STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185197	A. Building B. Wing	08/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northpoint/Lexington Healthcare Center	1500 Trent Boulevard Lexington, KY 40515

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44000 Based on interview, record review, and review of the facility's policies, the facility failed to administer prescribed pain medications timely for 1 of 2 sampled residents, Resident (R) 124. R124 returned to the facility on [DATE] at 12:30 PM, and orders were written for Oxycodone 5 milligrams (mg) every 12 hours as needed (an opioid pain medication) and Oxycodone 15 mg every six hours, for R124's fracture of the right and left femur. Observations and interviews revealed two Oxycodone 5 mg and two Oxycodone 5 mg/325 mg acetaminophen (a non-narcotic pain medication) were available in the medication emergency box, however, staff were unaware the medications were available to the resident. In addition, R124 first expressed pain to staff on 03/01/2024 at 3:10 PM. However, R124 did not receive Oxycodone until 03/02/2024 at 12:00 PM, approximately 21 hours after R124 had pain documented. (Cross Reference F656) The findings include: Review of the facility's policy titled, Ordering and Receiving Controlled Medications, dated 01/2023, revealed in an emergency situation, verbal authorization could be given by the prescriber to the pharmacist for a new order. Review of the facility's policy titled, Medication Administration, revised 01/17/2023, revealed medications were administered by licensed nurses, or other staff who were legally authorized to do so, as ordered by the physician and in accordance with professional standards of practice. Review of R124's Facesheet revealed the facility readmitted the resident on 03/01/2024 at 12:30 PM from the hospital, with diagnoses of new fracture of the right and left femur (upper leg), not requiring surgery. Review of R124's quarterly Minimum Data Set (MDS), with an assessment reference date (ARD) of 03/08/2024, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 15 of 15, indicating the resident was cognitively intact. Review of the Physician's Orders revealed Oxycodone 5 mg every 12 hours as needed for pain was ordered on 03/01/2024 at 2:00 PM. Oxycodone 15 mg scheduled every six hours was ordered on 03/02/2024 at 4:52 AM. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Review of R124's Medication Administration Record (MAR) revealed R124 received 15 mg of Oxycodone on 03/02/2024 at 12:00 PM and 6:00 PM and 5 mg of Oxycodone on 03/02/2024 at 9:15 PM. Further review revealed R124 did not receive Oxycodone 5 mg PRN for pain on 03/01/2024 at 3:10 PM; on 03/02/2024 at 9:49 AM; on 03/02/2024 at 1:24 PM; and on 03/02/2024 at 5:40 PM. Review of Resident 124's pain scores, on a scale of 0 to 10, with 10 being the highest, revealed on 03/01/2024 at 3:10 PM, the pain score was 5/10; on 03/02/2024 at 9:49 AM, the pain score was 8/10; on 03/02/2024 at 1:24 PM, the pain score was 8/10; and on 03/02/2024 at 5:40 PM, the pain score was 5/10. During interview with R124 at the time of the observation, she stated she was a nurse and had worked at several places. She stated she had experienced back pain all her life, and she had been receiving pain medication for a long time. She stated sometimes when she came back from the hospital, it might take 24 hours before she received any pain medication. She stated this happened four months ago. She further stated she did not remember being offered an as needed Oxycodone and was in a lot of pain. The resident stated she could not remember the 03/01/2024 incident off hand. However, when asked specific questions about the incident she stated during that time the pain was sharp, hitting the muscles. She said she did not get to sleep until 2:00 AM. During interview with Registered Nurse (RN) 4 on 08/14/2024 at 9:29 AM, she stated she did not remember the incident that occurred on 03/01/2024. Review of the schedule for 03/01/2024 revealed RN4 was the nurse who admitted R124. When specifically asked if she remembered the resident being in extreme pain, she said she did not think so. When asked if there was pain medication available in the emergency medication box, she stated she did not know. She stated in the admission process for a resident, she received a discharge summary that listed the medications. She stated she called the provider and went over the list of medications from the hospital, and she reviewed them with the provider. She stated, for a controlled medication, the process was filling out a prescription request form, and faxing the form to the provider's office. She stated the hospital sometimes sent the prescription request form. During interview with the provider's Office Manager on 08/14/2024 at 1:56 PM, she stated she reviewed the office records, and they did not receive any prescription faxes on 03/01/2024. She stated, on 03/02/2024 at 6:29 AM the Advanced Practice Registered Nurse (APRN) requested six Oxycodone 5 mg tablets, and a nurse from the facility called the office at 9:50 AM requesting the medication be shipped immediately. The Office Manager also stated Oxycodone 5 mg was shipped at 10:38 AM, and the medication got to the facility at 1:09 PM on 03/02/2024. During interview with the Assistant Director of Nursing (ADON) on 08/14/2024 at 2:05 PM, she stated she expected the nursing staff to give pain medication when a resident was in pain. During interview with the Director of Nursing (DON) on 08/14/2024 at 2:16 PM, she stated she expected nursing staff to give pain medication when a resident was in pain. She stated a medication could be given from the emergency medication box if needed, and a prescription would need to be faxed to the pharmacy when the medication was used. She stated she was not sure if Oxycodone 5 mg was available in the emergency medication box. At the time of the interview, she checked the emergency medication box and stated Oxycodone 5 mg was available. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Review of the list of medications in the emergency medication box revealed the box contained Oxycodone 5 mg tablets and Oxycodone-acetaminophen 5-325 mg tablets. However, the sheet did not document how many tablets were in the box. During interview with the Pharmacist on 08/16/2024 at 3:12 PM, he stated the emergency medication box contained two Oxycodone 5 mg tablets and two Oxycodone-acetaminophen 5-325 mg tablets. During interview with the APRN on 08/15/2024 at 12:21 PM, she stated she did not remember the incident on 03/01/2024. She stated the process when a resident transferred from the hospital was to review the medications with the nurse. She stated the nurse then entered the orders in the computer, and pharmacy reviewed the orders and sent the medications. She stated she knew R124 had chronic pain. During interview with the Administrator on 08/15/2024 at 3:32 PM, she stated she expected staff to follow the facility's policies.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 28707 Based on interview, record review, review of the facility's Long-Term Care Facility Self-Reported Incident Form, and review of the facility's policy, the facility failed to provide pharmaceutical services to meet the needs of each resident for 1 of 32 sampled residents, Resident (R) 114. R114 did not receive medications as scheduled on 04/22/2024, although nursing staff had already signed that the medications were given. The findings include: Review of the facility's policy titled, Medication Administration, last revised 01/17/2023, revealed staff was expected to observe the resident's consumption of medications and sign the resident's Medication Administration Record (MAR) after medications were administered. Review of R114's Admission Facesheet revealed the facility admitted the resident on 09/28/2022 with diagnoses to include unspecified dementia, type 2 diabetes mellitus without complications, and peripheral vascular disease unspecified. Review of R114's quarterly Minimum Data Set (MDS), with an assessment reference date (ARD) of 01/30/2023, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of five of 15, indicating severe cognitive impairment. Review of R114's MAR for April 2024 revealed R114 had scheduled doses of Metformin 850 milligrams (lowered blood glucose levels), Prostat 30 milliliters (concentrated protein liquid), Protonix 40 milligrams (lowered levels of stomach acid), Xarelto 2.5 milligrams (prevented blood clots), and a blood glucose check scheduled for 6:00 PM. Review of R114's Long-Term Care Facility Self-Reported Incident Form, Initial Report, dated 04/22/2024, revealed on 04/20/2024 Family Member (F) 9 reported concerns related to R124's medication administration that occurred on the afternoon of 04/20/2024. Review of R114's Long-Term Care Facility Self-Reported Incident Form, Final Report, dated 04/26/2024, revealed F9 felt Licensed Practical Nurse (LPN) 7 was neglectful in her actions of not checking R114's blood sugar or administering his medications. Continued review revealed LPN7 realized when confronted that she had missed administering R114's medications and was apologetic to F9. Per the report, LPN7 alerted Registered Nurse (RN) 5 that R114's medications had not been administered, and RN5 administered R114's medications later than scheduled. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 08/16/2024 at 5:00 PM with LPN7, she stated she was in the process of preparing to administer medications to R114 when she got side-tracked with two other residents, one who was calling for help, and a second who asked for assistance after helping the first. She stated after she had given care to both of those residents, she started giving medications again. She stated she completely forgot to give R114 his medications until F9 came to RN5 and her around 7:15 PM. She stated she had previously filled out the MAR that she gave R114's medications, although staff was not supposed to do that. She stated that was not her normal practice, and she received education regarding proper medication administration. In an interview with RN5 on 08/16/2024 at 10:41 AM, she stated she came to work at 7:00 PM on 04/20/2024 to relieve LPN7 and had received report from LPN7. She stated as she was counting the medication cart, F9, who was visiting R114, approached her and told her R114 did not receive medications that were due. RN5 stated she confirmed with LPN7 that R114's medications were not given, obtained his vital signs, and administered his medications. R5 stated the MAR for R114's 6:00 PM medications had been checked off as given, and R114's blood sugar was checked off as well. RN5 stated F9 reported to her R114 had not received his 6:00 PM meds at 7:10 PM or 7:15 PM, and she administered them at 7:35 PM. Regarding the medications administered late, RN5 stated his Protonix 40 milligrams was the most important to be administered on time because R114 was having bad acid reflux during that time. Additionally, RN5 stated medications were normally signed out on the MAR after they had been administered to ensure the resident did not refuse any medications. She stated if LPN7 had followed procedure, she would have realized she had not given R114 his medications. In an interview with the Director of Nursing (DON) on 08/16/2024 at 2:37 PM, she stated it was her understanding R114 did not miss any medications on 04/20/2024 but did receive his medications late on that date. She stated LPN7 had gotten distracted, had not given his medications, and did not realize they had been missed until approached by F9. She stated R114's 6:00 PM medications were administered at 7:35 PM. She stated LPN7 was suspended and received reeducation prior to her return to work. She stated it was the facility's policy and her expectation that medications were not signed out as administered until they were administered, as doing so left a lot of room for medication errors. During interview with the Administrator on 08/15/2024 at 3:32 PM, she stated she expected staff to follow the facility's policies.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46710 Based on observation and interview, the facility failed to provide a safe environment for residents, staff, and the public for one of three resident care units. The findings include: Observation on 08/12/2024 at 4:06 PM revealed the [NAME] Hall was crowded with four wheelchairs folded up against the handrail on the right side of the hallway, across from a linen cart on the left side of the hallway. In an interview on 08/16/2024 at 10:58 AM, Registered Nurse (RN) 5 stated the hallways in the facility were frequently crowded with linen carts, medication carts, meal tray carts, and extra resident equipment, such as wheelchairs. She further stated the excess equipment created a safety issue for residents trying to maneuver the hallway, especially in an emergency. RN5 stated the residents' rooms were crowded and family members often asked for wheelchairs to be placed in the hallway due to a lack of space in the resident's room. In interview on 08/16/2024 at 1:56 PM, the [NAME] Unit Manager stated the hallways needed to be kept clear for safety in case of an emergency. She further stated that on 08/12/2024, the hallway was crowded because staff had washed the four wheelchairs, but they did not have residents' names on them, so the staff members did not know where to put them. The Unit Manager stated she instructed staff to take the wheelchairs down to the therapy department so residents could use them there and keep the upstairs hallway clear. Additionally, the Unit Manager stated her expectations were for staff to store wheelchairs folded up in the residents' rooms or folded up in the shower room if the shower room was not in use. In an interview on 08/16/2024 at 2:58 PM, the Director of Nursing (DON) stated the hallways were to be kept clear of excess equipment for resident safety. She further stated wheelchairs should have been stored in resident rooms. The DON stated she expected management staff to be present on the units and assist with keeping the hallways clear. Additionally, the DON stated the hallways tended to be more crowded during mealtimes when the tray carts were on the floor in addition to regular equipment. In an interview on 08/16/2024 at 3:21 PM, the Administrator stated she expected the hallways to remain free from excess equipment for resident safety in case of an emergency.