

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

PRINTED: 08/19/2014  
FORM APPROVED  
OMB NO. 0938-0391

RECEIVED  
AUG 27 2014

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  C 08/05/2014
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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  An Abbreviated Survey investigating KY00021993 was intated and concluded on 08/05/14, with deficiencies cited at the highest Scope and Severity of a "D."	F 000		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323	F323  1. On 8-5-14 when facility was made aware of the unlocked crash cart on the Ivy Unit, the Respiratory Therapist immediately audited the crash cart on Ivy unit to ensure all items were accounted for and secured the crash cart. All materials were found in place and no issues were noted.	9/5/14

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	This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure the resident environment remained as free from accident hazards as was possible for one (1) of three (3) sampled residents (Resident #1).  Observation during initial tour on 08/05/14 revealed an emergency "crash cart" on the Ivy Unit was not secured which contained potentially hazardous items. Per interview and record review Resident #1 was a wanderer who resided on the Ivy Unit, and was severely cognitively impaired.  The findings include:  Interview with the Director of Nursing (DON) on 08/05/14 at 4:25 PM revealed the expectation		2. All other crash carts were audited by the Respiratory Therapist and none were found to be unsecured.  The Admin team performed a Facility audit round to ensure there were no other unsafe/unsecured conditions that could put the residents at risk for harm.  The Administrator, DON, ADONs will review the last 3 months of Incident/accidents to ensure no other residents were affected by unsafe environment.	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Dena M Hudson</i>	TITLE <i>Administrator</i>	(X6) DATE <i>8/27/14</i>
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that 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 323	Continued From page 1 was for emergency "crash carts" to be secured at all times. The DON revealed it was the responsibility of the Certified Respiratory Therapist (CRT) to ensure "crash carts" were secured and maintained.  Observation during initial tour of the facility on 08/05/14 at 10:50 AM, revealed an emergency "crash cart" on the facility's Ivy Unit which was not secured. Continued observation revealed no staff were visible in the area where the unsecured "crash cart" was located, and the "crash cart" was placed in such a way it was not visible to staff at the nurse's station down the hall. Further observation revealed three (3) residents were seated near the unsecured "crash cart" watching television.	F 323	3. On 8/05/14 the type of secure strap that was used to secure the crash carts was removed. The new strap has more resistance than the previous straps that were being used.  Covers for all of the emergency crash carts were purchased and installed on 8/22/2014. The covers will be used to draw less attention to the carts and the items that reside on the top of the cart.	
	Observation of the contents of the "crash cart" revealed: a suction machine stored on top of it; the first drawer contained a stethoscope and an adult blood pressure cuff; the second drawer contained oxygen tubing and a nasal cannula, two (2) tongue depressors, four suction kits, and packages of water based lubricant; the third drawer contained two (2) saline intravenous (IV) flushes, an IV start kit, antiseptic hand gel rinse, an IV extension set, a 1000 cubic centimeters (cc) bag of 0.9% sodium chloride injection, two (2) injection needles, two (2) IV catheters, alcohol prep pads and tape; and the fourth drawer contained cling gauze, sterile saline, one (1) pair of scissors, two (2) suction cannisters, two (2) protective gowns, two (2) face shields, masks, gloves, and an empty sharps box.  Interview with the CRT on 08/05/14 at 4:40 PM, revealed the "crash cart" on the Ivy Unit had been secure when he checked it at 10:30 AM that		The crash carts will also be assessed by the night shift nurse daily to ensure that the crash cart is secured in addition to the respiratory therapist completing their assessment during the day. The weekend supervisor will assess the crash carts on the weekend.  Respiratory Therapist will initiate education to all licensed nurses related to the crash cart securement to include securement after use.  The staff will be re-educated on environmental safety and adequate supervision to ensure	

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F 323	Continued From page 2 morning. The CRT stated he checked the "crash carts" throughout the facility every weekday morning as part of his job responsibilities. According to the CRT, if he were to observe a "crash cart" not secured, he would verify it's contents, replace any items missing from the inventory, and then place a breakaway lock on it to secure the cart. However, he indicated the "crash cart" should be secured. CRT revealed the facility's nursing supervisors were responsible for ensuring "crash cart" security during the evening hours and on weekends. He indicated he would generally receive notice if there had been an emergency on any of the units during those timeframes.  Review of Resident #1's medical record revealed the facility admitted the resident on 07/14/11, with diagnoses which included Dementia with Behavioral Disturbance, Psychosis, and Depressive Disorder. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 07/21/14, revealed the facility assessed Resident #1 to be severely cognitively impaired, with wandering behavior identified one (1) to three (3) days during the assessment period.  Interview with State Registered Nursing Assistant (SRNA) #1 on 08/05/14 at 1:28 PM, revealed she had never observed any residents on the Ivy Unit take "any interest" in the "crash cart", although she did acknowledge there were one (1) or two (2) residents on the unit who wandered, one (1) of which was Resident #1.  Interview with SRNA #2 on 08/05/14 at 1:45 PM, revealed she had observed Resident #1 wandering around on the Ivy Unit, although had never observed Resident #1 taking an interest in	F 323	that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  4. The certified respiratory therapist will monitor the crash carts on each unit to ensure that the covers are in place and the crash cart is secured daily during the work week. The night shift nurse will also complete an assessment for the cover and securement of the crash cart daily.  The monitoring tool of the crash carts 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,		

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F 323	<p>Continued From page 3</p> <p>the "crash cart" before. SRNA #2 stated she had observed Resident #1 attempting to take food items off the snack cart before and attempt to get behind the nurse's station on occasion. SRNA #2 stated the "crash cart" was usually supposed to be kept locked; however, acknowledged Resident #1 could potentially get obtain items stored on top of the "crash cart" or oxygen tubing.</p> <p>Interview with SRNA #4 on 08/05/14 at 2:26 PM, revealed Resident #1 could potentially get things off the "crash cart", and if that happened she would remove the resident from the "crash cart" storage area. SRNA #4 thought there could be hypodermic needles in the "crash cart" which Resident #1 might stick himself/herself with. Per interview, SRNA #4 stated it was "unlikely", but</p>	F 323	Social Services Director, Dietician, Quality of Life Director, and Unit Managers.	
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	<p>possible Resident #1 could knock equipment stored on top of the "crash cart" off of it and hurt himself/herself or anyone else standing nearby. She stated she "always assumed" the "crash cart" was supposed to be locked.</p> <p>Interview with Licensed Practical Nurse (LPN) #2 on 08/05/14 at 2:44 PM, revealed Resident #1 could accidentally hurt himself/herself if he/she handled items stored on top of or inside the "crash cart". LPN #2 stated she would be concerned Resident #1 could pull the suction machine stored on top of the "crash cart" over on top of him/her, and items stored inside of it would be of concern as well, such as oxygen tubing, and injection needles or scissors which could cause injuries. LPN #2 indicated the "crash cart" was supposed to be secured with a lock.</p> <p>Interview with the LPN #3/Ivy Unit Manager on 08/05/14 at 2:58 PM, revealed she had observed the "crash cart" unsecured earlier when the</p>			
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F 323	Continued From page 4 Surveyors had observed it unsecured, and had since secured the "crash cart". LPN #3/Ivy Unit Manager revealed "crash carts" were supposed to be kept secured to ensure resident safety, as some of the items stored in the "crash" cart could potentially be dangerous for residents if they obtained them.  Interview with the DON on 08/05/14 at 4:25 PM, revealed Resident #1 was the only true "wanderer" on the Ivy Unit, had previously been unaware Resident #1 had ever been interested in the "crash cart". Per interview, the DON stated she did not know why the "crash cart" on the Ivy Unit had not been secured earlier in the day, however the "crash cart" should have been secured.	F 323			