  
Based on interview, policy review and review of the facility's Plan of Correction (POC) for the 09/26/13 Recertification Survey and subsequent Revisit on 03/12/14, it was determined the facility failed to maintain an effective Quality Assessment and Assurance (QA) Program to ensure the facility's plans of correction implemented to address the prior deficiencies were monitored, evaluated and revised to ensure ongoing compliance was maintained. This was evidenced by repeat deficiencies cited related to the facility's failure to ensure: physician notification (see F157); revision of residents' Comprehensive Care Plans (see F280); and proper infection control practices were performed (see F441).

The findings include:  
Review of the facility's policy titled, "Continuous Quality Improvement (CQI) Committee", dated 06/17/04 and revised 08/07, revealed the purpose of the CQI Committee was to evaluate, implement, assess and revise, as needed, the facility's policies and procedures and to monitor compliance with federal, state and local regulatory agencies. Review of the functions of the CQI Committee revealed the committee

F 520  
training included an overview of the Infection Control Committee & associated responsibilities of surveillance, handwashing- including glove use & when to change gloves & cleaning of equipment including glucometers.

**How will the facility monitor its performance to ensure solutions are sustained?**

An audit tool was developed by the DON on 11/29/2014 to observe the technique used by the nurse's while cleaning glucometers between each finger stick (**Exhibit O**). Random, daily, including weekend ,audits will be conducted by the Unit Coordinators and House Supervisors using this tool to ensure nurses are using the proper procedure for disinfecting glucometers, including the 4 minute contact time as instructed by the product label and dry time.

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

PRINTED: 12/08/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185160	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  11/20/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  LEXINGTON COUNTRY PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 700 MASON HEADLEY ROAD LEXINGTON, KY 40504
---	--

(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 520 Continued From page 18

developed and monitored the implementation of CQI plans to ensure compliance with the requirements of federal, state, and local regulatory agencies, and included on-going surveillance to assess compliance with chart audit guidelines.

1. Review of the facility's POC for the 09/26/13 Recertification Survey for F157, Notification of Change, compliance date of 10/21/13, revealed staff were re-educated on appropriate communication regarding Physician notification and proper documentation related to significant changes. Continued review of the POC revealed the facility's monitoring process included the maintenance of a log as an audit tool to identify residents who had significant changes, which included verification the Physician was notified. The POC revealed the results of the audits would be discussed at the monthly CQI Committee meetings.

However, review Resident #6's medical record, during the current Recertification Survey, revealed the November 2014 Monthly Physician's Orders included an order to perform Accuchecks on Resident #6 four (4) times a day and if the results were greater than two-hundred and fifty (250) staff were to call the Physician. Review of the November 2014 documentation of Resident #6's fingerstick blood sugars (Accuchecks) results revealed multiple episodes when the fingerstick blood sugar (FSBS) was greater than 250. Further review of Resident #6's medical record revealed no documented evidence the Physician or the Advanced Practice Registered Nurse (APRN) were contacted when Resident #6's FSBS results were greater than 250 as per the Physician's Orders.

F 520

Random daily audits were initiated using the Handwashing Procedure Checklist (Exhibit F) on 12/09/2014 by the Unit Coordinators and House Supervisors daily, including weekends, to observe direct care staff for proper hand hygiene, including changing gloves when moving from an area where there are body fluids or a contaminated body site to a clean body site. These audits will be conducted daily for a minimum of six (6) weeks. Concerns identified during these audits will be corrected immediately.

The DON will review these audits & their accompanying corrective action weekly to ensure appropriate follow up has been implemented as indicated based on audit findings. The DON will continue to review & update the monthly Infection Control Log (Exhibit P) for any noted trends. The results of these weekly audits & results of the Infection Control Logs will be reported by the DON to the QAPI Committee, which includes but is not limited to the Administrator, Director of Nursing, Medical Director and Pharmacy

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

PRINTED: 12/08/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185160	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  11/20/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  LEXINGTON COUNTRY PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 700 MASON HEADLEY ROAD LEXINGTON, KY 40504
---	--

(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 520 Continued From page 19

Interview with Licensed Practical Nurse (LPN) #2, on 11/19/14 at 4:35 PM, and LPN #6 on 11/19/14 at 5:02 PM, revealed they had not always contacted the Physician or APRN when Resident #6's FSBS were above 250 as ordered.

Interview with the Director of Nursing (DON) on 11/20/14 at 4:55 PM, revealed it was her expectation staff notified the Physician of the FSBS results as per the orders.

2. Continued review of the facility's POC for F280, Care Plan Review and Revised, with the compliance date of 10/21/13, revealed staff were educated on care planning and ensuring revising and updating of residents' care plans. Continued review of the POC revealed the facility was to monitor its compliance by: performing care plan audits; presenting the findings at the monthly CQI Committee meetings; and additional action plans developed if problems were identified.

However, review of Resident #5's medical record revealed the resident had a Physician's Order to wear heel protector boots at all times. Resident #5's Comprehensive Care Plan included a care plan related to skin integrity with an intervention to ensure provision of redistribution products, such as, the heel protector boots as ordered.

Observations of Resident #5 on 11/18/14 at 12:28 PM and 5:36 PM, and on 11/19/14 at 10:51 AM, 11:11 AM, and 2:10 PM revealed the resident not wearing the heel protector boots at all times as per the care plan.

Interview with Registered Nurse (RN) #1 on 11/20/14 at 12:16 PM, revealed Resident #6 wore

F 520

Consultant monthly. Further action and or education will be implemented based on identified trends & Committee direction.

Completion Date: 12/19/2014

FS20

Facility Department Managers, including the Executive Director, Administrator, DON, Medical Records consultant, Social Service Director, Director of Maintenance, Wound Care Nurse, Nursing Unit Coordinators, MDS Nurses, Human Resource Director, Billing Office Manager, Food and Beverage Director, Marketing Liaison, Medical Records Assistant and Housekeeping Director were re-educated by the Director of Quality Assurance and Performance Improvement on 12/04/2014. Areas covered during this re-education included an overview of the facility's QAPI policy; including the five elements of QAPI, QAPI participant's roles,

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

PRINTED: 12/08/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185160	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  11/20/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  LEXINGTON COUNTRY PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 700 MASON HEADLEY ROAD LEXINGTON, KY 40504
---	--

(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 520 Continued From page 20  
the heel protector boots only about fifty percent of the time when he/she was up out of bed. RN #1 stated the care plan should have been revised/updated to address Resident #5's heel boot non-compliance and had interventions such as educating the resident or encouraging him/her to use the boots.

Interview with MDS Coordinator #1 on 11/20/14 at 2:44 PM, revealed she was not made aware of Resident #5's non-compliance with wearing the heel protector boots. The MDS Coordinator revealed Resident #5's care plan was supposed to be updated based on the cause of his/her non-compliance, and appropriate interventions implemented.

Continued interview with the DON on 11/20/14 at 4:55 PM, revealed Resident #5's care plan should have been revised to include the resident's non-compliance with the heel protector boots, and interventions implemented to address this.

3. Review of the facility's POC for F441, Infection Control, compliance date of 03/03/14, revealed staff were re-educated on the facility's infection control practices and topics covered included handwashing, the proper use of disinfectants, antiseptics, and germicides. The POC revealed to ensure sustained compliance the facility was: conducting audits of environmental cleanliness on a weekly basis; completing clinical competency assessments on randomly selected nursing staff; clinical competency assessment results forwarded to the DON; and results of all audits and competencies discussed at the monthly CQI Committee meetings.

(a) However, the product label instructions for the

F 520 responsibilities & reporting criteria, how to identify potential areas for improvement, initiating performance improvement projects/ action plans, analysis of data collected & using this information to develop quality improvement action plans.

The facility joined a regional, quality improvement initiative with atom Alliance National Nursing Home Quality Care Collaborative (NNHQCC) on 11/06/2014. Facility leadership has committed to remain active in the collaborative through September 30, 2016. Through this initiative the facility has formed an interdisciplinary team, including but not limited to the Administrator, DON, QAPI Co-chairs, MDS nurses, Unit Coordinators, Medical Director, & direct care staff, to work with atom Alliance on systems

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

PRINTED: 12/08/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185160	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  11/20/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  LEXINGTON COUNTRY PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 700 MASON HEADLEY ROAD LEXINGTON, KY 40504
---	--

(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 520 Continued From page 21

disinfectant wipe utilized by the facility for disinfecting blood glucose meters between residents, Sani-Cloth Bleach Wipes, revealed when the product was used the surface on which it was used was to remain visibly wet for a full four (4) minutes. Further review of the instructions revealed to use an additional wipe if needed to assure continuous wet contact time for the four (4) minutes, then allow the surface to air dry.

Observation during a glucose monitoring procedure on 11/19/14 at 4:02 PM, revealed the staff person wiped the glucose meter with a Sani-Cloth Bleach wipe, and placed the meter on a paper towel to air dry for four (4) minutes; however did not ensure the meter remained visibly wet for the four (4) minutes indicated on the product label.

Interview with Licensed Practical Nurse (LPN) #6 on 11/19/14 at 4:25 PM, LPN #7 on 11/19/14 at 5:35 PM, LPN #1 on 11/19/14 at 5:40 PM and RN #3 on 11/19/14 at 5:40 PM, revealed they all were not aware the product manufacturer recommended the product to remain visibly wet on the surface being disinfected for four (4) minutes to ensure the disinfection of the surface of the blood glucose meters.

Interview with the DON, who was also the Infection Control Nurse (ICN), on 11/20/14 at 11:05 AM, revealed the facility's procedure was to utilize a Sani-Cloth Bleach Wipe on the blood glucose meters, and allow the meter to air dry for four (4) minutes. The DON/ICN indicated being unaware of the product manufacturer's recommended four (4) minute visibly wet "kill time".

F 520 impacting quality of care & to improve the facility's systems of care in areas that are identified for improvement. These reviews will come from many sources including the facility's Pharmacy Consultant, Regional Director of Health visits, Medical Records Consultant visits, & areas identified by the facility's QAPI action teams. The facility will use identified areas from these reports to develop action plans to achieve NNHC objectives & to improve the facility's own performance improvement projects.

The Administrator, Executive Director and Director of Nursing have identified the need for an RN Staff Development Coordinator with experience teaching adults. The new Staff Development

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

PRINTED: 12/08/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185160	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  11/20/2014
NAME OF PROVIDER OR SUPPLIER  LEXINGTON COUNTRY PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 700 MASON HEADLEY ROAD LEXINGTON, KY 40504		
(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 520	<p>Continued From page 22</p> <p>(b) Observation of Resident #5's skin assessment by LPN #4/Wound Treatment Nurse on 11/20/14 at 9:35 AM, revealed he assessed the resident's perineal area and then without removing the contaminated gloves, washing his hands and donning new gloves assessed his/her upper front chest area.</p> <p>Interview with Wound Treatment Nurse/LPN #4 on 11/20/14 at 10:46 AM, revealed he was supposed to remove the contaminated gloves, wash his hands and put on new gloves after assessing the perineal area prior to moving to clean areas of the resident's body.</p> <p>Continued interview with the DON/ICN on 11/20/14 at 2:48 PM, revealed the nurse should have removed the contaminated gloves, washed or sanitized his hands and donned new gloves when he went from a dirty area to a clean area because of the risk of cross contamination.</p> <p>4. Review of the facility's POC for F520, Quality Assessment and Assurance, compliance date of 03/03/14, revealed the Department Managers, including the Administrator, Executive Director, DON, Staff Development Coordinator, Unit Coordinators, MDS Nurses, Treatment Nurse, Social Services, Director of Environmental Services and Activities Director were re-educated on the components of an effective Quality Assurance/Quality Improvement Program. The education included: the intent of the F520 regulation; responsibilities of the QI (Quality Improvement) Committee; how to identify areas appropriate for QI review; and implementation of a Quality Improvement Action Plan. Further review of the POC revealed the facility planned to</p>	F 520	<p>Coordinator will play an active role in educating new hires and current staff members as improvement opportunities are identified through the facility's QAPI program &amp; through identified best practices &amp; lessons learned through participation with the NNHQCC.</p>	

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

PRINTED: 12/08/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185160	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  11/20/2014
NAME OF PROVIDER OR SUPPLIER  LEXINGTON COUNTRY PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 700 MASON HEADLEY ROAD LEXINGTON, KY 40504	

(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 520 Continued From page 23  
monitor its performance by reviewing the action plans implemented monthly at the CQI Committee meetings to ensure the effectiveness of the systems in place.

Interview with the Administrator and Regional Nurse Consultant (RNC) on 11/20/14 at 5:29 PM, revealed the Administrator was not in her current position when the POC was implemented for the Recertification Survey and subsequent Revisit Surveys. The RNC revealed the facility changed their Quality Assurance (QA) process, in August or September 2014. Per interview, the facility moved from just fixing a specific problem by putting interventions in place, and auditing the results to implementing a change in culture by incorporating a Quality Assurance/Performance Improvement (QA/PI) system whereby, the facility identified the root cause of the problem. The RNC further revealed in looking at the last four (4) years of survey results the facility had identified a trend of deficiencies in the following areas: Infection Control, Physician Notification and Care Plans. Per the RNC, the facility's CQI Committee had realized the audits/monitors weren't effective because the root cause was never identified. The RNC stated they concluded the root cause involved staff training and education and the follow-up monitoring processes and looking at how to solve the problems. Further interview with the RNC revealed the facility felt it was important to provide education to staff which allowed them to better understand the facility's processes, and were trying to hire a RN with prior experience in educating adults. In addition, she revealed the facility were going to get MDS nurses additional education and credentialed for MDS. The RNC indicated through the move to the QA/PI system the facility felt it would be able to address

F 520 How will the facility monitor its performance to ensure solutions are sustained?

Quality Improvement Action Plans for Identified areas will be reviewed weekly in team meetings that include, but are not limited to, the Administrator, DON, QAPI co-Chairs, the action team leader and direct care staff as indicated.

The results of these weekly action plan meetings will be reported by the action team leader to the QAPI Committee, which includes but is not limited to the Administrator, Director of Nursing, Medical Director and Pharmacy Consultant monthly. Further action and or education to address the improvement area will be implemented based on identified trends & Committee direction.

Completion Date: 12/19/2014

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

PRINTED: 12/08/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185160	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  11/20/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  LEXINGTON COUNTRY PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 700 MASON HEADLEY ROAD LEXINGTON, KY 40504
---	--

(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 520	Continued From page 24 deficiencies cited and ensure ongoing compliance was maintained.
-------	---

F 520

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185180	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  11/19/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  LEXINGTON COUNTRY PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 700 MASON HEADLEY ROAD LEXINGTON, KY 40504
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

K 000	INITIAL COMMENTS  CFR: 42 CFR 483.70(a) Building: 01 Plan Approval: 1980 Survey under: NFPA 101 (2000 edition) Facility type: SNF/NF Type of structure: III (000) Smoke Compartment: Seven (7) Fire Alarm: Complete fire alarm with smoke detectors in resident rooms and at smoke barriers. Sprinkler System: Complete sprinkler system two (2) wet and three (3) dry systems. Generator: Type II diesel installed in 1986 A standard Life Safety Code survey was conducted on 11/19/14. Lexington Country Place was found to not be in compliance with the requirements for participation in Medicare and Medicaid. The census the day of the survey was eighty nine (89). The facility is licensed for one hundred ten (110). The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire) with the highest scope and severity (S/S) of a "D".	K 000		
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1	K 038	The following constitutes Lexington Country Place's plan of correction for the deficiencies cited and will serve as the facility's credible allegation that substantial compliance will be achieved by December 19, 2014. The submission of this plan of correction is not an admission on the part of the facility necessarily agrees with the accuracy of the surveyor's findings. Rather, it is being submitted as required by law.	



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <i>Aina W. Smith</i>	TITLE  N/A	(X6) DATE  12-17-14
---	------------------	---------------------------

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185160	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____		(X3) DATE SURVEY COMPLETED  11/19/2014
NAME OF PROVIDER OR SUPPLIER  LEXINGTON COUNTRY PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 700 MASON HEADLEY ROAD LEXINGTON, KY 40504		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 038	<p>Continued From page 1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exit egress was maintained according to National Fire Protection Associations (NFPA) standards. The deficiency had the potential to affect one (1) of seven (7) smoke compartments.</p> <p>The findings included:</p> <p>Observation on 11/19/2014 at 12:51 PM, revealed the Kitchen Door that staff used was equipped with a double lock. Interview, with the Maintenance Director, revealed he was not aware double locks could not be used on doors in the facility.</p> <p>Observation on 11/19/2014 at 12:01 PM, with the Maintenance Director, revealed a storage room on the Rehabilitation to Home wing had a door that projected into the corridor ten (10) inches in the fully open position. Interview, with the Maintenance Director, revealed he was not aware the door projected into the corridor enough to be an issue with egress.</p> <p>The findings were acknowledged by the Administrator during the exit conference.</p> <p>Reference: NFPA 101 (2000 Edition)</p> <p>7.2.1.5.4* A latch or other fastening device on a door shall be provided with a releasing device having an obvious method of operation and that is readily operated under all lighting conditions. The releasing mechanism for any latch shall be</p>	K 038	<p><b>K038</b></p> <p>The double lock on the kitchen door was removed by a Maintenance staff member on 11/20/2014.</p> <p>To prevent reoccurrence the Maintenance Director on 12/11/2014 audited (<b>Exhibit A</b>) all other doors to ensure they were not equipped with a double lock. No other doors found to contain the double lock.</p> <p>The Maintenance staff installed a spring hinge on the storage room door 11/20/2014 to ensure the door would stay closed when not in use.</p> <p>To prevent reoccurrence the Maintenance Director audited on 12/11/2014 the interior doors (<b>Exhibit B</b>) to make sure they did not protrude into the hallway more than the ten (10) inches in the fully open position. Any concerns were fixed immediately.</p> <p>Date of Completion: 12/19/2014</p>	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185160	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  11/19/2014
NAME OF PROVIDER OR SUPPLIER  LEXINGTON COUNTRY PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 700 MASON HEADLEY ROAD LEXINGTON, KY 40504	
(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)

K 038 Continued From page 2

located not less than 34 in. (86 cm), and not more than 48 in. (122 cm), above the finished floor. Doors shall be operable with not more than one releasing operation.

Exception No. 1:\* Egress doors from individual living units and guest rooms of residential occupancies shall be permitted to be provided with devices that require not more than one additional releasing operation, provided that such device is operable from the inside without the use of a key or tool and is mounted at a height not exceeding 48 in. (122 cm) above the finished floor. Existing security devices shall be permitted to have two additional releasing operations. Existing security devices other than automatic latching devices shall not be located more than 60 in. (152 cm) above the finished floor. Automatic latching devices shall not be located more than 48 in. (122 cm) above the finished floor.

Exception No. 2: The minimum mounting height for the releasing mechanism shall not be applicable to existing installations.

7.2.1.4.4\* During its swing, any door in a means of egress shall leave not less than one-half of the required width of an aisle, corridor, passageway, or landing unobstructed and shall not project more than 7 in. (17.8 cm) into the required width of an aisle, corridor, passageway, or landing, when fully open. Doors shall not open directly onto a stair without a landing. The landing shall have a width not less than the width of the door. (See 7.2.1.3.) Exception: In existing buildings, a door providing access to a stair shall not be required to maintain any minimum unobstructed width during its swing, provided that it

K 038

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185160	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____		(X3) DATE SURVEY COMPLETED  11/19/2014
NAME OF PROVIDER OR SUPPLIER  LEXINGTON COUNTRY PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 700 MASON HEADLEY ROAD LEXINGTON, KY 40504		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 062 SS=D	<p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.8.12, 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 automatic sprinkler systems were maintained according to National Fire Protection Association standards. The deficiency had the potential to affect one (1) of seven (7) smoke compartments, twenty (20) residents, staff and visitors.</p> <p>The findings included:</p> <p>Observation on 11/19/2014 at 10:58 AM, with the Maintenance Director, revealed a light fixture in Housekeeping that extended below the automatic sprinkler head that was located less than one (1) foot away.</p> <p>Observation on 11/19/2014 at 12:46 AM, with the Maintenance Director, revealed two (2) light fixtures in the Pantry Room that extended below the automatic sprinkler heads that were located less than one (1) foot away from each light fixture.</p> <p>Observation on 11/19/2014 at 12:48 AM, with the Maintenance Director, revealed a light fixture in the Diet Aid Room that extended below the automatic sprinkler head that was located less than one (1) foot away.</p>	K 062	<p><b>K062</b></p> <p>The Maintenance Director has received a requisition from a contractor to permanently relocate the sprinkler heads to ensure a further distance from the light fixtures. A fire watch was conducted and the Maintenance Director and his staff on 12/15/2014 temporarily moved all light fixtures that may have been within less than one (1) foot from the sprinkler head.</p> <p>The Maintenance Director on 11/21/14 audited (Exhibit C) Sprinkler Heads throughout the facility to ensure all sprinkler heads within less than one (1) foot were identified so that they also can be relocated.</p>	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185100	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  11/19/2014
NAME OF PROVIDER OR SUPPLIER  LEXINGTON COUNTRY PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 700 MASON HEADLEY ROAD LEXINGTON, KY 40504	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (X5) COMPLETION DATE
K 062	<p>Continued From page 4</p> <p>Observation on 11/19/2014 at 1:37 PM, with the Maintenance Director, revealed four (4) light fixtures in Rehabilitation that extended below the automatic sprinkler head that was located less than one (1) foot away.</p> <p>Interview on 11/19/2014 at 10:58 AM, with the Maintenance Director, revealed he was not aware any light fixtures were located to close to sprinkler heads.</p> <p>Observation on 11/19/2014 at 1:27 PM, with the Maintenance Director, revealed Riser #1 and Riser #2 for the automatic sprinkler system did not have placards identifying the risers has valves for the automatic sprinkler system. Interview, with the Maintenance Director, revealed he was not aware the plates were missing and relied on an outside contractor to ensure the automatic sprinkler system was maintained according to NFPA standards.</p> <p>The findings were acknowledged by the Administrator during the exit conference.</p> <p>Reference: NFPA 13 (1999 Edition)</p> <p>5-5.5.2.2 Sprinklers shall be positioned in accordance with the minimum distances and special exceptions of Sections 5-6 through 5-11 so that they are located sufficiently away from obstructions such as truss webs and chords, pipes, columns, and fixtures.</p> <p>Table 5-6.5.1.2 Positioning of Sprinklers to Avoid Obstructions to Discharge (SSU/SSP)</p>	K 062	<p>Riser one (1) and Riser two (2) did not display placards identifying that the Risers have valves for the automatic sprinkler systems. On 12/10/14 the Maintenance Director installed the appropriate play cards on Riser #1 and #2.</p> <p>Maintenance Director audited risers for placard placement on 12/11/2014 (Exhibit D). The Maintenance Director or Designee will audit Risers (Exhibit D) to ensure placards are in place monthly beginning in January x 3 months then annually.</p> <p>Maintenance Director will report findings from monthly audit at the monthly CQI (Administrator, Director of Nursing, Medical Director, and other team members as needed) meeting for review.</p> <p>Date of Completion: 12/19/2014</p>

PRINTED: 12/08/2014  
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:  185160	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  11/19/2014
NAME OF PROVIDER OR SUPPLIER  LEXINGTON COUNTRY PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 700 MASON HEADLEY ROAD LEXINGTON, KY 40504	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (X5) COMPLETION DATE
K 062	Continued From page 5  Maximum Allowable Distance of Distance from Sprinklers to Deflector above Bottom of Side of Obstruction (A) Obstruction (in.) (B) Less than 1 ft 0 1 ft to less than 1 ft 6 in. 2 1/2 1 ft 6 in. to less than 2 ft 3 1/2 2 ft to less than 2 ft 6 in. 5 1/2 2 ft 6 in. to less than 3 ft 7 1/2 3 ft to less than 3 ft 6 in. 9 1/2 3 ft 6 in. to less than 4 ft 12 4 ft to less than 4 ft 6 in. 14 4 ft 6 in. to less than 5 ft 16 1/2 5 ft and greater 18  For SI units, 1 in. = 25.4 mm; 1 ft = 0.3048 m. Note: For (A) and (B), refer to Figure 5-6.5.1.2(a).  Reference: NFPA 25 ( 1998 Edition) 9-3.2* Each control valve shall be identified and have a sign indicating the system or portion of the system it controls.  K 147 NFPA 101 LIFE SAFETY CODE STANDARD SS=D	K 062	

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

PRINTED: 12/08/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185160	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  11/19/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  LEXINGTON COUNTRY PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 700 MASON HEADLEY ROAD LEXINGTON, KY 40504
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

K 147	<p>Continued From page 6</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 an electrical outlet was maintained according to National Fire Protection Associations (NFPA) standards. The deficiency had the potential to affect one (1) of seven (7) smoke compartments, one (1) resident and two (2) staff.</p> <p>The findings included:</p> <p>Observation on 11/19/2014 at 11:03 AM, with the Maintenance Director, revealed one (1) electrical plug in the Magnolia Shower Room which was not on a Ground Fault Circuit Interrupter (GFCI). Interview, with the Maintenance Director, revealed he believed the electrical plug was already on a GFCI and was unaware it was lacking the required GFCI.</p> <p>The findings were acknowledged by the Administrator during the exit conference.</p> <p>Reference: NFPA 70 ( 1999 Edition)</p> <p>517-20. Wet Locations. (a) All receptacles and fixed equipment within the area of the wet location shall have ground-fault circuit-interrupter protection for personnel if interruption of power under fault conditions can be tolerated, or be served by an isolated power</p>	K 147	<p><b>K147</b></p> <p>On 11/20/2014 the maintenance staff installed a GFCI circuit on Unit II in the shower room.</p> <p>The Maintenance Director on 11/20/14 audited (<b>Exhibit E</b>) all other shower rooms to ensure they contained the proper GFCI circuit. No other concerns noted.</p> <p>Date of Completion: 12/19/2014</p>	
-------	---	-------	--	--

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

PRINTED: 12/08/2014  
FORM APPROVED  
OMB NO. 0938-0301

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185160	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  11/19/2014
NAME OF PROVIDER OR SUPPLIER  LEXINGTON COUNTRY PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 700 MASON HEADLEY ROAD LEXINGTON, KY 40504	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (X5) COMPLETION DATE
K 147  K 154 SS=D	<p>Continued From page 7</p> <p>system if such interruption cannot be tolerated.</p> <p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure a fire watch was established when fire safety features are effected for longer than four (4) hours in a twenty four (24) hour period. The deficiency had the potential to affect two (2) of seven (7) smoke compartments, forty (40) residents, staff and visitors.</p> <p>The findings included:</p> <p>Observation on 11/19/2014 at 12:01 PM, with the Maintenance Director, revealed ongoing construction in the Rehabilitation to Home Wing. Smoke Detector heads in the area were being protected from dust by covers which made the smoke detectors unable to sense smoke. Further observation revealed the automatic sprinkler system had been removed from the construction area. Interview, with the Maintenance Director, revealed a fire watch system was not being</p>	K 147  K 154	<p><b>K154</b></p> <p>A fire watch for rooms 300-304 (unoccupied) was immediately started on 11/19/2014 and continued until 11/20/14 when the automatic sprinkler system was placed back online.</p> <p>Staff were re-educated on 11/19/2014 regarding the Fire Watch and Safety. Information included, but was not limited to the purpose of the watch, how the fire watch works and when there is a need for a fire watch.</p> <p>To prevent reoccurrence staff were educated to notify Administrator/Executive Director or Maintenance Director in the event that the sprinkler system or fire alarm system is offline for more than 4 hours in a 24 hour period.</p>

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

PRINTED: 12/08/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185160	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  11/19/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  LEXINGTON COUNTRY PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 700 MASON HEADLEY ROAD LEXINGTON, KY 40504
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

K 154

Continued From page 8

performed. Further interview revealed when the fire alarm system and the sprinkler system were taken out of service a fire watch was established but since the rest of the buildings fire alarm and sprinkler system was operational the facility did not think a fire watch was required.

Interview on 11/19/2014 at 12:03 PM, with the Administrator, reveled the facility had documentation that a fire watch had been performed when the fire alarm and the automatic sprinkler systems were completely taken out of service, but thought the fire watch was no longer required in the construction area due to the rest of the buildings fire alarm and automatic sprinkler systems being operational.

Observation on 11/19/2014 at 1:30 PM, with the Maintenance Director, revealed a total of seven (7) ceiling tiles missing from the suspended ceiling in the Basement. Interview, with the Maintenance Director, revealed he was not aware the missing tiles would affect the activation of the automatic sprinkler heads in the Basement area. Further interview, revealed the ceiling tiles had been missing for a few months.

The findings were acknowledged by the Administrator during the exit conference.

References: NFPA 101 (2000 Edition)

4.6.10.1\* Buildings or portions of buildings shall be permitted to be occupied during construction, repair, alterations, or additions only where required means of egress and required fire protection features are in place and continuously maintained for the portion occupied or where

K 154

Seven (7) ceiling tiles were replaced on 12/10/14 by Maintenance staff. The Maintenance Staff audited (Exhibit F) all other ceiling tiles in the basement on 12/11/2014 to ensure they were in place.

The Maintenance staff will ensure that any future repairs that may require removal of ceiling tiles will be replaced immediately after repair. In-service started 12/11/2014 with Maintenance staff and has been completed.

The Maintenance Director, Housekeeping Director, Executive Director or Administrator will do monthly rounds to monitor the property for missing ceiling tiles. Any concerns will be brought to the monthly CQI meeting.

Completion Date: 12/19/2014

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

PRINTED: 12/08/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185180	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  11/19/2014
NAME OF PROVIDER OR SUPPLIER  LEXINGTON COUNTRY PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 700 MASON HEADLEY ROAD LEXINGTON, KY 40504	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 154	Continued From page 9 alternative life safety measures acceptable to the authority having jurisdiction are in place.  9.6.1.8* Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.7.6.1 Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service.	K 154		
K 211 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor: o The corridor is at least 6 feet wide o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) o The dispensers have a minimum spacing of 4 ft from each other o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. o Dispensers are not installed over or adjacent to an ignition source. o If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623	K 211	<b>K211</b>  The hand sanitizer dispenser was removed by Maintenance staff on 11/20/2014 and relocated.  The Maintenance staff audited ( <b>Exhibit G</b> ) all hand sanitizer dispensers to ensure proper placement for resident and staff safety. There were no concerns noted.  The Maintenance staffs were re-educated on 12/11/2014 regarding the proper placement of hand sanitizer dispensers in relation to electrical outlets.  Completion Date: 12/19/2014	

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

PRINTED: 12/08/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185160	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____		(X3) DATE SURVEY COMPLETED  11/19/2014
NAME OF PROVIDER OR SUPPLIER  LEXINGTON COUNTRY PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 700 MASON HEADLEY ROAD LEXINGTON, KY 40504		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 211	Continued From page 10  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure Alcohol Hand Sanitizers were installed according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of seven (7) smoke compartments, twenty (20) residents, staff and visitors.  The findings included:  Observation on 11/19/2014 at 11:27 AM, with the Maintenance Director, revealed one (1) Alcohol Hand Sanitizer was mounted directly above an electrical plug. Interview, with the Maintenance Director, revealed he did not know that the Alcohol Hand Sanitizer had been placed above the electrical plug but was aware this was not permitted by the code.  The findings were acknowledged by the Administrator during the exit conference.	K 211		