

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

PRINTED: 07/17/2014
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-C 07/22/2014
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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

{F 000}

An off-site revisit was conducted on 07/22/14. After review of the acceptable POC, it was determined the facility was deemed to be in compliance, as alleged on 07/22/14.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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 An Abbreviated Survey investigating KY00021755 was initiated on 06/10/14 and concluded on 06/11/14. KY00021755 was substantiated with deficiencies cited with the highest Scope and Severity of an "E".	F 000		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy, it was determined the facility failed to provide or arrange services by qualified persons in accordance with each resident's written plan of care for one (1) of three (3) sampled residents (Resident #3) and two (2) of three (3) unsampled residents (Unsampled Resident B and Unsampled Resident C). Resident #3 was care planned for staff assistance with toileting needs and staff assist with bed mobility every two (2) hours. Interview with Resident #3 revealed he/she was not assisted by staff with toileting needs and bed mobility every two (2) hours during the night shift, 11:00 PM to 7:00 AM. Unsampled Resident B was care planned for staff assist with turning and repositioning every two (2) hours and staff to offer the urinal every two (2) hours. Interview with Unsampled Resident B	F 282	 F282 1. On 6/13/14 Resident #3, Unsampled Resident B, and Unsampled Resident C care plans was reviewed by the unit manager to ensure that the care plan was appropriate and being followed. On 6/13/14 the rehab unit manager verbally educated the rehab staff on the procedure of rounding Q2 hours and as needed to assist with toileting and bed mobility needs. A formal in service will be held on 7/18/14 by the SDC to educate all staff on the procedure of rounding every 2 hours and as needed to assist with toileting and bed mobility needs. The week of 6/11/14, the rehab unit manager completed a skin assessment for Resident #3, Unsampled Resident B, and	7/22/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Silena M. Hudson</i>	TITLE <i>Administrator</i>	(X6) DATE <i>7/4/2014</i>
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F 282	<p>Continued From page 1</p> <p>revealed staff on night shift did not offer him/her the urinal or assist him/her with turning and repositioning every two (2) hours.</p> <p>Unsampled Resident C was care planned for staff to turn and reposition him/her every two (2) hours and staff assist of two (2) toileting needs. Interview with Unsampled Resident C revealed staff on night shift did not assist with his/her toileting needs every two (2) hours.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Care Plans - Comprehensive" revised October 2010, revealed each resident's comprehensive care plan was designed to: incorporate identified problems areas; incorporate risk factors associated with the identified problems; build on the resident's strengths; reflect the resident's expressed wishes regarding care and treatment goals; reflect treatment goals, timetables and objectives in measurable outcomes; identify the professional services responsible for each element of care; aid in preventing or reducing declines in the resident's functional status and/or functional levels; and enhance the optimal functioning of the resident by focusing on a rehabilitative program and reflect currently recognized standards of practice for problem areas and conditions.</p> <p>1. Record review revealed Resident #3 was admitted by the facility on 12/17/13, with a re-admission date of 01/28/14, with diagnoses which included Spina Bifida, Paraplegia, history of Pressure Ulcers and Urinary Frequency. Review of the 04/27/14 Quarterly Minimum Data Set (MDS) revealed Resident #3 was assessed by the facility to have a Brief Interview for Mental</p>	F 282	<p>Unsampled Resident C with no negative findings.</p> <p>2. On the week of 6/15/14 – 6/20/14 a 100 percent review of all resident's care plans was completed by the Unit Managers, DON, ADON, Restorative Nurse, evening shift RN supervisor, and weekend RN supervisor to ensure that care plans were appropriate and being followed related to toileting and bed mobility needs. During the review to identify any potential issues, residents were interviewed and skin assessments were completed with no negative findings.</p> <p>3. The SDC will educate all nursing staff on the procedure of Q2 hour checks to assist with any needs, including toileting and bed mobility by 7/21/14. The facility will implement a monitoring tool by 7/21/14 to ensure all residents are checked at least every 2 hours to ensure any needs are being met including bed mobility and toileting. The tool will consist of the nurse signing off with the</p>	
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F 282	Continued From page 2 Status (BIMS) score of fifteen (15) which indicated no cognitive impairment. Continued review of the MDS revealed Resident #3 was assessed by the facility to require assistance of two (2) staff for toileting needs, to require intermittent urinary catheterization and to be occasionally incontinent of urine and frequently incontinent of bowel. Review of Resident #3's Comprehensive Care Plan, 02/11/14, revealed the care plan to have been updated on 04/25/14 for the resident to in and out catheter self. Review revealed an update on 04/30/14 to reflect assistance of one (1) staff with the resident's toileting needs. Further review of Resident #3's Comprehensive Care Plan revealed the resident was care planned for Activities of Daily Living (ADL) self care deficit with interventions which included staff were to assist the resident with bed mobility every two (2) hours. Interview with Resident #3 on 06/10/14 at 12:10 PM, revealed he/she was not aware of urinating on himself/herself when he/she was asleep, and had requested staff wake him/her up every two (2) hours throughout the day and night to check for incontinence. Resident #3 stated he/she "hardly ever" got "checked at night" on the night shift, 11:00 PM to 7:00 AM. According to Resident #3, on night shift he/she did not usually get checked by staff until between 5:00 AM and 6:00 AM. Even though the resident's care plan indicated staff were to assist with the resident's toileting needs and assist him/her with bed mobility every two (2) hours. Interview with State Registered Nursing Assistant (SRNA) #4 on 06/11/14 at 11:52 AM, revealed	F 282	SRNA that the Q2 hour checks were completed. The SDC will complete an education session for all nursing staff by 7/21/14 for the implementation of the monitoring tool. 4. The monitoring tool will be reviewed in the morning clinical meeting Monday thru Friday by the Unit Managers, Restorative Nurse, DON, ADON or other nursing supervisors, during the weekend, the Weekend RN Supervisor will review the monitoring tool to ensure that the Q2 hour checks are completed. The daily review will be completed daily for one month, then 3 times a week for 4 weeks, then weekly for 4 weeks. 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 282	<p>Continued From page 3</p> <p>Resident #3 had requested to be woke up every two (2) hours and checked for incontinence during the day and night. SRNA #4 stated she had informed SRNAs on other shifts of the resident's request.</p> <p>2. Record review revealed Unsamped Resident B was admitted by the facility on 12/13/13, with diagnoses which included Cerebrovascular Accident, Anxiety, Depression and Legal Blindness. Review of the 12/22/13 Admission MDS revealed Unsamped Resident B was assessed by the facility to have a BIMS score of fifteen (15) which indicated no cognitive impairment. Further review of the MDS revealed the facility assessed Unsamped Resident B to require extensive assist of two (2) staff for toileting and to be occasionally incontinent of urine.</p> <p>Review of Unsamped Resident B's Comprehensive Care Plan, dated 12/24/13, the resident was care planned for a potential for complications associated with incontinence of bowel and/or bladder related to occasional bladder incontinence. Further review of the Comprehensive Care Plan revealed staff were to offer the urinal every two (2) hours and assist the resident with turning and repositioning every two (2) hours.</p> <p>Interview with Unsamped Resident B on 06/11/14 at 9:15 AM, revealed staff did not come in every two (2) hours at night to check him/her or to offer the urinal. Unsamped Resident B indicated staff also did not assist him/her to turn and reposition every two (2) hours. Even though the resident's care plan indicated staff were to assist him/her with turning and repositioning every two (2) hours</p>	F 282	Social Services Director, Dietician, Quality of Life Director, and Unit Managers.	
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F 282	<p>Continued From page 4 and offer the urinal every two (2) hours.</p> <p>3. Record review revealed Unsampled Resident C was admitted by the facility on 09/20/08, with diagnoses which included Neurogenic Bladder, Anxiety, Depression and Alzheimer's Disease. Review of the Annual MDS Assessment, dated 04/23/14, revealed the facility assessed Unsampled Resident C to have a BIMS score of eight (8), which indicated the resident was interviewable. Continued review of the MDS revealed the facility assessed Unsampled Resident C to require extensive assistance of two (2) staff with toileting, and to be frequently incontinent of bowel and bladder.</p> <p>Review of Unsampled Resident C's Comprehensive Care Plan, dated 04/09/14, revealed the resident was care planned for the potential for skin breakdown related to decreased bed mobility and a history of bowel incontinence. Interventions included turning and repositioning the resident every two (2) hours, assist of two (2) staff with bed mobility and assistance of two (2) staff with his/her toileting needs.</p> <p>Interview with Unsampled Resident C on 06/11/14 at 9:26 AM, revealed staff did not check him/her at night for incontinence. Even though the resident's care plan indicated staff were to assist the resident with his/her toileting needs and bed mobility, and assist the resident to turn and reposition every two (2) hours.</p> <p>Interview with SRNA #1 on 06/10/14 at 3:20 AM, revealed night shift staff were to check residents during the walking rounds with the previous shift at 11:00 PM. SRNA #1 stated night shift staff were then to check residents at 1:00 AM, 3:00</p>	F 282		
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F 282	Continued From page 5 AM and again at 5:00 AM. She stated however, if staff were busy residents might have to wait to be checked on and assisted with turning and repositioning. Interview with the Director of Nursing, on 06/11/14 at 2:41 PM, revealed she expected staff to perform rounds checking on residents every two (2) hours day or night. She stated incontinent residents should be woke up and checked for incontinence with provision of perineal care as needed. According to the DON, if a resident had problems with bed mobility, these residents should also be awakened and offered assistance to turn and reposition and to toilet every two (2) hours. The DON indicated staff should follow the residents' care plans. Interview with the Administrator, on 06/11/14 at 5:10 PM, revealed her expectation was for staff to make rounds on each resident at least every two (2) hours.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of	F 309	F309 1. Resident #1 was assessed for pain on 6/10/14 and no complaints of pain were voiced. 2. A 100 percent review will be completed by 7/11/14 per the unit managers for all residents receiving any prn pain medication to ensure that a pain assessment was completed per	7/22/14

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F 309	<p>Continued From page 6</p> <p>the facility's policy, it was determined the facility failed to ensure each resident received the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care for one (1) of the three (3) sampled (Resident #1). The facility failed to ensure pain management protocols were adhered to for Resident #1.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Pain Management" dated December 2010, revealed pain was a stressor and unrelieved it could cause both physical and psychological strain. Policy review revealed each resident identified by the facility with pain would have ongoing assessments, a monitoring system and a specific plan of care to address the issues. Continued review revealed pain should be rated on a scale of 0 to 10 if possible, to determine the severity of the pain, and pain medication administration would be determined based on the resident's perception of the pain, per the pain scale. The Policy revealed staff should utilize medications appropriate to the resident's current level of pain and progress by increasing the dose of the drug until maximum benefit was obtained. Further review revealed Tylenol to be recommended for mild pain whereas Oxycodone was recommended for moderate pain. The Policy noted when a PRN (as needed) medication was administered documentation should include the complaints or symptoms for which the medication was given and the results achieved from giving the dose and the time results were noted.</p> <p>Record review revealed Resident #1 the facility</p>	F 309	<p>the facility policy for any requested prn pain medication.</p> <p>3. The SDC will in service all licensed nurses by 7/21/14 related to the facility's pain management policy.</p> <p>4. Each unit manager will complete an audit on three random residents receiving prn pain medication to ensure a pain assessment was completed with any prn pain medication given, daily Monday thru Friday for two weeks then 5 a week for the next four weeks, then 2 a week for two weeks. 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.</p>	
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F 309	<p>Continued From page 7</p> <p>admitted the resident on 06/02/14, with diagnoses which included Splenectomy after Peritonitis and Gout. Record review revealed Resident #1 was a new admission with an Admission Minimum Data Set (MDS) dated 06/09/14 in progress. Continued review of the MDS in progress revealed the facility assessed Resident #1 to have an initial Brief Interview for Mental Status (BIMS) score of 13 out of 15, indicating he/she was cognitively intact. Review of the admission Interim Plan of Care revealed Resident #1 was care planned for alteration in comfort/pain. Further review of the Interim Plan of Care revealed comfort measures were to be provided as ordered and the Physician was to be notified for a new onset or change in pain with the use of the pain scale to monitor.</p> <p>Review of Resident #1's Physician's Orders dated 06/02/14, revealed two (2) medications ordered for pain, Tylenol and Oxycodone.</p> <p>Observation of resident care on 06/10/14 at 4:30 AM, revealed Resident #1 requested State Registered Nursing Assistant (SRNA) #1 to inform his/her nurse he/she was in pain. Continued observation at 4:35 AM revealed Licensed Practical Nurse (LPN) #1 administered two (2) Tylenol 325 mg tablets to Resident #1 without assessing the resident for severity, location or intensity of his/her pain.</p> <p>Interview with LPN #1 on 06/10/14 at 6:50 AM, revealed the facility did have a pain assessment protocol. She stated pain was assessed for the level of pain prior to administration of pain medication, then one (1) hour after administration. She indicated she assessed Resident #1 at 11:00 PM, the beginning of her</p>	F 309		
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F 309	Continued From page 8 shift; however, did not assess Resident #1 prior to administering the pain medications. LPN #1 stated she should have assessed Resident #1 for pain prior to administering the pain medication, and indicated at the time of the interview, she had not assessed Resident #1 for the effectiveness of the pain medication. Interview with the Director of Nursing (DON) on 06/11/14 at 2:41 PM, revealed her expectation was for staff to utilize the pain assessment protocol for administration of pain medications in order to assess the type of pain, rating of pain, location of pain and effectiveness of the pain medication. The DON revealed LPN #1 should have assessed Resident #1 for pain prior to administration of a pain medication as per the protocol. Further interview revealed LPN #1 should have completed a reassessment of Resident #1's pain approximately one (1) hour after administration of the pain medication to assess the effectiveness of the medication. Interview with the Administrator on 06/11/14 at 5:10 PM, revealed her expectation was for staff to follow the facility's policy. Further interview revealed residents should be assessed for pain prior to the administration of a medication and approximately one (1) hour after administration for effectiveness of the medications.	F 309		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that	F 315	F315 1. A skin assessment was completed on Resident #3, Unsampled Resident B, and Unsampled Resident C on 6/13/14 with no negative findings.	7/22/14

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F 315	<p>Continued From page 9</p> <p>catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, interview and review of the facility's policies, it was determined the facility failed to ensure residents with or without a catheter received the appropriate care and services to prevent infections to the extent possible for one (1) of three (3) sampled residents (Resident #3) and two (2) of three (3) unsampled residents (Unsampled Resident B and Unsampled Resident C). The facility failed to ensure staff checked each resident for incontinence or toileting needs every two (2) hours.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Disposable Brief Program for Bowel and Bladder Incontinence", effective December 2010, revealed regular use of briefs was implemented when a resident did not respond to or meet criteria for other continence management programs. Continued policy review revealed residents utilizing briefs would be checked at least every two (2) hours and as needed for incontinent episodes and removal and replacement of soiled briefs. Policy review revealed staff could check residents during the night without awakening the resident. Further review revealed residents should however, be informed that he/she would be checked during</p>	F 315	<p>2. All incontinent residents or those with toileting needs have the potential to be affected by the alleged deficient practice therefore the facility will implement the corrective actions and monitoring procedures outlined in #'s 3 and 4 below.</p> <p>3. The SDC will educate all nursing staff on the procedure of Q2 hour checks to assist with any needs, including toileting and bed mobility by 7/21/14. The facility will implement a monitoring tool by 7/21/14 to ensure all residents are checked at least every 2 hours to ensure any needs are being met including bed mobility and toileting. The tool will consist of the nurse signing off with the SRNA that the Q2 hour checks were completed. The SDC will complete an education session for all nursing staff by 7/21/14 for the implementation of the monitoring tool.</p> <p>4. The Unit Managers, Evening Shift RN Supervisor, Weekend RN Supervisor, DON, ADON, and/or Restorative Nurse</p>	
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F 315	Continued From page 10 the night for episodes of incontinence. In addition, the policy noted some residents might request to be awakened during the night to be reminded to eliminate. Review of the facility's policy titled, "Care Plans-Comprehensive" with a revision date of October 2010, revealed each resident's comprehensive care plan was designed to include incorporation of residents expressed wishes regarding care and treatment goals, and aid in preventing or reducing declines in residents' functional status and/or functional levels. 1. Review of Unsampled Resident B medical record revealed the facility admitted the resident on 12/13/13, with diagnoses which included Cerebrovascular Accident, Legal Blindness, Anxiety and Depression. Review of the Admission MDS, dated 12/22/13, revealed the facility assessed Unsampled Resident B to have a BIMS score of a 15 out of 15, indicating he/she was cognitively intact. Further review of the MDS revealed the facility assessed Unsampled Resident B to be occasionally incontinent of urine and to require extensive physical assist of two (2) staff for toileting. Review of Unsampled Resident B's Comprehensive Care Plan, dated 12/24/13, revealed he/she was care planned for the potential for complications associated with incontinence of bowel and/or bladder. Further review revealed staff were to assist with turning and repositioning every two (2) hours, as well as, offer the urinal every two (2) hours. Interview, on 06/11/14 at 9:15 AM, with	F 315	Supervisor will audit 10 incontinent residents weekly to ensure they are checked at least every 2 hours for incontinence or toileting needs for four weeks, then 5 weekly for two weeks, and then 3 a week for two weeks. 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 315	<p>Continued From page 11</p> <p>Unsampled Resident B, revealed he/she did not wear an adult brief and used a urinal. Unsampled Resident B stated staff did not come in every two (2) hours during the night to check him/her for incontinence or to offer the urinal. Further interview revealed if staff came in every couple hours at night to assist him/her to find the urinal, he/she might have less frequent episodes of incontinence.</p> <p>2. Review of Resident #3's medical record revealed the facility admitted the resident on 12/17/13, with a re-admission date of 01/28/14, with diagnoses which included Spina Bifida (a birth defect in which the spinal column does not close all of the way), Paraplegia, Urinary Frequency, and history of Pressure Ulcers. Review of the Quarterly Minimum Data Set (MDS), dated 04/27/14, revealed the facility assessed Resident #3 to have a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating the resident was cognitively intact. Further review of the MDS revealed the facility assessed Resident #3 to require physical assist of two (2) staff for toileting needs, intermittent urinary catheterization and to be occasionally incontinent of urine and frequently incontinent of bowel.</p> <p>Review of Resident #3's Comprehensive Care Plan, dated 02/11/14, revealed the resident had a care plan for the risk for complications related to in and out catheterization which was updated on 04/30/14, to reflect staff assistance of one (1) with toileting needs. Continued review of the Comprehensive Care Plan revealed a care plan for Activities of Daily Living (ADL) self care deficit which indicated the resident was to be assisted with bed mobility by staff every two (2) hours.</p>	F 315		
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F 315	<p>Continued From page 12</p> <p>Interview, on 06/10/14 at 12:10 PM, with Resident #3 revealed when he/she was asleep he/she had no awareness of urinating on himself/herself. Resident #3 revealed he/she had requested staff to wake him/her up every two (2) hours throughout the day and night to check for incontinence. Continued interview revealed during the night shift, 11:00 PM to 7:00 AM, he/she "hardly ever" got "checked at night". Resident #3 stated staff usually did not make rounds to check him/her for incontinence until between 5:00 AM and 6:00 AM on the night shift.</p> <p>Interview, on 06/11/14 at 11:52 AM, with State Registered Nursing Assistant (SRNA) #4 revealed Resident #3 had requested to her to be awakened and checked for incontinence every two (2) hours during day and night hours. Further interview revealed SRNA #4 did relay this request to the SRNAs on other shifts.</p> <p>3. Review of Unsampled Resident C's medical record revealed the facility admitted the resident on 09/20/08, with diagnoses which included Neurogenic Bladder, Alzheimer's Disease, Depression and Anxiety. Review of the Annual MDS Assessment, dated 04/23/14, revealed the facility assessed Unsampled Resident C to have a BIMS score of eight (8), indicating the resident was interviewable. Further review of the MDS revealed the facility assessed Unsampled Resident C to be frequently incontinent of bowel and bladder, and to require extensive assist of two (2) staff with toileting.</p> <p>Review of Unsampled Resident C's Comprehensive Care Plan, dated 04/09/13 revealed the resident to be at risk for skin</p>	F 315		
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F 315	<p>Continued From page 13</p> <p>breakdown related to bowel incontinence. Continued review of the care plan revealed interventions included to turn and reposition the resident every two (2) hours with physical assist of two (2) staff. Further review revealed Unsampld Resident C was also care planned for assist of two (2) staff for his/her toileting needs.</p> <p>Interview, on 06/11/14 at 9:26 AM, with Unsampld Resident C revealed the resident wanted to be awakened during the night to be checked for incontinence. Unsampld Resident C stated however, staff did not check him/her for incontinence throughout the night.</p> <p>Interview, on 06/10/14 at 3:20 AM, with State Registered Nursing Assistant (SRNA) #1 revealed staff on night shift were to check residents upon arriving at 11:00 PM by utilizing walking rounds with the off going shift. SRNA #1 stated night shift was also supposed to do rounds checking residents at 1:00 AM, 3:00 AM and again at 5:00 AM. SRNA #1 revealed her unit generally was staffed with two (2) nurses and two (2) SRNA's to care for the needs of forty (40) residents. SRNA #1 stated the unit could use an additional SRNA on night shift in order to be able to spend more time with the residents. Further interview revealed staff made the designated rounds on residents; however, is staff were busy the rounds might be made late.</p> <p>Interview, on 06/11/14 at 2:41 PM, with the Director of Nursing (DON) revealed her expectation was for staff to round on the residents every two (2) hours day or night. The DON revealed at night incontinent residents should be awakened and checked for incontinence with perineal care provided as</p>	F 315		
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F 315	Continued From page 14 needed. Further interview revealed should a resident have bed mobility issues the resident should be awakened every two (2) hours and offered assistance with bed mobility and toileting. Interview, on 06/11/14 at 5:10 PM, with the Administrator revealed her expectation was for staff to make rounds on each resident at least every two (2) hours on all shifts.	F 315		
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. (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	F 441	F441 1. Resident #1 and Resident #2 was assessed on 6/11/14 by the unit manager for any clinical signs of infection. Unsampled Resident A's medical record was reviewed on 6/11/14 to see if there were any indication of possible infection. No adverse signs were noted. 2. All residents have the potential to be affected by the alleged deficient practice; therefore the facility will implement the corrective actions and monitoring procedures outlined in #'s 3 and 4 below. 3. The SDC, Weekend RN Supervisor, Evening RN Supervisor, and ADON started in servicing on 6/12/14 to all nursing staff on the facility's policy titled "Infection Control" in regards to hand washing and	7/22/14

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F 441	Continued From page 15 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 policies and guidelines, 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 for two (2) of three (3) sampled residents (Residents #1 and #2) and one (1) of three (3) unsampled residents (Unsampled Resident A). Observation of resident care provided for Resident #1, Resident #2 and Unsampled Resident A revealed staff did not wash or sanitize their hands as per the facility's policies and guidelines during the provision of care. Additionally, observation revealed a nurse dropped Resident #1's medication, found the medication on the resident's bed, picked it up with bare hands and administered the medication to the resident. The findings include: Review of the facility's policy titled, "Policies and Practices-Infection Control", revised August 2012, revealed the facility's infection control policies and practices were intended to facilitate maintaining a	F 441	medication administration. The in servicing is ongoing and will be completed by 7/21/14. Any nursing staff that does not receive the education by 7/21/14 will not permitted to work until completed. The SDC, Weekend RN Supervisor, Evening shift RN Supervisor, ADON, and DON started completing competencies for hand washing and incontinence care on 6/12/14 for all nursing staff and will be completed by 7/21/14. 4. Each unit manager will observe 10 occurrences of hand washing and incontinence care weekly for four weeks, to ensure the appropriate procedure is being followed per the facility's policy. Then each unit manager will observe 5 occurrences of hand washing and incontinence care per week for 2 weeks, then 2 occurrences a week for 4 weeks. The DON and/or ADON will observe 4 nurses during medication pass weekly for 4 weeks, to ensure appropriate procedure is being followed per	
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F 441	Continued From page 16 safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infection. Continued policy review revealed the objectives of the infection control policies and practices included to prevent, detect, investigate, and control infections in the facility. Further review of the objectives revealed they included to maintain a safe, sanitary and comfortable environment for personnel, residents, visitors, and the general public. Review of the facility's policy titled, "Handwashing" effective December 2010, revealed staff and residents should wash their hands as necessary to prevent the spread of infections or germs. Continued policy review revealed staff should wash their hands before and after caring for each resident to include handling anything the resident had touched. Further review revealed staff should wash their hands according to policy and procedure guidelines. Review of the facility's Hand Hygiene Guidelines, posted in the staff bathrooms, revealed hands should be free of potential pathogens when providing hands-on resident care. Review of the Guidelines revealed washing with water was required when hands were dirty or contaminated with blood or body fluids. Continued review revealed alcohol hand rubs were better than washing when hands were free of blood or body fluids and could be used on the move without sinks or towels. The Guidelines noted handwashing and/or application of alcohol hand rub was to be completed before and after glove removal. Further review revealed gloves should always be removed after resident contact or between "dirty" and "clean" body site-care on the	F 441	the facility's policy. Then 2 nurses during medication pass will be observed weekly for 2 weeks, then 1 nurse during medication pass a week for 4 weeks. 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 441	<p>Continued From page 17 same resident.</p> <p>1. Observation of perineal care provided to Resident #1, on 06/10/14 at 4:30 AM, revealed State Registered Nursing Assistant (SRNA) #1 and SRNA #2 did not wash their hands or utilize alcohol hand rub when entering the residents room to provide care. Observation revealed SRNA #1: donned gloves; provided perineal care moving from "dirty" and "clean" body site-areas; and adjusted Resident #1's bed linen and clothing without removing her gloves and washing or sanitizing her hands. Continued observation revealed SRNA #1 then cleaned the bedpan and replaced the bedpan in Resident #1's cabinet touching multiple surfaces also without removing her gloves, washing her hands and donning clean gloves between tasks. Further observation revealed SRNA #1 washed her hands after completing Resident #1's care utilizing her potentially contaminated hands to turn the handle of the faucet on, and after washing her hands, SRNA #1 then turned the faucet off with her bare hands. In addition, observation revealed SRNA #2 did not wash his hands prior to exiting Resident #1's room.</p> <p>2. Observation of perineal care given to Resident #2, on 06/10/14 at 5:13 AM, revealed SRNA #1 and SRNA #2 did not wash their hands when entering the resident's room to provide care. Observation revealed SRNA #1 and SRNA #2 donned gloves and provided the perineal care for the resident. Continued observation revealed SRNA #1 removed her soiled gloves, and without washing her hands, donned clean gloves. SRNA #1 was observed to assist Resident #2 to dress, then assisted the resident into a wheel chair and brushed the resident's hair. Observation revealed</p>	F 441		
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F 441	<p>Continued From page 18</p> <p>SRNA #1 then removed her gloves and without washing or sanitizing her hands, donned clean gloves to assist Resident #2 to brush his/her dentures, touching multiple surfaces in Resident #2's room without removing her gloves, washing her hands and donning clean gloves. Further observation revealed SRNA #1 removed her gloves and washed her hands upon exiting Resident #2's room again turning the sink faucet on with her potentially contaminated hands, washing her hands and touching the faucet to turn the water off. Additionally, SRNA # 2 removed his gloves and left the room without washing his hands.</p> <p>3. Observation of care provided for Unsampled Resident A, on 06/10/14 at 5:01 AM, revealed staff were assisting the resident up to the bathroom. Observation revealed SRNA #1 removed her gloves, bagged soiled items, took the bag of soiled items to the soiled utility room. Continued observation revealed SRNA #1 then went into the bathroom of resident room 112 (vacant), then to the nurse's station and returned to Unsampled Resident A's room without washing or sanitizing her hands.</p> <p>Interview with SRNA #1 on 06/10/14 at 7:12 AM, revealed she should have washed her hands or used alcohol hand gel before and after resident care. SRNA #1 stated she should have washed her hands or used alcohol hand gel when changing gloves and when moving from a "dirty" to "clean" area when providing perineal care. Continued interview revealed the facility had provided hand hygiene education to her, and she should have washed her hands to decrease the risk of spreading infections.</p>	F 441		
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F 441	<p>Continued From page 19</p> <p>Interview with SRNA #2 on 06/10/14 at 7:49 AM, revealed hand hygiene should be performed before and after resident care and when moving from a "dirty" or contaminated area to a "clean" area when providing resident care. SRNA #2 revealed hands should be washed or sanitized anytime gloves were removed or changed, and hand hygiene should be utilized for infection control purposes.</p> <p>Interview with the Director of Nursing (DON) on 06/11/14 at 2:41 PM, revealed the Infection Control Nurse was on vacation and she was covering for all infection control issues. The DON revealed staff should wash their hands or use alcohol hand sanitizer gel prior to donning gloves for provision of resident care. The DON stated staff should remove their gloves and wash their hands after providing resident care and prior to provision of to another resident. Continued interview revealed hands should be washed or sanitized when moving from a soiled or "dirty" area to a "clean" area during the provision of care and gloves changed.</p> <p>4. Review of the facility's policy, titled "Medication Administration" dated December 2012, revealed hands were to be washed with soap and water and gloves applied prior to handling tablets.</p> <p>Observation of a medication administration on 06/10/14 at 4:35 AM, revealed Licensed Practical Nurse (LPN) #1 dropped Resident #1's medication tablet on his/her bed. Continued observation revealed LPN #1 searched Resident #1's bed linen for the tablet, found and picked the tablet up with her bare hands, placed the tablet back into the medication administration cup and administered the tablet to the resident.</p>	F 441		
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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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 06/11/2014
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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 441	Continued From page 20 Continued interview with the Director of Nursing (DON) on 06/11/14 at 2:41 PM, revealed licensed nursing staff should dispose of medications which were dropped and obtain another dose of the medication to administer to the resident. The DON stated staff should not touch medications with their bare hands, nor should they administer the medication after it had been dropped due to the risk of cross contamination and infection control issues. Continued interview revealed staff should utilize the facility's infection control policies to decrease the risk of cross contamination and transmission of infection to other residents. Further interview revealed she was not aware staff were not consistently utilizing the infection control guidelines. In addition, the DON stated the facility had not identified any infection control issues.	F 441		
F 514 SS=D	483.75(I)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and	F 514	F514 1. On 6/12/14, Resident #1's medical record was corrected to reflect the accurate order. No adverse was noted related to the discrepancy on the physician's order because the MAR was transcribed correctly per the	7/22/14

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F 514	<p>Continued From page 21 systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy, it was determined the facility failed to maintain residents' clinical records in which were complete and accurately documented for one (1) of the three (3) sampled residents (Resident #1).</p> <p>Resident #1's Physician's Admission Medication Orders were incorrectly and inaccurately transcribed to the resident's Medication Administration Record (MAR).</p> <p>The findings include: Review of the facility's policy titled, "Health Information Management" effective March 2013, revealed all medical records should be maintained in a systematic order.</p> <p>Interview with the Director of Nursing (DON) on 06/11/14 at 1:32 PM, revealed the facility did not have a policy specific for ensuring complete and accurate medical records.</p> <p>Record review revealed Resident #1 was</p>	F 514	<p>discharge summary dated 6/2/14.</p> <p>2. All residents have the potential to be affected by the alleged deficient practice; therefore the facility will implement the corrective actions and monitoring procedures outlined in #'s 3 and 4 below.</p> <p>3. Each unit manager will review all admits and readmits for the time period of 4/1/14 thru 6/30/14 to ensure transcription of physician orders, medication administration record, and treatment administration record are accurate per the discharge summaries. The SDC will initiate an in service on 7/7/14 to be complete by 7/21/14 related to complete and accurate medical records to include transcribing physician orders, medication administration record, and treatment administration record per the discharge summaries.</p> <p>The current 24 hour audit will be changed to include the DON, ADON, or Restorative Nurse</p>		

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F 514	<p>Continued From page 22</p> <p>admitted by the facility on 06/02/14, with diagnoses which included Splenectomy after Peritonitis, Hypertension, Gout, Gastroesophageal Reflux Disease and Coronary Artery Disease. Review of Resident #1's Admission Minimum Data Set (MDS) dated 06/09/14, revealed it was in progress. Continued review of the MDS Assessment revealed the facility assessed Resident #1 to have an initial Brief Interview for Mental Status (BIMS) score of thirteen (13) out of fifteen (15), indicating he/she was cognitively intact. Review of the Interim Plan of Care developed on Resident #1's admission, revealed the resident was care planned for alteration in comfort/pain. Continued review of the alteration in comfort/pain care plan revealed comfort measures were to be implemented as ordered with the Physician to be notified for a new onset or change in pain.</p> <p>Review of Resident #1's acute care hospital Discharge Summary medication list dated 06/02/14, utilized by the facility as the Physician's Admission Medication Orders, revealed Acetaminophen (a pain reliever) 650 milligrams (mg) was to be given by mouth every four (4) hours PRN (as needed) for pain or fever. However, review of the facility's Physician's Admission Medication orders dated 06/02/14 for Resident #1, revealed the order for the Acetaminophen 650 mg was transcribed to be given every four (4) hours for pain or fever with no documented evidence of the PRN.</p> <p>Review of Resident #1's MAR for June 2014, revealed the order for the resident's Acetaminophen 650 milligrams was to be given by mouth every four (4) hours for pain or fever and transcribed to include the PRN.</p>	F 514	<p>Supervisor to review and co-sign each audit completed by the unit manager.</p> <p>4. The DON, ADON, Unit Managers, and RN Supervisors will audit all admissions and readmissions for one month related to the variance of admissions from month to month, then 50% of all admissions and readmissions for 4 weeks, and then continue with 25% of admissions and readmissions for 4 weeks. 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.</p>	
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F 514	Continued From page 23	F 514		
	<p>Interview with Unit Manager #5 on 06/11/14 at 12:02 PM, revealed the transcription process for Physician's Orders should be correct and accurate. Unit Manager #5 indicated Resident #1's Acetaminophen should have been transcribed correctly on the Physician's Orders and MARs. Further interview revealed she conducted a twenty-four (24) hour audit to check for accuracy of transcription of Physician's Orders.</p>			
	<p>Interview with the DON on 06/11/14 at 2:41 PM, revealed the Physician's Orders should be transcribed correctly from the Discharge Summary onto the Physician Orders, and indicated this should have occurred for Resident #1's Acetaminophen order. Continued interview revealed the facility's back up process to ensure correct and accurate transcription was having the Unit Manager do a twenty-four (24) hour check for accuracy of new orders transcribed. Further interview revealed Resident #1's MAR was correct per the hospital Discharge Summary medication list.</p>			