

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

PRINTED: 01/25/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185146	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  R 01/25/2016
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NAME OF PROVIDER OR SUPPLIER  FOUNTAIN CIRCLE CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 200 GLENWAY ROAD WINCHESTER, KY 40391
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{F 000}	INITIAL COMMENTS	{F 000}		
	<p>An offsite revisit was conducted, and based on the Acceptable Plan of Correction (POC), the facility was deemed to be in compliance on 12/19/15 as alleged.</p>			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE 01/13/2016
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000 INITIAL COMMENTS

F 000

F 241  
SS=E

483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY

F 241

F241

12-19-15

The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

1. On 11-18-15, Unit Manager changed the catheter bag on Resident #1 to the catheter bag that the facility uses and provided a cover for the catheter bag.

This REQUIREMENT is not met as evidenced by:  
Based on observation, interview, and record review, it was determined the facility failed to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality for one (1) of twenty four (24) sampled residents (Resident #15) and eight (8) unsampled residents, (Unsampled Residents A, B, C, D, E, F, G and H).

On 11-19-15, education was provided to srna #3 and srna #4 in regards to dignity and privacy with regards to knocking on residents' doors and asking permission to enter prior to entering a resident's room.

Observation revealed Resident #1's Foley catheter drainage bag was not covered with a dignity bag and could be seen from the hallway.

2. All residents with catheter bags were reviewed on 11/19/15 by Central Supply, Nursing Supervisor, Medical Records, or Signature Care Consultant to ensure resident's privacy and dignity was maintained. No further concerns were noted.

Observation further revealed the facility failed to ensure staff knocked on resident doors or gained permission to enter resident rooms for unsampled residents (A, B, C, D, E, F, G and H).

The findings include:

Interview on 11/19/15 at 4:55 PM, with the Administrator, revealed the facility had no policy

All residents with a BIMS of 8 or greater will be interviewed

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Debra M. Hudson</i>	TITLE Administrator	(X6) DATE 1/13/16
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F 241	<p>Continued From page 1</p> <p>related to dignity; however, she stated her expectation was for staff to treat the residents with dignity and to strive to provide the highest standard of care.</p> <p>1. Review of Resident #15's medical record revealed the facility admitted the resident on 10/10/15 with diagnoses including Coronary Artery Disease, Diabetes Mellitus, Hypertension, and Urinary Retention. Review of the Admission Minimum Data Set (MDS) Assessment dated 10/17/15 revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of thirteen (13) out of fifteen (15) indicating no cognitive impairment.</p> <p>Observation on 11/17/15 at 11:00 AM, of Resident #15, revealed the resident's Foley Catheter drainage bag was hanging on the side of his/her bed which faced the hallway and there was no dignity bag covering the urinary drainage bag, therefore the urine could be seen in the bag. Continued observation on 11/17/15 at 2:05 PM, revealed Resident #15's was in his/her room and the urinary drainage bag was connected to his/her wheelchair, facing the door way and the bag was uncovered allowing the urine to be seen. Further observations revealed on 11/18/15 at 8:55 AM, and 11/19/15 at 10:15 AM, the resident's urinary drainage bag was attached to his/her bed and was not covered with a dignity bag, and the urine in the bag could be seen from the hallway.</p> <p>Interview on 11/19/15 at 10:20 AM, with Resident #15, revealed he/she did not know the urinary drainage bag did not have a dignity cover and she/he would have preferred a dignity bag to cover the urinary drainage bag so people in the hall could not see the urine.</p>	F 241	<p>by 12/18/15 in regards to privacy and dignity and if they have any concerns. On 12/10/15, during a resident council meeting, residents were educated about dignity and privacy. Those residents with a BIMS of 7 or less will have an observation by a member of the management team, including but not limited to: Social Services, Central Supply, Nursing Supervisor, Medical Records, Business Office Manager, HR Director, Assistant Administrator, Director of Nursing, Administrator, Environmental Services, and Quality of Life Director to ensure that privacy and dignity are provided.</p> <p>3. Education with all staff started on 12/17/15 in regards to Resident Rights, including providing privacy - knock before entering resident rooms and dignity - ensuring catheter bag covers are in place to protect the resident. Education was provided by Staff Development Coordinator, Director of Nursing, HR Director, Administrator,</p>		

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F 241	Continued From page 2  Interview on 11/19/15 at 3:38 PM, with Registered Nurse (RN) #1, revealed when a resident comes from the hospital with a catheter urinary drainage bag the facility was to change out the system with one of their bags that had a dignity bag. Continued interview with RN #1, revealed she did not realize the bag was not changed out. She stated this was a dignity concern and it was the resident's right to have his/her dignity protected.  Interview on 11/19/15 at 3:55 PM, with the Nurse Unit Manager of the A Wing and the Rehabilitation Unit, revealed all Foley catheter bags were changed out during the admission process to the facility. Continued interview revealed all staff were aware they were to change out the system and the resident's dignity should have been preserved.  2. Observation on 11/17/15, from 12:30 PM until 12:41 PM, of the lunch meal service revealed lunch trays were being delivered to resident rooms on the Rehabilitation and A Hall. SRNA #3 was observed to enter Unsamped Resident's A, D, and F's rooms without knocking or gaining permission to enter. Continued observation revealed SRNA #4 entered Unsamped Resident's B, C, and E's rooms without knocking or gaining permission to enter.  Observation on 11/18/15, from 12:30 PM until 12:43 PM, of the lunch meal service revealed lunch trays were being delivered to resident rooms on the Rehabilitation and A Hall. SRNA #3 was observed to enter Unsamped Resident A, D, F, and G's rooms without knocking or gaining permission to enter. Continued observation revealed SRNA #4 entered Unsamped B, C, E,	F 241	Assistant Administrator, Quality of Life Director, Dietary Director, QA Nurse, Nursing Supervisor, Environmental Services Director, Medical Records Director, Rehab Services Manager, Business Office Manager, VP of Operations, or Signature Care Consulting team. Education was completed by 12/18/15, and certified letters were sent out to those who had not received the education, on leave of absence, or on vacation. Agency staff will receive the education from their supervisor prior to working at our facility. All new hires will receive the education in orientation.  4. A member of the management team, including but not limited to Chaplain, Quality of Life, Environmental Services, HR Director, Social Services, Administrator, Assistant Administrator, Nursing Supervisor, Medical Records, Dietary Director, or Central Supply will conduct an audit daily to observe how staff are entering resident rooms to	
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F 241	<p>Continued From page 3</p> <p>and H's rooms without knocking or gaining permission to enter.</p> <p>Review of Unsampled Resident H's medical record revealed the facility admitted the resident on 06/22/15 with diagnoses which included, End Stage Renal Disease, and Acute Pulmonary Edema. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 10/21/15, revealed the facility assessed the resident as having a Brief Interview for Mental Status of a fifteen (15) out of fifteen (15) indicating no cognitive impairment. Interview on 11/19/15 at 12:45 PM, with Unsampled Resident H, revealed he/she wanted staff to knock before entering because he/she could be in the bathroom.</p> <p>Interview on 11/19/15 at 2:55 PM, with SRNA #3 revealed she was informed while in facility orientation she was to knock on a resident's door before entering and she sometimes forgot to knock. Continued interview revealed she should have knocked on the door and gained permission to enter to protect residents dignity.</p> <p>Interview on 11/19/15 at 2:55 PM, with SRNA #4 revealed she was informed she should knock before entering a resident room; however, she did not think she needed to knock if the door was open and the resident could see her. Continued interview revealed she would prefer for someone to knock before entering her home even if the door was open, and she should always knock before entering a resident room.</p> <p>Continued interview with RN #1, revealed she expected staff to respect residents' dignity and they should have knocked before entering the resident rooms.</p>	F 241	<p>ensure that staff are properly entering resident rooms and that privacy is being provided. The audit will be conducted daily for four weeks, then three times per week for two weeks, then weekly.</p> <p>Catheter bags will be audited by Unit Managers, Director of Nursing, Staff Development, QA Nurse, Manager on Duty, or by a Nursing Supervisor daily to ensure dignity is being provided and no further concerns or issues are noted. The audit will be conducted daily for two weeks, then three times per week for two weeks, then weekly.</p> <p>The above monitoring tools will be discussed in our monthly Quality Assurance meeting to discuss any issues. The ongoing process will be discussed in the Quality Assurance committee meeting monthly for three months, for recommendations and for further follow up as indicated. The members of the Quality Assurance committee include, but not limited to the Medical Director, Administrator, Director of Nursing, Assistant</p>	
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F 241	Continued From page 4	F 241	Director of Nursing, SDC, Social Services Director, Dietician, Quality of Life Director, and Unit Managers.	
F 364 SS=E	<p>483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP</p> <p>Continued interview with the Unit Manager, revealed it was her expectation for every employee to respect all resident rights including protecting their dignity because this was their home.</p> <p>Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of facility policy, it was determined the facility failed to ensure food was prepared to conserve flavor, and food was palatable and served at the proper temperature.</p> <p>Observation of the test tray temperature results on 11/18/15, revealed food was not served at acceptable temperatures and was not palatable. In addition, staff interview revealed food temperatures were taken in the satellite kitchen on the Unit after placing food on steam tables; however, there was no documented evidence food temperatures were monitored or recorded in the main kitchen. Also, interview with Unsampled Resident I, Unsampled Resident J, and residents in the Group Interview conducted by the surveyor, revealed food was delivered cold to the resident rooms and dining room.</p>	F 364	<p>F 364</p> <p>1. On 11/18/15 the temperature on the plate warmer was raised to help with the holding temperature of the trays once they were sent to the units.</p> <p>On 11/29/15 a temperature log was started in the cook kitchen for temperatures to be recorded.</p> <p>2. All residents have the risk to be affected by pallable food temperatures. Residents will have the opportunity to express any concerns with food temperatures through resident council, care plan conferences, food committee, and grievance process. A resident council meeting was held on 12/02/15 and no concerns were identified.</p> <p>3. Education was started on 12/9/15 with all dietary staff in regards to the facility's policy on food temperatures.</p>	12-19-15

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F 364

Continued From page 5

The findings include:

Review of the facility "Food Temperatures", Policy, undated, revealed food would be maintained at proper temperature to ensure food safety. Per the Policy, the point of service temperatures for foods served to residents would be in a range from 120 to 140 degrees Fahrenheit (F). Further review revealed temperatures should be at point of tray assembly 180-190 degrees F, Meat 160 degrees F, Casseroles and Creamed Foods 160 degrees F, Potatoes and Vegetables 160 degrees F and all cold foods 40 degrees F or below. Further review revealed the temperature of all foods would be taken and recorded for all meals and the cook was responsible for ensuring all food was at the proper temperature.

Review of the facility "Test Tray and Service Time Audit", dated 11/04/15 through 11/16/15, revealed the lunch test tray on 11/16/15 was delivered to the Unit at 12:59 PM and was served at 1:13 PM, fourteen (14) minutes later. Per the Audit, the temperature obtained for the soup was 141 degrees F, the meat was 140 degrees F, the starch 137 degrees F and the vegetable was 46 degrees F.

Group Interview on 11/17/15 at 3:30 PM, conducted by the surveyor, revealed there was resident concerns about food being served cold.

Review of Unsampled Resident I's medical record revealed the facility admitted the resident on 05/20/13 with diagnoses of Parkinson's Disease, Major Depression, Bipolar Disorder and Type 2 Diabetes Mellitus. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated

F 364

Education was provided by the Dietary Director or Registered Dietician. All dietary staff had to complete a post test and obtain 100% on the post test. All dietary staff was educated by 12/9/15. The facility does not utilize agency dietary staff. All new dietary staff will complete the education during orientation.

4. Food temperatures will be monitored daily by the Dietary Manager or the Assistant Dietary Manager for two weeks to ensure compliance with the cook temperatures and logging the temperature at the cook kitchen. The ongoing audit will continue to be reviewed three times per week for month, then weekly.

On 11/20/15, a test tray was conducted to ensure the holding temperature for the increase in the plate warmer. This audit revealed that the temperature of the food was delivered at proper temperatures.

On 11/23/15 temperature audits were started for test trays delivered to different units, and

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F 364 Continued From page 6  
11/06/15, revealed the facility assessed the resident as cognitively intact with a Brief Interview for Mental Status (BIMS) score of fifteen (15) out of fifteen (15) indicating the resident had no cognitive impairment. Interview on 11/17/15 at 3:15 PM, with Unsampld Resident I, revealed he/she ate in the dining room for breakfast and hated the food because the food was always cold. The resident stated the food was also delivered cold to his/her room.

Review of Unsampld Resident J's medical record revealed the facility assessed the resident on 09/22/04 with diagnoses of Urinary Tract Infection, Dementia, and Gastro-esophageal Reflux Disease. Review of the Annual Minimum Data Set (MDS) Assessment, dated 09/02/15 revealed the facility assessed the resident as cognitively intact with a Brief Interview of Mental Status (BIMS) score of thirteen (13) out of fifteen (15) indicating the resident was cognitively intact. Interview on 11/17/15 at 3:20 PM, with Unsampld Resident J, revealed he/she liked to eat breakfast in the dining room and liked to eat lunch and supper in his/her room; however, the food was always delivered cold in the dining room or if served in his/her room.

Interview on 11/17/15 at 12:00 PM, with Cook #1, revealed the food was cooked in the main kitchen and taken to the satellite kitchen to be served. Further interview revealed temperatures were checked during food preparation in the main kitchen and then checked again in the satellite kitchen before service. However, Cook #1 stated, food temperatures were not recorded in the main kitchen, just the satellite kitchen.

Observation on 11/18/15 at 11:30 AM, of the hot

F 364 different meals 3 times per week for two weeks, then twice per week for four weeks, then weekly.

The above monitoring tools will be discussed in our monthly Quality Assurance meeting to discuss any issues. The ongoing process will be discussed in the Quality Assurance committee meeting monthly for three months, for recommendations and for further follow up as indicated. The members of the Quality Assurance committee include, but not limited to the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, SDC, Social Services Director, Dietician, Quality of Life Director, and Unit Managers.

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F 364	Continued From page 7 lunch food holding temperatures in the satellite kitchen revealed Swedish Meatballs beginning temperature was 147 degrees F and the food had to be sent back to the kitchen to be reheated. The Rice was 185 degrees F and the Broccoli Casserole was 172 degrees F.  Observation on 11/18/15 at 12:00 revealed the lunch cart was delivered to the 200 Unit and the test tray (last tray passed on the lunch cart) was tested at 12:45 PM. The test tray revealed the temperature of the Swedish Meatballs was 120 degrees F, the Rice was 115 degrees F, the broccoli casserole was 123 degrees F and the banana pudding was 39 degrees Fahrenheit. The heated taste test of the food revealed the hots foods were lukewarm and not palatable.  Interview on 11/19/15 at 11:00 AM, with Assistant Supervisor/Cook #1, revealed there was a temperature log for the satellite kitchen; however temperatures were not recorded in the main kitchen. Further interview revealed Test Trays were conducted once weekly and sometimes monthly on different units.  Interview on 11/19/15 at 11:15 AM, with Dietary Aide/Cook #2 revealed he recorded temperatures on the back of his menus in the main kitchen. He stated, if foods were not to temperature in the satellite kitchen, he reheated the food and then sent the food back to the satellite kitchen.  Interview on 11/19/15 at 4:15 PM, with State Registered Nurse Assistant (SRNA) #1 revealed if the residents complained their food was cold they were offered a substitution. She further revealed residents complained about food being cold occasionally.	F 364			

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F 364

Continued From page 8

Interview on 11/19/15 at 4:17 PM, with SRNA #2, revealed staff tried to team up and serve the food as quickly as possible; however, residents' did occasionally receive a cold tray.

Interview on 11/19/15 at 4:20 PM with Licensed Practical Nurse (LPN) #1, revealed the food did occasionally arrive cold and the residents were offered a substitution tray.

Interview on 11/19/15 at 2:50 PM, with the Dietary Manager, revealed food temperatures were not recorded in the main kitchen, but were checked in the satellite kitchen which was the service area for the resident tray line. He stated if any food was not to temperature in the satellite kitchen, it was reheated in the main kitchen and transported back to the satellite kitchen. He stated he had received concerns through the resident food committee about cold food temperatures and had been trying to address the issue. He further stated the trays were taking too long to be passed and served to the residents; however, he had not brought this concern up to the nursing staff. He further revealed the point of service temperatures should be between 130 degrees Fahrenheit and 140 degrees F. Continued interview revealed the safety zone for holding food temperatures should be below 40 degrees F and at or above 140 degrees F to prevent food from being potentially hazardous to the residents. He stated the hot foods on the test tray observed by the surveyor on 11/18/15 were not at an acceptable temperature.

Interview on 11/19/15 at 4:50 PM, with the Regional Nurse Consultant, revealed his expectations for the Food Service Department

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F 364	Continued From page 9 was to follow policy and procedure and food should be served at the correct temperatures. He stated foods should be palatable for residents and the facility should adhere to all safe food practices for infection control.	F 364	F371 1. On 11/18/15, Ecolab was contracted to adjust the facility's dish machine to proper temperature for proper sanitization.	12-19-15
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility policy, it was determined the facility failed to prepare, distribute, and serve food under sanitary conditions. Observation revealed the dishwasher was not maintaining temperatures to properly sanitize the dish ware.  In addition, observation revealed a staff member with a beard was not wearing a beard net.  The findings include:  Review of the facility "Infection Control" Policy, undated, revealed the Dietary Manager was responsible for the supervision of sanitation for	F 371	On 11/17/15, Dietary Aide #2 was educated about personal hygiene and applied a beard net to cover his beard.  2. All residents can be affected by unsanitary conditions.  3. Education was started and completed on 12/9/15 to all dietary staff in regards to sanitary conditions, which included proper covers used for hair, and dish machine policy and procedure, which included proper temperatures for the wash and rinse cycle. The protocol for the back up system in case the dish machine was not up to proper temperatures was also provided. The education was provided by the Dietary Director. All new dietary staff will receive the education during orientation. The facility does not utilize agency staffing for dietary.	

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F 371	<p>Continued From page 10</p> <p>safe food storage, preparation and service. The Policy stated, all the dishes, pots, pans, flatware and drinking glasses were to be properly cleaned and sanitized.</p> <p>Review of the Lexington-Fayette County Health Department Food Manager Certification Booklet revised June 2004, revealed hot water sanitizing dishmachines should have 180 degrees Fahrenheit as the final rinse water. If the dishmachine was not properly sanitizing, it was a critical violation of Kentucky's Food Code. Further review, revealed food borne illness outbreaks had been traced back to improperly sanitized dishes, pans and utensils.</p> <p>Observation on 11/17/15 at 9:05 AM, revealed the dishwasher in the satellite kitchen final rinse temperature was 170 degrees Fahrenheit (F). Review of the facility form titled "Dishwasher Temperature/Chemical Record" (form in which staff recorded dishwash temperatures) revealed temperatures of the dishwasher were being taken three (3) times a day 11/01/15 through 11/17/15 and the rinse temperatures recorded were at least 180 degrees F. Interview with the Dietary Manager on 11/17/15 at 9:10 AM, revealed the dishwasher was not reaching the final rinse temperature of 180 degrees Fahrenheit and the dish ware needed to be sanitized with bleach. He stated he would need to call right away and have the dish machine repaired.</p> <p>Interview on 11/18/15 at 2:50 PM, with the Dietary Manager, revealed if dish ware was not sanitized this could be an infection control issue and he had not been informed by staff the dishwasher was not functioning correctly and was unaware until notified by the surveyor on 11/17/15.</p>	F 371	<p>4. The Dietary Manager, Assistant Dietary Manager, or Registered Dietician will review the dish machine and log the temperature daily for two weeks, then three times per week for four weeks, then weekly.</p> <p>The Dietary Manager, Assistant Dietary Manager, or Registered Dietician will monitor sanitary conditions, including proper beard guard placement, daily for two weeks, then three times per week for four weeks, then weekly.</p> <p>The above monitoring tools will be discussed in our monthly Quality Assurance meeting to discuss any issues. The ongoing process will be discussed in the Quality Assurance committee meeting monthly for three months, for recommendations and for further follow up as indicated. The members of the Quality Assurance committee include, but not limited to the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, SDC,</p>	
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F 371	Continued From page 11  2. Review of the facility "Personal Hygiene" Policy, undated, revealed all hair covering the head was to be covered with a net.  Observation on 11/17/15 at 1:00 PM, revealed Dietary Aide (DA) #2 who had a beard, was not wearing his beard net in the satellite kitchen while handling clean dish ware and while on the clean side of the dish room.  Observation on 11/17/15 at 4:30 PM, revealed DA #2 was not wearing his beard net while pouring beverages into the glasses for supper service during tray line.  Observation on 11/18/15 at 12:15 PM, revealed DA #2 was not wearing his beard net in the satellite kitchen.  Interview on 11/19/15 at 10:45 AM with DA #2 revealed he should have been wearing his beard net for sanitation to ensure dirt or hair did not get into the food.  Interview on 11/19/15 at 11:00 AM with Assistant Supervisor/Cook #1, revealed staff should always wear the beard net so hair would not fall into the food. Further interview revealed hair could contaminate food with germs, and dirt.  Interview on 11/19/15 at 11:15 AM, with Diet Aide/Cook #2, revealed all hair must be covered when working in the food preparation area.  Further interview on 11/18/15 at 2:50 PM, with the Dietary Manager, revealed Staff was required to wear hair nets and beard protectors to prevent infection control or cross contamination issues.	F 371	Social Services Director, Dietician, Quality of Life Director, and Unit Managers.	
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F 371	Continued From page 12	F 371			
F 411	<p>Interview on 11/19/15 at 4:50 PM, with the Regional Nurse Consultant, revealed his expectations for the Food Service Department was to follow policy and procedures and to adhere to all safe food practices for infection control.</p> <p>483.55(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS</p> <p>The facility must assist residents in obtaining routine and 24-hour emergency dental care.</p> <p>A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of facility policy, it was determined the facility failed to provide or obtain from an outside resource routine dental services or an annual inspection of residents' oral cavity for signs of disease or diagnoses of dental disease for five (5) of twenty-four (24) sampled residents (Residents #4, #5, #10, #14, and #16). Record review revealed there was no documented evidence these residents had been seen by a dentist for</p>	F 411	<p>F411</p> <p>1. Resident #4 was last seen on 8/07/2014 by a dentist. No further actions were to be taken until the physician and POA could come to an agreement.</p> <p>Resident #5 was seen by a dentist on 12/16/2015. No treatment necessary and Resident #5 next visit is to be within 12 months.</p> <p>Resident #14 had an order on 11/18/15 to be seen by a dentist on the next in facility visit. On 11/19/15, Resident #14 accepted in house services to provide dental services. On 11/25/15, Resident #14's POA refused and does not want dental services to be provided or a consultation to be completed.</p> <p>Resident #16 was last seen on 01/22/2015 by dental services in house. At that time, dental prosthesis was good and no further concerns noted. On</p>	12-19-15	

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F 411

Continued From page 13  
routine annual dental screening.

The findings include:

Review of the facility "Dental Services" Policy, undated, revealed all residents' shall undergo a dental assessment upon admission and annually. Per the Policy, a complete record of residents' dental care and services would be maintained according to current regulations.

1. Review of Resident #4's medical record revealed the facility admitted the resident on 07/08/14 with diagnoses of Alternated Mental Status, Parkinson's Disease, Dementia, and Skin Cancer. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 09/21/15, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of three (3) out of fifteen (15) indicating the resident had severe cognitive impairment.

Review of Resident #4's Physician's Orders, dated 07/22/14, revealed orders for a dental consult as needed. Review of the current Physician's Order Sheet dated November 2015, revealed orders for dental consult as needed.

Review of Resident #4's Comprehensive Care Plan, dated 07/24/14 revealed the resident had an increased potential for alteration in comfort due to broken teeth. Further review of the Comprehensive Care Plan revealed an intervention, dated 07/24/14 to ensure the resident was on the list for the next in house dental visit.

Further review of the medical record, revealed no documented evidence a dentist had seen the

F 411

11/19/15 an order for Resident #16 to have a dental consult was obtained for in house services. On 11/20/15, Resident #16 signed up for in facility services and paperwork was submitted to OnHealthCare Services. Resident will see dentist through OnHealthCare once sign up is complete.

Resident #10 had an appointment on 12/16/15 to see dental physician. However, Resident #10 refused to attend appointment.

2. All other residents were assessed for dental needs by nursing and notification to physician was made for any concerns. All residents were provided the opportunity to sign up with OnHealthCare services or with the dental provider of their choice. Any resident that did not have a signed consent form, either declining or accepting services was mailed out on 12/18/15 by social services, which included 4 residents. Upon admission to the facility dental services are offered by the Admissions

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F 411	Continued From page 14 resident for routine dental care and services since admission to the facility.  2. Review of Resident #5's medical record revealed the facility admitted the resident on 11/08/11 with diagnoses of Dementia, Depression, Hypertension, and Anemia. Review of the Quarterly MDS Assessment, dated 10/12/15, revealed the facility assessed the resident as having a BIMS score of three (3) out of fifteen (15) indicating the resident had severe cognitive impairment.  Review of Resident #5's Comprehensive Care Plan, dated 07/22/13, revealed the resident had the potential for alteration in oral tissues due to he/she was edentulous and refused to wear his/her dentures. Further review of the Care Plan revealed an intervention to observe for any changes to the oral tissues, contact the physician and provide oral care after meals.  Review of current Physician Orders dated November 2015, revealed no orders for a dental consult as needed. Further review of the medical record revealed no documented evidence an annual dental visit was offered and no documented evidence a dentist had seen the resident for routine dental care and services since admission.  3. Review of Resident #14's medical record revealed the facility admitted the resident on 03/24/14 with diagnoses of Alzheimer's Dementia, Anxiety, Altered Mental Status, and Feeding Issues. Review of the Quarterly MDS Assessment dated 10/22/15 revealed the facility assessed the resident to have a BIMS score of three (3) out of fifteen (15) indicating the resident had severe	F 411	Coordinator to the responsible party or the resident. A new form does not have to be completed yearly for the resident to maintain enrollment with OnHealthCare services.  3. All licensed nursing staff, social services, registered dietician, medical records and speech pathologists will be educated on the facility's policy for Dental Services. Education was provided by Staff Development Coordinator, Director of Nursing, HR Director, Administrator, Assistant Administrator, Quality of Life Director, Dietary Director, QA Nurse, Nursing Supervisor, Environmental Services Director, Medical Records Director, Rehab Services Manager, Business Office Manager, VP of Operations, or Signature Care Consulting team. Education was completed by 12/18/15, and certified letters were sent out to those who had not received the education, on leave of absence, or on vacation. Agency staff will receive the education from	
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F 411	<p>Continued From page 15 cognitive impairment.</p> <p>Review of the Comprehensive Care Plan dated 05/06/15, revealed the resident was at risk for oral pain due to cavities with an approach for dental consult as needed and notify Physician of any oral health problems.</p> <p>Review of the Physician's Orders dated 07/22/14 revealed orders for a dental consult as needed. Also, review of the current November 2015 Physician's Orders revealed orders for a dental consult as needed.</p> <p>Further review of the medical record, revealed no documented evidence a dentist had seen the resident for routine dental care and services since admission to the facility.</p> <p>4. Review of Resident # 16's medical record revealed the facility admitted the resident on 02/20/13 with diagnoses of Schizoaffective Disorder, Sleep Apnea, and Congestive Heart Failure. Review of the Annual MDS assessment dated 10/30/15 revealed the facility assessed the resident as having a BIMS score of fifteen (15) out of fifteen (15) indicating the resident was cognitively intact.</p> <p>Interview conducted with Resident # 16 on 11/19/15 at 4:00 PM revealed the resident complained of having a crack in his/her lower denture plate. Resident # 16 stated he/she reported the problem with the lower denture plate to his/her assigned nurse " a few weeks ago " and requested to be placed on the facility's dental waiting list.</p> <p>Interview on 11/19/15 at 4: 50 PM, with the</p>	F 411	<p>their supervisor prior to working at our facility. All new hires will receive the education in orientation.</p> <p>4. All current resident's charts will be reviewed for last date a dental consultation was completed and a dental assessment was completed on all current residents by nursing staff. All residents that want to be seen by dental will be sent to the provider of their choice, or be seen by the dentist that is provided by OnHealthCare.</p> <p>All dental concerns will be monitored daily, Monday thru Friday, by social services during the clinical meeting, by review of the 24 hour report or any nurse's notes that may trigger for a dental consultation. Social Services will monitor and address any dental concerns during care plan meetings by asking the family, resident, or responsible party if any concerns or if they would like to have dental services provided. If the resident or responsible party would like to</p>	
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F 411 Continued From page 16  
 facility's Director of Social Services (DSS), revealed she had not been notified by the facility's nursing staff of Resident # 16's request to be seen by the dentist for examination of the cracked dental plate and review of the facility' dental waiting list revealed the resident was not placed on the list to be seen by the dentist.

5. Review of Resident #10's medical record revealed the facility admitted the resident on 09/18/14 with diagnoses including, Diabetes, Dementia Hypertension and Depression. Review of the Quarterly MDS Assessment revealed the facility assessed the resident as having a BIMS score of three (3) out of fifteen (15) indicating the resident had severe cognitive impairment.

Review of Resident #10's Medicaid On Healthcare Service Sheet dated 09/18/14, revealed a signature of the responsible party consenting for the resident to receive dental services. Review of the Physician Order Sheet dated 09/18/14, revealed an order for Dental Consult as needed. Review of the current November 2015 Physician's Order Sheet revealed orders for Dental Consult as needed.

Further review of Resident #10's medical record revealed there was no documented evidence dental services were provided since admission. Continued review revealed there was no documented evidence of the responsible party declining dental services.

Further interview with the Director of Social Services (DSS) on 11/19/15 at 4:23 PM revealed all residents admitted following the facility change of ownership last year were provided a consent for dental services. However, she stated she was

F 411

have services provided or to sign up, the social services director will ensure completion and refer for dental consultation.

The above monitoring tools, the review of the care plan notes, 24 hour report, and any new dental consultations for services will be discussed in our monthly Quality Assurance meeting to discuss any issues. The ongoing process will be discussed in the Quality Assurance committee meeting monthly for three months, for recommendations and for further follow up as indicated. The members of the Quality Assurance committee include, but not limited to the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, SDC, Social Services Director, Dietician, Quality of Life Director, and Unit Managers.

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F 411 Continued From page 17  
unaware until today, she was responsible for going back and ensuring other residents already present in the facility prior to the change in ownership, had been given the opportunity for routine dental services.

F 411

Interview with the Administrator, on 11/19/15 at 5:47 PM, revealed it was her expectation any time a resident required a dental consult, the facility would provide consultation and services for the resident. The Administrator revealed, she was unaware until the survey, there was residents who had not been given the opportunity for routine dental services.

F441

12-19-15

F 441 483.65 INFECTION CONTROL, PREVENT SS=E SPREAD, LINENS

F 441

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.

1. On 11/17/15, the Dietary Manager was notified of the ice scoop and immediately sanitized the ice scoop and the ice machine. Dietary Manager educated Dietary Aide #1 on infection control policy.

- (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.

2. All residents can be affected by unsanitary conditions.

- (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.

3. On 12/9/15 education was started and completed for all dietary staff in regards to Infection Control policy, including sanitary conditions. Education was provided by the Dietary Director.

All staff will be educated on Infection Control Policy, which includes, clean uniforms,

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(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 STANDARD is not met as evidenced by:  
Based on observation, interview, and review of facility policy, it was determined the facility failed to maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. Observation on 11/17/15 revealed a staff member dropped an ice scoop on the floor, picked up the ice scoop and continued to dip ice out of the ice machine and distribute the ice into beverage pitchers.

The findings include:

Review of the facility "Infection Control" Policy, undated, revealed the Dietary Manager had the ultimate responsibility for all sanitation procedures to maintain the environment for safe preparation and service of food. Per Policy, all

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personal hygiene, hand washing, cleaning and sanitizing, proper handling and storage including ice scoop use, storage, and sanitization. Education was provided by Staff Development Coordinator, Director of Nursing, HR Director, Administrator, Assistant Administrator, Quality of Life Director, Dietary Director, QA Nurse, Nursing Supervisor, Environmental Services Director, Medical Records Director, Rehab Services Manager, Business Office Manager, VP of Operations, or Signature Care Consulting team. Education was completed by 12/18/15, and certified letters were sent out to those who had not received the education, on leave of absence, or on vacation. Agency staff will receive the education from their supervisor prior to working at our facility. All new hires will receive the education in orientation.

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

PRINTED: 12/07/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185146	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  11/19/2015
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NAME OF PROVIDER OR SUPPLIER  FOUNTAIN CIRCLE CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 200 GLENWAY ROAD WINCHESTER, KY 40391
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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dishware was to be properly cleaned, sanitized and handled according to long term care regulations.

Review of the facility "Infection Control" Policy, undated, revealed the facility would endeavor to prevent the spread of infection by teaching staff safe food handling practices to limit cross-contamination.

Observation on 11/17/15 at 3:50 PM, revealed Dietary Aide (DA) #1 was filling pitchers with ice from the ice machine and the ice scoop dropped onto the floor. DA #1 was observed to pick up the scoop and continue to dip the scoop into the ice machine and fill the pitchers with ice.

Interview on 11/17/15 at 5:00 PM, with DA #1 revealed she dropped the ice scoop and had caught the scoop by the handle. She stated she thought the scoop was still safe and continued to use the scoop. Further interview revealed the scoop should have been sanitized because contaminated utensils could be potentially harmful to the residents with their compromised immune systems.

Interview on 11/19/15 at 10:45 AM, with DA#2 revealed if the ice scoop was dropped on the floor, it should have been taken back to the dish washer and sanitized. Dietary Aide #2 stated, another ice scoop could have been used from the kitchen.

Interview on 11/19/15 at 11:15 AM, with DA/Cook #2, revealed if an ice scoop was dropped, it should have been brought back to the kitchen to be sanitized because anything that fell on the floor was considered unsanitary and could harm

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4. An audit on ice machine and ice scoop storage, sanitization, cleanliness, and proper handling of ice scoop will be completed daily for two weeks, then three times per week for four weeks, then weekly. Audits will be completed by but not limited to Dietary Director, Assistant Dietary Director, Registered Dietician, Administrator, Assistant Administrator, Director of Nursing, Environmental Services, Social Services, Manager on Duty, or Nursing Supervisor.

The above monitoring tools will be discussed in our monthly Quality Assurance meeting to discuss any issues. The ongoing process will be discussed in the Quality Assurance committee meeting monthly for three months, for recommendations and for further follow up as indicated. The members of the Quality Assurance committee include, but not limited to the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, SDC, Social Services Director,

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NAME OF PROVIDER OR SUPPLIER  FOUNTAIN CIRCLE CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 200 GLENWAY ROAD WINCHESTER, KY 40391
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 441	<p>Continued From page 20 the residents.</p> <p>Interview on 11/19/15 at 2:50 PM, with the Dietary Manager, revealed the ice scoop should have been picked up and sanitized immediately. Further interview revealed using an ice scoop which had been on the floor was an infection control and cross contamination issue for resident safety.</p> <p>Interview on 11/19/15 at 4:50 PM, with the Regional Nurse Consultant, in the absence of the Director of Nursing (DON), revealed his expectation was for the Dietary Department to follow policy and procedures concerning infection control for resident safety.</p>	F 441	Dietician, Quality of Life Director, and Unit Managers.	
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185146	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING 0101  B. WING _____	(X3) DATE SURVEY COMPLETED  11/19/2015
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NAME OF PROVIDER OR SUPPLIER  FOUNTAIN CIRCLE CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 200 GLENWAY ROAD WINCHESTER, KY 40391
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K 000	INITIAL COMMENTS  CFR: 42 CFR 483.70(a)  Building: 01  Plan Approval: 2/23/68  Survey Under: 2000 Existing  Facility Type: SNF/NF  Type of Structure: One (1) Story, Type II (222) protected with one (1) room basement.  Smoke Compartments: Sixteen (16)  Fire Alarm: Complete supervised automatic fire alarm system fully sprinklered, supervised (Wet and Dry system)  Emergency Power: Three (3) Type II Natural Gas  A Life Safety Code Survey was conducted on 11/19/15. The facility was found to be in compliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility is licensed for one hundred seventy-nine (179) beds and the census was one hundred thirty-three (133) on the day of the survey.	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Jenna M. Anderson* TITLE *Administrator* (X6) DATE *1/13/16*

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.