

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

PRINTED: 01/05/2015  
FORM APPROVED  
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>185146 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br>R-C<br>12/31/2014 |
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| NAME OF PROVIDER OR SUPPLIER<br><br>FOUNTAIN CIRCLE CARE & REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE<br>200 GLENWAY ROAD<br>WINCHESTER, KY 40391 |
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{F 000} INITIAL COMMENTS

An On-Site Revisit was initiated on 12/23/14 and concluded on 12/31/14. Based on the facility's acceptable Plan of Correction it was determined the facility had corrected the deficient practice as alleged on 12/01/14.

{F 000}

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

An Abbreviated/Partial Extended Survey investigating KY00022333 and KY00022378 was concluded on 11/06/14. KY00022378 was unsubstantiated without identified deficiencies. KY00022333 was substantiated with related deficiencies cited. Immediate Jeopardy (IJ) was identified on 10/22/14 and was determined to exist on 10/03/14 with deficiencies cited at 42 CFR 483.20 Resident Assessment, F-282; 42 CFR 483.25 Quality of Care, F-323; and 42 CFR 483.75 Administration, F-490 all at a Scope and Severity (S/S) of a "J". Substandard Quality of Care (SQC) was identified at 42 CFR 483.25, F-323. The facility was notified of the Immediate Jeopardy on 10/22/14.

Interview and record review revealed the facility failed to have an effective system in place to maintain a safe environment and provide supervision and monitoring for Resident #1. On 10/03/14 during a scheduled activity outside the facility, Resident #1, who had diagnoses of Right Hemiplegia (paralysis) and Right Above the Knee Amputation, was assisted from his/her personal wheelchair with a self-releasing seat belt, into a manual wheelchair with no self-releasing seat belt. Resident #1 was assisted by staff onto the facility van and his/her wheelchair was secured to locks on the van floor; however, staff failed to ensure the resident was safely and securely restrained in a seat belt prior to the van moving. During transport in the facility's van unsecured, at approximately 2:15 PM, the van suddenly stopped for a red light and Resident #1 "flew" out of his/her wheelchair onto the center aisle of the van, landing on his/her right side. Registered Nurse (RN) #1, who was present in the van,



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Selma M. Hudson* TITLE: *Administrator* (X6) DATE: *12/11/14*

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F 000 Continued From page 1  
assessed Resident #1 and the resident was then transported to the hospital Emergency Room (ER). Resident #1 was diagnosed at the ER with a "large" Hematoma to the right forehead area measuring approximately 4.5 centimeters (cm) by 2.6 cm. The ER Physician documented he was "unable to complete" a full eye examination "due to the amount of swelling" in Resident #1's right eye. The resident returned to the facility at 4:52 PM on 10/03/14.

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An acceptable credible Allegation of Compliance (AOC) related to the Immediate Jeopardy was received on 10/29/14, alleging removal of the Immediate Jeopardy on 10/25/14. On 11/06/14, the State Survey Agency verified the Immediate Jeopardy was removed on 10/25/14 as alleged with remaining non-compliance at 42 CFR 483.20 Resident Assessment, F-282; 42 CFR 483.25 Quality of Care, F-323; and 42 CFR 483.75 Administration, F-490 all at a Scope and Severity (S/S) of a "D", while the facility develops and implements the Plan of Correction (POC) and the facility's Quality Assurance monitors the effectiveness of the systemic changes.

F282

F 282 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN  
SS=J

F 282

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

1. On 10-22-2014 the DON and ADON reviewed resident #1's care plan to ensure all of resident #1's current care needs were care planned and being followed. On 10/23/14 the care plan for Resident #1 was updated to reflect the manual wheelchair that includes the self-releasing seat belt that is to

12/01/14

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F 282: Continued From page 2

failed to have an effective system in place to ensure residents' Comprehensive Care Plans were implemented to ensure safety of residents through provision of necessary assistive devices for one (1) of three (3) sampled residents (Resident #1).

During an activity outing on 10/03/14, Resident #1 was transferred from his/her own motorized wheelchair with a self-releasing seat belt, which he/she was care planned to have related to poor upper body balance, into a manual wheelchair with no self-releasing seat belt. Resident #1 was assisted onto the facility van and his/her manual wheelchair was locked into place on the van floor; however, staff failed to ensure Resident #1 had a seat belt in place prior to movement of the van. At approximately 2:15 PM during the transportation to the activity outing, the van suddenly stopped at a red light, and Resident #1 "flew" out of the manual wheelchair, in which he/she had been unrestrained, onto the center aisle of the van landing on his/her right side. Registered Nurse (RN) #1 who was in the van, immediately assessed Resident # 1, and he/she was transported to the hospital Emergency Room (ER), where the resident was diagnosed with a large Hematoma to the right forehead area which measured approximately 4.5 centimeters (cm) by 2.6 cm. The resident returned to the facility at 4:52 PM on 10/03/14. (Refer to F-323)

The facility's failure to have an effective system in place to ensure residents' Comprehensive Care Plans were implemented regarding provision of assistive devices to ensure the safety of residents was likely to cause serious injury, harm, impairment or death. The Immediate Jeopardy was identified on 10/22/14 and was determined to

F 282

be used when the resident is on a facility outing.

2. On 10-22-2014 the DON, ADON, MDS Nurses, and Nursing Supervisors reviewed 100% of all care plans for those residents in the facility to ensure all current care needs were care planned and being followed.

3. All new orders are reviewed daily Monday thru Friday in the clinical white board meetings by the DON, ADON, Unit Managers and Restorative Nurse to ensure all new resident needs get care planned. An in-service was started on 10/22/14 and completed by 10/24/14 by the SDC, Administrator, DON, Nursing Supervisor, MDS, Quality of Life Director, Human Resource Director, Environmental Services Director, Social Services Director, Admissions Director, Medical Records, Chaplain, and ADON was given to all staff related to the care plan process.

4. On 10-22-2014 the facility implemented the process of the DON, ADON, SDC or Nursing

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| F 282  | <p>Continued From page 3 exist on 10/03/14.</p> <p>The facility provided an acceptable credible Allegation of Compliance (AOC) on 10/29/14 which alleged removal of the Immediate Jeopardy on 10/25/14. The Immediate Jeopardy was verified to be removed on 10/25/14, as alleged, with remaining non-compliance in the area of 42 CFR 483.20, Resident Assessment, F-282 at a Scope and Severity of a "D" while the facility develops and implements a Plan of Correction (POC), and the facility's Quality Assurance monitors the effectiveness of the systemic changes to ensure compliance.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Care Plans-Comprehensive", revised October 2010, revealed care plan interventions were designed after careful consideration between each resident's problem areas and the causes. Per the Policy, care plan development was to include developing interventions which were targeted and meaningful to each resident.</p> <p>Interview with the Director of Nursing (DON) on 10/16/14 at 2:00 PM, revealed although the facility's care plans policies did not address staff following care plan interventions, it was her expectation for this to be done.</p> <p>Record review revealed the facility admitted Resident #1 on 01/14/12, with diagnoses which included Right Above the Knee Amputation (AKA), Cerebrovascular Accident (CVA) with Right Hemiplegia (paralysis) and Aphasia. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 09/02/14, revealed the</p> | F 282  | <p>Supervisor to observe the care delivery for 5 different residents on each unit daily Monday thru Friday by a Nursing Supervisor and on the weekends by the Weekend Supervisor until 10-25-2014. The observations for care delivery were then performed 3 times a week for four weeks, then continue weekly for 4 more weeks. The DON, ADON, and all Nursing Supervisors will continue to monitor care delivery per the residents care plan during daily observations on each unit.</p> <p>The monitoring tool of the care delivery observations was discussed in our weekly 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</p> |                      |   |

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F 282 Continued From page 4  
 facility assessed Resident #1 to be moderately cognitively impaired. Continued review of the MDS Assessment revealed the facility assessed Resident #1 as being dependent on two (2) staff assist for all transfers. Review of Resident #1's Physician's Order dated 07/24/14, revealed an order for the resident to have a self-releasing seat belt when up in the wheelchair related to his/her sense of security regarding the diagnosis of Right AKA.  
 Review of Resident #1's Comprehensive Care Plan (CCP), dated 10/31/13, revealed Resident #1 was care planned to be at risk for a fall related injury related to requiring assistance with transfers. Continued review of the CCP revealed interventions which included the self-releasing seat belt, ordered on 07/24/14, to be placed on Resident #1 when he/she was up in the wheelchair for his/her safety and security related to poor upper body balance.  
 Review of the Nurse's Notes revealed a "late entry" Note dated 10/03/14 timed 6:00 PM, which stated Resident #1 was assisted out of his/her motorized wheelchair for an outing that day at approximately 1:30 PM, and into a manual wheelchair. The Note revealed once on the facility's van Resident #1's manual wheelchair was locked into place on the van floor, but the resident's "seat belt was not sufficiently latched", and the resident was thrown from the wheelchair onto the van floor when the van suddenly stopped for a red light. Further review revealed Resident #1 "bumped" his/her head, was transferred to the ER and had a Hematoma "dark in color". Review of the hospital ER record dated 10/03/14 at 2:52 PM, revealed Resident #1 was diagnosed with a Hematoma to the right forehead area.

F 282

Director, Dietician, Quality of Life Director, and Unit Managers.

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| F 282  | <p>Continued From page 5</p> <p>Interview, on 10/21/14 at 2:45 PM, with Resident #1 revealed he/she did not have a self-releasing seat belt when in a manual wheelchair for facility outings. Resident #1 stated she did not feel secure without having his/her self-releasing seat belt on. Per interview, Resident #1 reported he/she went on outings "all the time" to go shopping; however, this was the first time something like this had happened. Resident #1 stated he/she did not recall staff putting a seat belt on him/her prior to the van moving on the day of his/her fall.</p> <p>Interview, on 10/21/14 at 1:30 PM, with Certified Nursing Assistant (CNA) #1 revealed Resident #1 usually had a self-releasing seat belt on when up in his/her motorized wheelchair. CNA #1 revealed Resident #1's CNA Care Plan noted he/she was supposed to have a seat belt. She stated on 10/03/14, she and CNA #2 assisted Resident #1 from his/her motorized wheelchair on 10/03/14, into a manual wheelchair with no seat belt attached to go on a facility outing. Per interview, even though she was aware Resident #1 needed a self-releasing seat belt, she did not say anything to the Activity Director or RN #1 as she thought they knew the resident needed it.</p> <p>Interview, on 10/21/14 at 4:45 PM, with RN #1 revealed she was not aware Resident #1 wore a self-releasing seat belt, and stated she did not know the resident was not wearing one (1) in the manual wheelchair.</p> <p>Interview, on 10/16/14 at 3:05 PM, with the Activities Director revealed on 10/03/14, she had assisted residents in wheelchairs, including Resident #1 onto the van and locked the</p> | F 282   |   |   |

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F 282 Continued From page 6  
wheelchairs into place on the van floor. The Activity Director indicated she was not aware Resident #1 used a self-releasing seat belt when in a wheelchair.

F 282

Interview, on 10/22/14 at 3:30 PM, with Licensed Practical Nurse (LPN) #1, who was the Unit Manager on Resident #1's unit, revealed the self-releasing seat belt which Resident #1 was care planned for was to be worn when he/she was up in a wheelchair for the resident's sense of security in the motorized wheelchair in the facility. LPN #1 stated it would not be her expectation for Resident #1 to have a self-releasing seat belt when up in a manual wheelchair as it was for the motorized wheelchair. However, review of the care plan revealed the self-releasing seat belt was noted to be in use when Resident #1 was in a wheelchair, with no specification for use only in the motorized wheelchair.

Interview with RN #4, an MDS Nurse on 10/22/14 at 2:50 PM, revealed Resident #1 was care planned for a self-releasing seat belt when in his/her motorized wheelchair. RN #4 stated she was not aware Resident #1 was ever in a manual wheelchair, but if he/she was the seat belt should have been in place for his/her security, as per the care plan.

Interview with the Director of Nursing on 10/21/14 at 2:00 PM and 10/22/14 at 4:05 PM, revealed Resident #1 did not have a self-releasing seat belt in place on 10/03/14 when the incident occurred. The DON revealed her expectation was for staff to follow residents' care plan interventions. However, at the time of the incident on 10/03/14, the facility was unclear about what had happened on the van that day.

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F 282 Continued From page 7

whether Resident #1 had a lap belt in place or not, and how Resident #1 ended up coming out of the wheelchair on the van. She indicated if Resident #1 was care planned to have a self-releasing seat belt when up in the wheelchair, then the resident should have had one (1) in place as per the care plan. The DON stated however, she thought the self-releasing seat belt was only for when Resident #1 was in his/her motorized wheelchair, not if he/she was in a manual wheelchair, even though this was not specified in his/her care plan.

The facility provided an acceptable, credible Allegation of Compliance (AOC) on 10/29/14, with alleged removal of Immediate Jeopardy (IJ), effective 10/25/14. Review of the AOC revealed the facility implemented the following:

1. The initial investigation of Resident #1's fall was started by the Director of Nursing (DON) on 10/10/14. The investigation included: Resident #1 was assessed by the Assistant Director of Nursing (ADON) on 10/10/14; staff statements were obtained 10/10/14 through 10/14/14 by the Administrator, Director of Nursing (DON), Social Services Director (SSD) and ADON; resident's statements were obtained 10/10/14 through 10/14/14 by the Administrator, DON, ADON, or SSD, from the residents who were on the van when the 10/03/14 incident involving Resident #1 occurred; "the wheelchair placement area" on the van with the "failed seat belt function", was placed out of service on 10/10/14 by the Maintenance Director.
2. Contacts, which started on 10/03/14 by the Administrator, were made to several agencies to get all seat belts on the van assessed for proper

F 282

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| F 282  | Continued From page 8<br>function and safety. An officer with the Kentucky State Police (KSP) Vehicle Enforcement provided education/training on 10/24/14 for eight (8) nursing administration staff, two (2) nursing staff, one (1) Medical Records staff person, three (3) Quality of Life (Activity) Staff, the Chaplain, seven (7) administrative staff, two (2) housekeeping staff, and the Rehabilitation (Rehab) Services Manager, who were all designated transport staff, regarding pre-trip vehicle inspection and properly securing resident passengers on the van. Return demonstration was completed by these staff at the training that was held on 10/24/14. All the designated transport staff were to complete a demonstration to the Administrator prior to going on another outing to ensure understanding of proper safety belt function. Any new designated transport staff will demonstrate to the Administrator proper safety belt application prior to going on an outing with the residents.<br><br>3. A new process was put in place to ensure residents' safety while on the van which included a safety check off sheet implemented on 10/3/14 by the Administrator. The facility also implemented changes to the "Outings Guidelines" which included: staff utilizing the "Pre-Trip Vehicle Safety Form", which was revised 10/22/14, prior every outing to ensure safety of residents; and a copy of the Certified Nursing Assistant (CNA) "care guide" for each resident would be taken on every outing to ensure residents' care plans were followed. The designated transport staff and two (2) van drivers received education/training on the new process on 10/03/14, by the ADON. The designated transport staff was educated on the updated "Pre-Trip Vehicle Safety Form", which began on 10/22/14 and was completed on 10/24/14. Resident #1 was provided with a | F 282  |   |                      |   |

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

PRINTED: 11/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

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| F 282  | Continued From page 9<br>transport wheelchair, to include a self-release seat belt, on 10/23/14 that met resident care needs and ensured the residents safety during transport in the facility van. An investigation of the 10/03/14 incident involving Resident #1 was completed by the DON on 10/15/14.<br><br>4. The new "Outing Guidelines" process which included the "Pre-Trip Vehicle Safety Form" and copy of the CNA "care guide" for each resident, that were to be taken and followed on all outings, would also ensure residents' care plans were followed on the outing when the residents were on the van. All Department Managers received education/training on 10/22/14, regarding the new "Outing Guidelines" process provided by the SCC.<br><br>5. All residents were assessed by the DON, ADON, or Registered Nurse (RN) Supervisor on 10/22/14, for electric wheelchair usage, to determine if residents' safety needs were met, along with any care planned safety devices for safety needs during transport in the facility van, as outlined by residents' care plans.<br><br>6. All residents were assessed. Residents with a Brief Interview Mental Status (BIMS) score greater than eight (8), were interviewed beginning 10/22/14 and completed on 10/23/14, by the Administrator, DON, ADON, SSD, Registered Dietician (RD), Chaplain or Medical Records staff for any concerns. Residents with a BIMS score less than eight (8) were physically assessed by the DON, ADON, Unit Managers, or RN supervisor. The assessments, interviews and questionnaires were reviewed by the Administrator or Signature Care Consultant (SCC) on 10/23/14. | F 282  |   |                      |   |

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

PRINTED: 11/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

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|--------------------|--|---------------|---|----------------------|

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| F 282 | Continued From page 10  | F 282 |  |  |
|       | <p>7. All personnel files were audited 10/22/14 by Human Resources staff, Chaplain or Nursing Supervisor for any concerns, with results given to the SCC on 10/23/14, for review. Additionally, all accident/incident reports from July to 10/22/14 were reviewed on 10/23/14 by the DON, ADON, SDC or SCC to identify any concerns and ensure incident reports and a thorough investigation was completed, with no concerns identified.</p> <p>8. All residents' care plans and CNA care plans were reviewed and updated as needed to include residents' wheelchair safety devices, on 10/22/14 by the DON, ADON, Nursing Supervisor or Minimum Data Set (MDS) Nurses to ensure each resident's care plan and CNA care plan reflected the current care needs of the resident.</p> <p>9. Facility environmental rounds were completed by the Housekeeping Director, Activity Director or Administrator on 10/22/14, to ensure the residents' environment was free of accidents and hazards.</p> <p>10. On 10/22/14, the SCC educated the facility's management staff which included the Administrator, DON, ADON, RN Supervisors, MDS, Quality of Life (Activity) Director, HR staff, Environmental Services Director (ESD), SSD, Admissions Director, Medical Records and Chaplain on the facility's care plan policy, accident/incident policy and the revised "Outing Guidelines" process. These staff could not return to work until the education was provided, post-test administered and a score of one hundred percent was obtained. If they did not score one hundred percent on the post-test, the staff person was immediately re-educated and</p> |       |  |  |

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

PRINTED: 11/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

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| NAME OF PROVIDER OR SUPPLIER<br><br>FOUNTAIN CIRCLE CARE & REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE<br>200 GLENWAY ROAD<br>WINCHESTER, KY 40391 |
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|--------------------|--|---------------|---|----------------------|
|--------------------|--|---------------|---|----------------------|

F 282 Continued From page 11  
post-test re-administered. The process continued until all the above management staff obtained one hundred percent on the post-test. All post-tests were reviewed for compliance by the SCC.

F 282

11. The management staff which included, the Administrator, DON, ADON, RN Supervisor, MDS, Quality of Life (Activity) Director, HR staff, ESD, SSD, Admissions Director, Medical Records staff, or Chaplain, after completion of the education, re-educated all facility staff on the facility's care plan policy, accident/incident policy and the revised "Outing Guidelines" process starting on 10/22/14. By 10/24/14, one hundred and twenty-six (126) of the facility's one hundred and eighty-nine (189) staff had been re-educated. All employees who had not received the education were sent a certified letter on 10/27/14, providing notification to staff not to return to work until education was completed, with no staff allowed to work until education was provided. All staff provided the re-education completed an abuse post-test and a one-hundred percent score had to be obtained, or the staff were immediately re-educated and the post-test was re-administered. This process was to continue until staff obtained a score of one hundred percent on the post-test. This education was to be included during orientation for all newly hired staff who would not be allowed to work until the education was provided, the post-test administered and a score of one hundred percent obtained. The facility does not employ or utilize agency staffing.

12. A nurse from the facility's regional or corporate office was onsite beginning 10/22/14, and was to remain in the facility daily until the

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

PRINTED: 11/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

|  |  |  |   |
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| NAME OF PROVIDER OR SUPPLIER<br><br>FOUNTAIN CIRCLE CARE & REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE<br>200 GLENWAY ROAD<br>WINCHESTER, KY 40391 |
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|--------------------|--|---------------|---|----------------------|
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| F 282 | <p>Continued From page 12</p> <p>Immediate Jeopardy (IJ) was lifted. These nurses assisted with investigations, observed staff treatment of residents, performed chart audits, observed environment safety, observed care delivery to ensure it was provided as per residents' care plans and provided oversight and consultation. The facility's corporate Vice President (VP) of Operations, the Special Projects Administrator or the Director of Clinical Programs was to be in daily contact with the SCC and were to review allegations until the IJ was lifted.</p> <p>13. Per the AOC, the DON, ADON, SDC or Nursing Supervisor would observe the care delivery for five (5) different residents on different units for a total of fifteen (15) residents for any concerns daily until removal of the IJ, then would perform the observations weekly for four (4) weeks. Results of the care delivery/observation audits were to be reported to the facility's Quality Assurance (QA) Committee weekly to determine the need for continued staff education or revision of plan. Concerns identified would be corrected immediately and reported to the Administrator to ensure investigations were completed and, if necessary reported as per the facility's guidelines. The Administrator, DON, or member of the facility's regional staff were to review all the resident care delivery audits daily to identify any concerns. Investigations of any concerns were to be initiated upon receipt of the concern starting on 10/23/14. The Administrator and one (1) of the following: VP of Operations; Special Projects Administrator; or SCC would review the investigations daily to ensure the above areas were covered. All the above was to continue until removal of the IJ.</p> | F 282 |  |  |
|-------|---|-------|--|--|

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

PRINTED: 11/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

|  |  |   |   |   |
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| F 282  | <p>Continued From page 13</p> <p>14. The VP of Operations, SCC or Special Projects Administrator would provide administrative oversight of the facility daily until removal of the IJ beginning 10/22/14, after removal of the IJ administrative oversight by the above would continue weekly for four (4) weeks, then monthly. A QA meeting would be held weekly for four (4) weeks beginning 10/22/14, then monthly afterwards for recommendations and further follow up regarding the AOC. The QA Committee would determine at what frequency any ongoing audits would need to continue. The Administrator had the oversight to ensure an effective plan was in place to meet residents' well-being, as well as, an effective plan to identify facility concerns and implement a plan of correction to involve all staff of the facility. Corporate Administrative oversight of the QA Committee meeting would be completed by the Special Projects Administrator, Regional VP of Operations, or member of the regional staff daily until removal of the IJ beginning 10/22/14, then weekly for four (4) weeks, then monthly thereafter.</p> <p>The State Agency validated the implementation of the facility's AOC as follows:</p> <p>1. Review of the facility's investigation report revealed: it was initiated 10/10/14 by the DON; Resident #1 was assessed by the ADON on 10/10/14, witness statements of staff and residents on the van had been obtained by the Administrator, DON, ADON and SSD; and per the Plant Operations Director (POD) written statement, the "wheelchair placement area" on the van with the "failed seat belt function" had been placed "out of service" as per the AOC.</p> | F 282   |   |   |

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

PRINTED: 11/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

|  |  |  |   |
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| NAME OF PROVIDER OR SUPPLIER<br><br>FOUNTAIN CIRCLE CARE & REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE<br>200 GLENWAY ROAD<br>WINCHESTER, KY 40391 |
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|--------------------|--|---------------|---|----------------------|
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| F 282 | Continued From page 14<br>Interview with the SCC on 11/04/14 at 10:30 AM, revealed the van had not transported residents since the incident involving Resident #1 on 10/03/14, and he verified the facility's investigation completion as above.<br><br>2. Review of the statement signed by the Administrator, undated, revealed she contacted an officer with the KSP, who agreed to offer training regarding safety on the van. Continued review of the Administrator's written statement revealed the KSP officer provided the training on 10/24/14 at 10:30 AM.<br><br>Review of the In-Service sign-in sheets, dated 10/24/14, revealed the officer provided instruction on "Outing Education and Safety" for twenty-four (24) facility staff who signed the in-service sheets.<br><br>Observation on 11/05/14 at approximately 1:00 PM, revealed the Quality of Life (Activity) Director and the Chaplain performed a demonstration of what they had been trained on by the KSP officer.<br><br>Interview on 11/05/14 with the Human Resources (HR) staff person at 11:07 AM, Activity Aide Assistant #1 at 1:56 PM, Activity Aide Assistant #2 at 2:08 PM and on 11/06/14 with the Activities Director at 12:19 PM and the DON at 12:47 PM revealed they had all received the training provided by the KSP officer on 10/24/14, completed return demonstration and had taken a post-test on which they had to score one hundred percent. Per the DON, any new staff designated to assist with outings would go through the same education, return demonstration and post-testing.<br><br>3. Review of the facility's, "Outing Guidelines Form", undated, revealed the facility had | F 282 |  |  |
|-------|--|-------|--|--|

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

PRINTED: 11/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

|  |  |  |   |
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| NAME OF PROVIDER OR SUPPLIER<br><br>FOUNTAIN CIRCLE CARE & REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE<br>200 GLENWAY ROAD<br>WINCHESTER, KY 40391 |
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|--------------------|--|---------------|---|----------------------|
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| F 282 | Continued From page 15<br>implemented the use of a the "Pre-Trip Vehicle Safety Form" which was to be completed by staff to double check the security of all residents and their wheelchairs when on the van. Continued review of the Form revealed a copy of residents' CNA care guides were to brought on each outing for every resident attending. The Form noted staff members were secure empty wheelchairs on the bus to ensure safety of residents.<br><br>Interview on 11/05/14 with the HR staff person at 11:07 AM, Activity Assistant Aide #1 at 1:56 PM, Activity Assistant Aide #2 at 2:08 PM and on 11/06/14 with the Activities Director at 12:19 PM revealed they had all been educated on the new process for transportation of residents on outings. They all reported being educated on the updated "Pre-Trip Vehicle Safety Form" between 10/22/14 and 10/24/14. Interview on 11/06/14 at 12:47 PM with the DON revealed: she had also been educated on the updated "Pre-Trip Vehicle Safety Form"; Resident #1 was provided a wheelchair which had a self-releasing seat belt for outings; and she had completed a thorough investigation of the 10/03/14 incident involving Resident #1 on 10/15/14, which was sent to the State Survey Agency.<br><br>Review of Resident #1's medical record revealed the resident was assessed by Occupational Therapy (OT) and was provided a transport wheelchair with a self-releasing seat belt on 10/23/14.<br><br>Interview with the SCC on 11/06/14 at 1:58 PM, revealed revisions were made to the facility's, "Outings Guidelines" as per the AOC. He stated the "Outings Guidelines" process was a check off system for to ensure safety of residents on the | F 282 |  |  |
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/21/2014  
FORM APPROVED  
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|--|--|--|---|

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| NAME OF PROVIDER OR SUPPLIER<br><br>FOUNTAIN CIRCLE CARE & REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE<br>200 GLENWAY ROAD<br>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 |
|--------------------|--|---------------|---|----------------------|
|--------------------|--|---------------|---|----------------------|

F 282 Continued From page 16

facility's van. Continued interview revealed changes were made to the process to address vehicle safety and to ensure all residents were secure restrained in their seat belts, including residents in wheelchairs. He revealed the "Pre-Trip Vehicle Safety Form" was revised and the "Outings Guidelines" were revised to include the addition of bringing the residents' CNA care cards on outings.

4. Review of the facility's, "Outing Guidelines Form", undated, revealed the facility had implemented the use of a the "Pre-Trip Vehicle Safety Form" which was a check-off sheet to be completed by staff to double check the security of all residents and their wheelchairs when on the van, and noted a copy of each residents' CNA care guides was to brought on each outing for every resident attending.

Review of the in-service titled, "Outing Guidelines" revealed the training was conducted by the SCC on 10/22/14.

Interview on 11/05/14 with the Director of Housekeeping and Laundry at 2:27 PM and on 11/06/14 with the Activities Director at 11:19 AM and with the DON at 12:47 PM, revealed they had all been educated on the new "Outing Guidelines" process on 10/22/14.

Interview with the SCC on 11/06/14 at 1:08 PM, revealed he provided the in-service training on 10/22/14 at 8:00 PM as per the AOC. The SCC revealed the in-service was completed with all of the department managers as per the AOC, who in turn provided the education to staff in their departments regarding the new "Outing Guidelines".

F 282

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

PRINTED: 11/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

|  |  |  |   |
|--|--|--|---|
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| NAME OF PROVIDER OR SUPPLIER<br><br>FOUNTAIN CIRCLE CARE & REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE<br>200 GLENWAY ROAD<br>WINCHESTER, KY 40391 |
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|--------------------|--|---------------|---|----------------------|
|--------------------|--|---------------|---|----------------------|

F 282 Continued From page 17

F 282

5. Review of the facility's "Census Board" Report dated 10/22/14, revealed residents were assessed for use of electric wheelchairs. Resident #1 and Resident #4 were determined to have the electric wheelchairs during the assessment.

Interview on 11/05/14 with OT #1 at 11:43 AM and OT #2 at 1:47 PM revealed they assessed Resident #1 and Resident #4 and determined the residents needed special transport chairs for outings which the residents were provided with and their care plans updated to include this information.

Review of Resident #1's and Resident #4's care plans revealed the care plans were updated to reflect the new transport chairs provided by OT.

Interview with the SCC on 11/06/14 at 1:58 PM revealed the assessment of all resident's who had electric wheelchairs was performed as per the AOC on 10/22/14. He revealed Resident #1 and Resident #4 were assessed by OT to require special transport wheelchairs for outings. Per interview, Resident #1's transport wheelchair was equipped with a self-releasing seat belt as per the resident's care plan.

6. Review of the facility's interviews conducted with residents who had a BIMS score greater than eight (8) revealed the residents were asked to answer questions on a questionnaire regarding any concerns. Continued review of the resident interviews revealed the DON, ADON and SSD questioned the residents on 10/22/14. Review of the CNA Skin Care Alert for residents with a BIMS of less than eight (8) revealed physical

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

PRINTED: 11/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>185146 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br>C<br>11/06/2014 |
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|--------------------|--|---------------|---|----------------------|

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| F 282 | <p>Continued From page 18</p> <p>assessments of those residents were completed by the DON, ADON, Unit Managers or RN Supervisor.</p> <p>Interview with the SCC on 11/06/14 at 1:58 PM, revealed resident interviews were conducted as per the AOC for residents with a BIMS of eight (8) or greater. The SCC revealed as per the AOC, residents with a BIMS of less than eight (8) were physically assessed for injury. Per interview, staff were also asked if they were aware of any concerns regarding residents.</p> <p>7. Review of the facility's personnel file audits revealed all files were audited by the Chaplain, HR Director and LPN #5, Unit Manager, who signed and dated the completion of the review of the files on 10/23/14. The State Survey Agency reviewed five (5) personnel records with no concerns identified.</p> <p>Review of the facility's "Healthcare-Event" Incident/Accident Report audit sheet revealed it included review of all incidents from 07/22/14 through 10/22/14, with no concerns identified.</p> <p>Interview with the HR Director on 11/05/14 at 11:07 AM, revealed she, along with the Chaplain and LPN #5 reviewed all employee personnel files.</p> <p>Interview with the SCC on 11/06/14 at 1:08 PM, revealed all staffs' personnel files were checked as per the AOC with no concerns identified. Continued interview revealed the audits of the Incident/Accident forms were performed as per the AOC, with no concerns identified. Per interview, the audits would continued and the clinical team would address any issues. The</p> | F 282 |  |  |
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

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|--------------------|--|---------------|---|----------------------|

F 282 Continued From page 19

SCC revealed the audits would also be performed on weekends and holidays. If any concerns were noted during the audits of the Incident/Accident Reports staff would notify the Administrator and DON.

8. Review of the facility's audits of residents' care plans and CNA Care Plans, which began on 10/22/14 with a completion date of 10/29/14, revealed all the residents' care plans and CNA Care Plans were reviewed and/or updated and revised as necessary to show the resident's current care needs. revisions in the comprehensive care plans, as well as, the Certified Nursing Assistance Care Plans.

Interview, on 11/06/14 at 12:47 PM, with the DON revealed the ADON, Nursing Supervisor, MDS Nurse and herself had performed the care plan reviews and ensured the care plans reflected each resident's assessed needs.

Interview with the SCC on 11/06/14 at 1:08 PM, revealed all residents' care plans and CNA Care Plans (care cards) were audited and reviewed by the DON, ADON, Nursing Supervisor or MDS Nurse to ensure they were correct according to the resident's assessed needs. He reported he along with the other Corporate Consultants looked over the completed care plans after the audit to ensure they were correct.

9. Review of the "Environmental Rounds" check sheet revealed the facility's department heads would be responsible for conducting the environmental rounds of the facility which began on 10/22/14. Review of the 10/22/14 "Environmental Rounds" check sheet revealed the rounds were completed by the Housekeeping

F 282

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

PRINTED: 11/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

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| F 282 | <p>Continued From page 20</p> <p>Director, Activity Director or Administrator. Review of the "Environmental Rounds" schedule revealed department head managers were assigned to check the facility's environment for accident and safety hazards.</p> <p>Interview with the Director of Environmental Services, on 11/05/14 at 3:04 PM, revealed he had been assigned to conduct the "Environmental Rounds" checking for concerns related to safety of residents. We reported that if he noticed a concern while conducting the environmental tour, he would repair the problem himself.</p> <p>Interview with the Administrator on 11/06/14 at 3:35 PM, revealed the "Environmental Rounds" were completed by the Housekeeping Director, Activity Director or herself on 10/22/14 as per the AOC. She stated these continued to be performed by the facility's department head managers.</p> <p>10. Review of the in-service sign-in sheets dated 10/22/14 revealed signatures for the Administrator, DON, ADON, RN Supervisor, MDS Nurse, Activity Director, HR Director, ESD, SSC, Admissions Director, Medical Records staff person and Chaplain. Continued review revealed the in-service was conducted by the SCC regarding the facility's care plan policies, incident/accident policy and the revised "Outing Guidelines" process. Review of the post-tests taken by the above staff revealed all had scored one hundred percent as per the AOC.</p> <p>Interview on 11/05/14 with the HR Director at 11:07 AM, the Director of Environmental Services at 3:04 PM and on 11/06/14 with the Activity Director at 12:20 PM, with the DON at 12:47 PM,</p> | F 282 |  |  |
|-------|---|-------|--|--|

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

PRINTED: 11/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

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| F 282  | <p>Continued From page 21</p> <p>with the SSD at approximately 1:15 PM, with the SDC at 1:35 PM, with the Administrator at 3:35 PM, revealed they were all in-serviced by the SCC on 10/22/14, regarding the facility's care plan policy, revised "Outing Guidelines" process and accident/incident policy prior to returning to work that day. They reported having to receive a score of one hundred percent on the post-test.</p> <p>11. Review of the in-service sign-in sheets and documentation revealed all the in-services began on 10/22/14 and were completed by 11/03/14. Review of the certified mail receipts, dated for 10/27/14, revealed letters were mailed to staff who were not scheduled to work during the in-services. Review of staffs' post-tests revealed scores of one-hundred percent.</p> <p>Interview on 11/05/14 with the HR Director at 11:07 AM, the Director of Environmental Services at 3:04 PM and on 11/06/14 with the Activity Director at 12:20 PM, with the DON at 12:47 PM, with the SSD at approximately 1:15 PM, with the SDC at 1:35 PM, with the Administrator at 3:35 PM, revealed they all had assisted with in-servicing staff after their training on 10/22/14, regarding the facility's care plan policy, accident/incident policy and revised "Outings Guidelines" process. They stated post-tests were administered to all the staff after the in-service training with staff having to score one hundred percent or be re-educated until the score was obtained. Per interview, no staff person was allowed to work until they had received the in-service and scored one hundred percent on the post-test.</p> <p>Interview on 11/05/14 with Certified Nursing Assistant (CNA) #1 at 10:45 AM, with CNA #2 at</p> | F 282  |   |                      |   |

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

PRINTED: 11/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

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| F 282  | Continued From page 22<br>11:26 AM, with Activity Aide Assistant #1 at 1:56 PM, with Activity Aide Assistant #2 at 2:08 PM and the Director of Housekeeping and Laundry at 2:27 PM, and on 11/06/14 with CNA #3 at 8:57 AM, with CNA #4 at 9:17 AM, with CNA #5 at 9:30 AM, with the Activities Director at 11:19 AM, with CNA #7 at 12:10 PM, revealed they all reported having been in-serviced on the care plan policy, accidents/incidents policy and the revised "Outing Guidelines" process. They stated they had not been allowed to work until they had received the in-services. Further interview with the above staff revealed they all took a post-test in which they had to score one hundred percent or re-take the test. They all reported receiving the required one hundred percent on the post-test.<br><br>12. Interview with the SCC on 11/06/14 at 1:58 PM, revealed he had been onsite since the IJ was called 10/22/14. He reported he worked a minimum of eight (8) hours a day to ensure staff understood the facility's inservices and revised "Outing Guidelines" process, assisted with any investigations, performed observations of staff providing care to ensure residents received care as per their care plan, assisted with chart audits and provided oversight and consultation as necessary. He stated he made rounds on all shifts to ensure the facility's policies were implemented and followed.<br><br>13. Review of the facility's "Care Delivery Audits" revealed the DON, ADON, SDC, or Nursing Supervisor observed care delivery for five (5) different residents on different units for a total of fifteen (15) residents for any suspected neglect concerns of residents as per the AOC.<br><br>Interview on 11/06/14 with the DON at 12:47 PM | F 282  |   |                      |   |

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

PRINTED: 11/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

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| F 282 | Continued From page 23 and SDC at 1:35 PM, revealed they both had assisted with performing the "Care Delivery Audits" on five (5) different residents on different units.<br><br>Interview on 11/06/14 at 3:35 PM with the Administrator revealed the "Care Delivery Audits" had been performed on five (5) different residents on different units since 10/22/14 as per the AOC. She stated the results of the audits were being reviewed by the DON, corporate staff or herself daily, and were being taken to the facility's QA Committee weekly.<br><br>Interview with the SCC on 11/06/14 at 1:58 PM, revealed the care delivery audits were being performed for five (5) different residents on different units as per the AOC. He stated the audit began on 10/23/14 and the last listed audit was on 10/29/14. He reported the audit would continue for four (4) weeks and the results of the care audits would be reported to the facility's QA Committee weekly to determine the further need for continued staff education. The SCC revealed no concerns had been identified at the time, but if there were concerns, an investigation would be immediately initiated.<br><br>14. Interview with the SCC on 11/06/14 at 1:58 PM, revealed he was providing daily oversight of the facility until the IJ was lifted. Then he would provide weekly oversight which would continue for four (4) weeks, then monthly thereafter. Continued interview revealed the QA Committee meeting would be held weekly, beginning 10/22/14, and for four (4) weeks total to discuss any concerns regarding the processes implemented, and to determine at what frequency any ongoing audits would need to continue. He | F 282 |  |  |
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

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| F 282  | Continued From page 24<br>stated the QA Committee meetings would then be performed monthly for continued follow up and monitoring. Per interview, the Administrator was responsible for oversight to ensure an effective plans were in place to meet each residents' needs, and ensure identification of concerns and implementation of plans involving all facility staff.  | F 282  |   |                      |   |
| F 323<br>SS=J  | 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview, record review, review of the facility's policy and procedures, Activities Director job description, and incident and investigation report it was determined the facility failed to have an effective system in place to maintain a safe environment and provide supervision and monitoring to prevent falls for one (1) of three (3) sampled residents (Resident #1).<br><br>On 10/03/14, during a scheduled activity outing, Resident #1 was assisted out of his/her personal wheelchair which had a self-releasing seat belt, into a manual wheelchair without a self-releasing seat belt. Resident #1 was then assisted onto the facility van where staff locked the manual wheelchair into place; however, staff failed to ensure the resident had a seat belt in place and | F 323  | F323<br><br>1. Resident #1 was assessed immediately on 10/3/14 by the RN on the facility van. Facility staff drove Resident #1 to Clark County Hospital where she was assessed by a physician and returned to the facility at approximately 5pm.<br><br>On 10/23/14 Resident #1 was assessed by the facility's Occupational Therapist and provided a manual wheelchair with a self-releasing seat belt to use during any facility outings.<br><br>2. On 10/03/14 all residents on the facility outing was brought back to the facility and a head to toe assessment was completed by the licensed nurses on duty. No negative findings were identified.<br><br>All accident/incident reports from July 2014 to October 22, 2014 have been reviewed on 10/23/14 by the Director of Nursing, the Assistant Director of Nursing, Staff Development Coordinator or Signature Care | 12/01/14             |   |

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

PRINTED: 11/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

|  |   |  |   |                      |   |
|--|---|--|---|----------------------|---|
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| F 323  | <p>Continued From page 25</p> <p>fastened on his/her wheelchair prior to the van moving. While being transported on the van, at approximately 2:15 PM, the van suddenly stopped at a red light, and Resident #1, who had no fastened seat belt in place "flew" out of his/her wheelchair onto the center aisle of the van, landing on his/her right side. Registered Nurse (RN) #1, who was in the van, assessed Resident #1 who was then transported to the hospital Emergency Room (ER) where he/she was diagnosed with a large Hematoma measuring approximately 4.5 centimeters (cm) by 2.6 cm to the right forehead area. The ER Physician documented being unable to fully examine Resident #1's right eye "due to the amount of swelling". The resident returned to the facility at 4:52 PM on 10/03/14.</p> <p>The facility's failure to have an effective system in place to maintain a safe environment and provide supervision and monitoring to prevent falls was likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy was identified on 10/22/14 and was determined to exist on 10/03/14.</p> <p>An acceptable credible Allegation of Compliance (AOC) was received on 10/29/14, which alleged removal of the Immediate Jeopardy on 10/25/14. On 11/06/14, the State Survey Agency verified the Immediate Jeopardy was removed on 10/25/14 as alleged with remaining non-compliance at 42 CFR 483.25 Quality of Care, F-323 at a Scope and Severity (S/S) of a "D", while the facility develops and implements a Plan of Correction (POC) and the facility's Quality Assurance monitors the effectiveness of the systemic changes.</p> | F 323  | <p>Consultant to identify any concerns of suspected abuse/neglect and ensure thorough investigation of accident/incident was completed. No concerns were identified.</p> <p>Facility environmental rounds were completed by the housekeeping director, QOL Director, or Administrator on 10/22/14 to ensure an environment free of accidents and hazards exist for the residents.</p> <p>3. On 10/22/14 the DON and ADON reviewed each resident in the facility to determine the use of motorized wheelchairs. One other resident was found to be utilizing a motorized wheelchair. The facility's Occupational Therapist assessed this resident for a manual wheelchair on 10/23/2014. The manual wheelchair was provided for the resident to use on any facility outings.</p> <p>A new Pre-Trip Vehicle Safety Form was developed on 10/3/2014 and then was revised</p> |                      |   |

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

PRINTED: 11/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

|  |  |  |   |
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|--------------------|--|---------------|---|----------------------|
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| F 323 | Continued From page 26<br>The findings include:<br><br>Review of the facility's policy titled "Safety Precautions for Activities", revised January 2009, revealed it was the intent of the facility to provide supervision, safety and a safe environment for all residents during activity programs and while in activity areas. The Policy revealed the Activity staff assumed responsibility for the supervision of a resident while they were engaged in activity programs.<br><br>Review of the facility's, "Outing Guidelines", undated, revealed the safety and well-being of residents was "always" the facility's "first priority". Per the Guidelines, staff should "double check" the security of residents, and/or wheelchairs of residents being transported in a wheelchair on the facility's van. The Guidelines stated staff were to "not assume" residents had been secured properly on the van.<br><br>Review of the Activities Director job description, updated December 2011, revealed the Director was to initiate and promote activities within the facility and outside the facility, as weather permitted, ensuring the safety and well-being of each resident at all times. Continued review of the job description revealed the Activities Director was to also coordinate and verify assistance was provided to residents as necessary.<br><br>Review of the facility's policy titled, "Accidents and Incidents-Investigating and Reporting", revised April 2013, revealed "all accidents or incidents involving residents" should be investigated and reported to the Administrator. Continued review revealed the Nurse Supervisor/Charge Nurse and/or Department | F 323 | on 10/22/2014 to include a copy of the SRNA Care Guide. All staff was re-educated on the updated form, Outing Guidelines, Accidents and Incidents starting on 10/22/2014 and was completed on 10/24/14 by the Administrator, DON, ADON, Nursing Supervisor, MDS Coordinators, QOL Director, HR Director, Environmental Services Director, Social Services Director, Admissions Director, Medical Records, Chaplain, and Staff Development Coordinator.<br><br>On 10/24/2014 Officer Tinsley from the KY State Police Vehicle Enforcement provided education and training which included vehicle pre-trip inspection along with properly securing passengers to Nursing Administration, Nursing Staff, Medical Records Staff, Quality of Life staff, Chaplain, Administrative Staff, Housekeeping Staff, and Rehab Services Manager. A return demonstration on how to properly fasten the safety belts |  |
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED  
OMB NO. 0938-0391

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| NAME OF PROVIDER OR SUPPLIER<br><br>FOUNTAIN CIRCLE CARE & REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE<br>200 GLENWAY ROAD<br>WINCHESTER, KY 40391 |
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|--------------------|--|---------------|---|----------------------|

F 323 Continued From page 27

Director or Supervisor should promptly initiate and document investigation of the accident or incident.

Record review for Resident #1 revealed a "late entry" Nurse's Note dated 10/03/14 timed 6:00 PM which noted Resident #1 was non-ambulatory and used a motorized wheelchair for mobility. Continued review revealed Resident #1 was assisted out of his/her motorized wheelchair, and into a "non-motorized" wheelchair for an outing on 10/03/14 at approximately 1:30 PM. Per the Note, Resident #1's wheelchair was "strapped to" the van; however, his/her "seat belt was not sufficiently latched". The Note revealed Resident #1 "came out" of the wheelchair when the van stopped suddenly and "bumped" his/her head on the van floor "resulting in a Hematoma dark in color". Further review revealed Resident #1 was assessed and transported to the hospital ER at approximately 2:20 PM.

Review of the hospital ER record dated 10/03/14 at 2:52 PM, revealed Resident #1 had sustained an injury to his/her head after "striking" his/her head "on something" when falling out of his/her wheelchair while being transported on the facility's van. Review of the "Triage Assessment" revealed Resident #1 had "bruising" that was "dark purple, yellow" on his/her forehead and right eye. Review of the ER Physician's documentation revealed Resident #1 had "sustained injury" to his/her head which included a Hematoma with swelling and tenderness. The ER Physician noted Resident #1 also had neck pain, upper and lower back pain, left shoulder pain and headache, and radiology scans were ordered. Continued review of the ER Physician's documentation revealed Morphine (narcotic pain

F 323

was completed at the training held on 10/24/14.

All Quality of Life Department staff, D.O.N., A.D.O.N., Staffing Coordinator, and Chaplain is designated transport staff. Other staff members may assist with transport of residents on outings, but will be checked off on seat belt function by the Administrator or DON and on the Outing Guidelines by the Quality of Life Department prior to the outing taking place. All new staff that is hired will have education on the Outing Guidelines in orientation. Education will be provided annually to all staff on the Outing Guidelines.

4. All transport staff will have to demonstrate to the Administrator or DON how to properly fasten the safety belts prior to going on another outing to ensure understanding of proper safety belt function.

A Pre-Trip Vehicle Safety Form will be completed with every facility outing and will be signed off by the Administrator

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

PRINTED: 11/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

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| F 323 | Continued From page 28<br>reliever) 4 milligrams (mg) was administered per intramuscular (IM) injection at 3:02 PM, with decreased pain noted at 3:58 PM. Review of the Computerized Tomography (CT) scan of Resident #1's head and neck revealed a "large" right anterior scalp Hematoma to the right forehead area measuring approximately 4.5 centimeters (cm) by 2.6 cm. Additionally, review of the ER Physician's documentation revealed he was unable to fully examine Resident #1's right eye due to the swelling, and recommended a follow-up appointment with an Ophthalmologist. Further review of the ER record revealed Resident #1 was diagnosed with a Hematoma to the right forehead and was discharged back to the facility in stable condition at 4:52 PM.<br><br>Review of the facility's Incident Report dated 10/03/14, revealed Resident #1 was in a wheelchair for an outing and fell out of the wheelchair into the aisle of the facility van, hitting his/her head on the floor of the van. Per the Incident Report, RN #1 immediately assessed Resident #1, and the resident was then transferred to the ER for evaluation and treatment. Continued review of the Incident Report revealed one (1) of the contributing factors for the fall was Resident #1 had difficulty maintaining his/her sitting balance related to his/her diagnoses of CVA with Hemiplegia and Right AKA. However, record review revealed the facility failed to investigate the accident "promptly", per the facility's policy, in order to perform a root cause analysis and attempt to determine the cause of the resident's fall. Review of the facility's investigation revealed the investigation was not initiated until 10/10/14, seven (7) days later. | F 323 | or DON. Prior to the driver departing any location, the driver is responsible for completing a physical observation, which includes pulling on the seat belts to ensure that the safety belts are properly fastened on the residents and staff on board. The Chaplain, Quality of Life Director, and Staffing Director are supervisors who are responsible for ensuring the final check for proper seatbelt application prior to departing any location on resident outings. Any forms completed or new transport staff that has completed demonstrations will be reviewed during the monthly Quality Assurance Meeting for 3 months.<br><br>All accidents/incident reports are reviewed daily, Monday thru Friday, by the DON, ADON, and/or Nursing Supervisors.<br><br>The SRNA Care Guide is a record explaining care needs for each individual resident and will be used on outings to |  |
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

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| NAME OF PROVIDER OR SUPPLIER<br><br>FOUNTAIN CIRCLE CARE & REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE<br>200 GLENWAY ROAD<br>WINCHESTER, KY 40391 |
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|--------------------|--|---------------|---|----------------------|

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| F 323 | Continued From page 29<br>Review of the facility's "Final Investigation" document, undated, revealed on 10/03/14, a State Adult Protective Services (APS) Agency worker came to the facility to investigate an "allegation of caretaker neglect". Per the Document, the facility initiated an investigation after interviewing staff and learning the APS worker saw and talked to Resident #1 on 10/10/14, who had experienced a fall on the facility's van on 10/03/14 which resulted in the resident "hitting" his/her head. The Document stated Resident #1 was interviewed and stated on 10/03/14, his/her "seat belt was not fastened"; however, he/she had not told anyone. Continued review revealed when the van came to a sudden stop at a traffic light, Resident #1 fell forward out of his/her wheelchair, was assessed by RN #1 and taken to the hospital ER. The Document revealed the facility substantiated Resident #1's fall on 10/03/14, and "initiated" a checklist to ensure that all proper steps" were taken before "departure to and from future" facility outings.<br><br>Record review revealed the facility admitted Resident #1 on 01/14/12, with diagnoses which included Cerebrovascular Accident (CVA) with Right Hemiparesis (paralysis) and Right Above the Knee Amputation (AKA). Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 09/02/14, revealed the facility assessed Resident #1 to have a Brief Interview for Mental Status (BIMS) score of eight (8), indicating moderate cognitive impairment. Continued review of the MDS Assessment revealed the facility assessed Resident #1 to be totally dependent on two (2) staff for all transfers and to require a wheelchair for mobility. Review of Resident #1's Physician Orders revealed an order dated 07/24/14, for the resident to have a | F 323 | ensure that all current plan of care is being followed.<br><br>The ongoing processes 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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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

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|--------------------|--|---------------|---|----------------------|
|--------------------|--|---------------|---|----------------------|

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| F 323 | <p>Continued From page 30</p> <p>self-releasing seat belt when up in wheelchair related to his/her sense of security regarding the Right AKA.</p> <p>Review of the Comprehensive Care Plan (CCP), dated 10/31/13, revealed the facility care planned Resident # 1 as at risk for a fall related injury with interventions which included the resident having a self-releasing seat belt to when up in the wheelchair for "security" related to poor upper body balance.</p> <p>Interview with Certified Nursing Assistant (CNA) #1 on 10/21/14 at 1:30 PM and 11/05/14 at 10:40 PM, revealed she and CNA #2 assisted with transferring Resident #1 from his/her own motorized wheelchair to a manual wheelchair prior to his/her boarding the facility van on 10/03/14. CNA #1 stated all residents in motorized wheelchairs were transferred to manual wheelchairs when they were going to be out on the facility's van. She stated this was because the manual wheelchairs could be fastened and secured to the van floor and motorized wheelchairs could not be securely locked into place on the floor of the van. CNA #1 revealed she was aware Resident #1 did not have a self-releasing seat belt when she transferred him/her to the manual wheelchair, and stated she did not "tell anybody" because she "thought" they already knew. According to CNA #1 she and CNA #2 assisted with lifting Resident #1 into the facility van; however, they never actually boarded the van, as they were driving to the outing in a separate vehicle. CNA #1 indicated the Activities Director was at the back of the van to assist with residents' wheelchairs. Per CNA #1, there was also a nurse on the van, and the nurse and Activities Director should have locked Resident</p> | F 323 |  |  |
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

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|--------------------|--|---------------|---|----------------------|
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| F 323 | <p>Continued From page 31</p> <p>#1's wheelchair and other residents' wheelchairs into place and ensured all the residents' seat belts were securely fastened. Per interview, CNA #1 had never received any formal training on attending an activity outing with residents riding on the van, but had assisted with previous outings and was aware of the "Outing Guidelines" which the Activity Director had gone over before the outings. CNA #1 stated she was aware of staff "double check" the security of residents prior to movement of the van, and not to assume residents had been secured properly on the van. However, as indicated previously she and CNA #2 had not boarded the van.</p> <p>Interview with Registered Nurse (RN) #1 on 10/21/14 at 4:45 PM, revealed she had sat in the front of the bus and remembered checking the seatbelts of the residents who sat in the front of the bus when the Activities Director asked if "everybody's" seatbelt was fastened prior to the movement of the van. RN #1 stated she did not remember seeing anyone fastening Resident #1's seatbelt, and stated she was not aware the resident was to have a self-releasing seat bell. She stated she did not "traditionally" go out on the van for residents' outings and had never received any formal training on what to do. RN #1 reported the Activity Director only "quickly" reviewed the Guidelines with her prior to the outing. According to RN #1, she never assisted residents on the van who were in wheelchairs with seat belt application, the aides or Activity Director normally did that. Per interview, she remembered it was raining on 10/03/14, when the van suddenly stopped and Resident #1 "flew" out of his/her wheelchair onto the floor. She stated she assessed Resident #1, and the resident was neurologically intact; however, was complaining</p> | F 323 |  |  |
|-------|--|-------|--|--|

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

PRINTED: 11/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

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| F 323  | <p>Continued From page 32</p> <p>of right shoulder and head pain. According to RN #1, the Activities Director wanted to return to the facility, but she told her to take Resident #1 "immediately" to the ER so a "doctor" could examine him/her which was done.</p> <p>Interview with the Activities Director on 10/16/14 at 3:05 PM, revealed she was present at the back of the bus to assist Resident #1 from off the van's wheelchair lift on 10/03/14, for the scheduled outing. The Activities Director stated she remembered fastening Resident #1's manual wheelchair into the four (4) floor locks; however, did not specifically remember fastening and securing Resident #1 with the two (2) seatbelts, one (1) of which went horizontally, and the other laterally, prior to the movement of the van. The Activities Director revealed she "loudly" inquired if "everybody's seat belt" was on prior to moving the van on 10/03/14, with no one voicing they weren't secured. The Activities Director stated however, she did not visually inspect all the residents' seat belts prior to the movement of the van. She reported always having "support staff" on the van to monitor the needs of the residents and a nurse was present on the van that day. Per interview, she assumed the nurse had checked to make sure all of the residents' seat belts were securely fastened.</p> <p>Interview with Resident #1 on 10/21/14 at 2:45 PM, revealed he/she did not recall staff applying a seat belt to him/her prior to the van moving. Resident #1 stated he/she went out on the van to go shopping "all the time", but this was the first time something like this had happened.</p> <p>Interview on 10/16/14 at 1:45 PM with Activities Assistant Aide #1 and at 2:00 PM with Activities</p> | F 323  |   |                      |   |

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

PRINTED: 11/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

|  |  |  |   |
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|--------------------|--|---------------|---|----------------------|

F 323 Continued From page 33

Assistant Aide #2, revealed they both assisted with residents on activity outings. Activities Assistant Aide #1 revealed however, she had received no formal training on safety of residents when they were on the van for an outing, and reported also not having been trained on safety of residents with wheelchairs and seat belt use on the van. Activities Assistant Aide #2 revealed she had received safety training regarding residents using the van several years previously when another company owned the facility, but had not been formally trained since then.

Interview with the Director of Nursing (DON) on 10/21/14 at 2:00 PM and on 10/22/14 at 4:05 PM, revealed the Activities Director was supposed to "informally" go over the facility's "Outing Guidelines" with staff prior to an outing. She stated the facility was "unclear" what happened on 10/03/14 and, thought Resident #1's fall was an accident. The DON revealed an Incident Report had been completed on 10/03/14 after the facility was notified of Resident #1's fall. She stated facility staff did not do an investigation to perform "root cause analysis" and determine the cause of the fall until 10/10/14. Per the DON, the facility did not perceive the incident involving Resident #1 as any type of abuse/neglect, and therefore did not perform an investigation, as it was considered to just be an accident. However, review of the facility's policy revealed "all accidents or incidents involving residents" should be investigated and the investigation should be initiated promptly. She stated the "Event Manager", the computer system the facility utilized for accidents/incidents, determined the "contributing factor" was Resident #1 had difficulty maintaining his/her sitting balance. Per interview, she was aware Resident #1 required

F 323

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

PRINTED: 11/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

|  |  |  |   |
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|--------------------|--|---------------|---|----------------------|
|--------------------|--|---------------|---|----------------------|

F 323

Continued From page 34

the self-releasing seat belt which he/she was care planned for, but thought the seat belt was only for use in his/her motorized wheelchair, not for a manual wheelchair used on outings. The DON reported she was not aware Resident #1's van seat belts were not applied. She indicated she thought the seat belts were in place prior to the van moving and Resident #1 had released them.

Interview with the Administrator on 10/21/14 at 2:45 PM, revealed she first became aware of the incident when the Activities Director called her from the ER on 10/03/14. She stated she "immediately" notified the DON and Assistant Director of Nursing (ADON) to have a full assessment completed on all of the residents who went on the outing when they returned to the facility. The Administrator revealed at first she thought Resident #1's seat belt may have malfunctioned, so the seat belts on the van were inspected upon return to the facility for any tears, rips, worn or torn areas, and the seat belts were found to be in intact and functioning properly. She stated the management team met on 10/03/14, following the incident and a new form was developed titled "Outing Safety Checklist" to be utilized for outing safety. Per interview, an in-service was held on 10/03/14 to discuss the new checklist which was attended by eight (8) staff members; however, no further in-services had been held because the facility was waiting for Corporate's approval. However, she indicated an investigation had not been initiated on 10/03/14 to determine the cause of Resident #1's fall, as the facility did not think the incident was abuse/neglect, and was just an accident. However, review of the facility's policy revealed "all accidents or incidents involving residents" should be investigated and the investigation

F 323

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

PRINTED: 11/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

|  |  |  |   |
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| NAME OF PROVIDER OR SUPPLIER<br><br>FOUNTAIN CIRCLE CARE & REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE<br>200 GLENWAY ROAD<br>WINCHESTER, KY 40391 |
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|--------------------|--|---------------|---|----------------------|

F 323 Continued From page 35 should be initiated promptly.

The facility provided an acceptable, credible Allegation of Compliance (AOC) on 10/29/14, with alleged removal of Immediate Jeopardy (IJ), effective 10/25/14. Review of the AOC revealed the facility implemented the following:

1. The initial investigation of Resident #1's fall was started by the Director of Nursing (DON) on 10/10/14. The investigation included: Resident #1 was assessed by the Assistant Director of Nursing (ADON) on 10/10/14; staff statements were obtained 10/10/14 through 10/14/14 by the Administrator, Director of Nursing (DON), Social Services Director (SSD) and ADON; resident's statements were obtained 10/10/14 through 10/14/14 by the Administrator, DON, ADON, or SSD, from the residents who were on the van when the 10/03/14 incident involving Resident #1 occurred; "the wheelchair placement area" on the van with the "failed seat belt function", was placed out of service on 10/10/14 by the Maintenance Director.
2. Contacts, which started on 10/03/14 by the Administrator, were made to several agencies to get all seat belts on the van assessed for proper function and safety. An officer with the Kentucky State Police (KSP) Vehicle Enforcement provided education/training on 10/24/14 for eight (8) nursing administration staff, two (2) nursing staff, one (1) Medical Records staff person, three (3) Quality of Life (Activity) Staff, the Chaplain, seven (7) administrative staff, two (2) housekeeping staff, and the Rehabilitation (Rehab) Services Manager, who were all designated transport staff, regarding pre-trip vehicle inspection and properly securing resident passengers on the van. Return

F 323

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

PRINTED: 11/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

|  |   |  |   |                      |   |
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| F 323  | Continued From page 36<br>demonstration was completed by these staff at the training that was held on 10/24/14. All the designated transport staff were to complete a demonstration to the Administrator prior to going on another outing to ensure understanding of proper safety belt function. Any new designated transport staff will demonstrate to the Administrator proper safety belt application prior to going on an outing with the residents.<br><br>3. A new process was put in place to ensure residents' safety while on the van which included a safety check off sheet implemented on 10/3/14 by the Administrator. The facility also implemented changes to the "Outings Guidelines" which included: staff utilizing the "Pre-Trip Vehicle Safety Form", which was revised 10/22/14, prior every outing to ensure safety of residents; and a copy of the Certified Nursing Assistant (CNA) "care guide" for each resident would be taken on every outing to ensure residents' care plans were followed. The designated transport staff and two (2) van drivers received education/training on the new process on 10/03/14, by the ADON. The designated transport staff was educated on the updated "Pre-Trip Vehicle Safety Form", which began on 10/22/14 and was completed on 10/24/14. Resident #1 was provided with a transport wheelchair, to include a self-release seat belt, on 10/23/14 that met resident care needs and ensured the residents safety during transport in the facility van. An investigation of the 10/03/14 incident involving Resident #1 was completed by the DON on 10/15/14.<br><br>4. The new "Outing Guidelines" process which included the "Pre-Trip Vehicle Safety Form" and copy of the CNA "care guide" for each resident, that were to be taken and followed on all outings. | F 323  |   |                      |   |

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

PRINTED: 11/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

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| F 323 | Continued From page 37<br>would also ensure residents' care plans were followed on the outing when the residents were on the van. All Department Managers received education/training on 10/22/14, regarding the new "Outing Guidelines" process provided by the SCC.<br><br>5. All residents were assessed by the DON, ADON, or Registered Nurse (RN) Supervisor on 10/22/14, for electric wheelchair usage, to determine if residents' safety needs were met, along with any care planned safety devices for safety needs during transport in the facility van, as outlined by residents' care plans.<br><br>6. All residents were assessed. Residents with a Brief Interview Mental Status (BIMS) score greater than eight (8), were interviewed beginning 10/22/14 and completed on 10/23/14, by the Administrator, DON, ADON, SSD, Registered Dietician (RD), Chaplain or Medical Records staff for any concerns. Residents with a BIMS score less than eight (8) were physically assessed by the DON, ADON, Unit Managers, or RN supervisor. The assessments, interviews and questionnaires were reviewed by the Administrator or Signature Care Consultant (SCC) on 10/23/14.<br><br>7. All personnel files were audited 10/22/14 by Human Resources staff, Chaplain or Nursing Supervisor for any concerns, with results given to the SCC on 10/23/14, for review. Additionally, all accident/incident reports from July to 10/22/14 were reviewed on 10/23/14 by the DON, ADON, SDC or SCC to identify any concerns and ensure incident reports and a thorough investigation was completed, with no concerns identified. | F 323 |  |  |
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

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|--------------------|--|---------------|---|----------------------|

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| F 323 | Continued From page 38<br>8. All residents' care plans and CNA care plans were reviewed and updated as needed to include residents' wheelchair safety devices, on 10/22/14 by the DON, ADON, Nursing Supervisor or Minimum Data Set (MDS) Nurses to ensure each resident's care plan and CNA care plan reflected the current care needs of the resident.<br><br>9. Facility environmental rounds were completed by the Housekeeping Director, Activity Director or Administrator on 10/22/14, to ensure the residents' environment was free of accidents and hazards.<br><br>10. On 10/22/14, the SCC educated the facility's management staff which included the Administrator, DON, ADON, RN Supervisors, MDS, Quality of Life (Activity) Director, HR staff, Environmental Services Director (ESD), SSD, Admissions Director, Medical Records and Chaplain on the facility's care plan policy, accident/incident policy and the revised "Outing Guidelines" process. These staff could not return to work until the education was provided, post-test administered and a score of one hundred percent was obtained. If they did not score one hundred percent on the post-test, the staff person was immediately re-educated and post-test re-administered. The process continued until all the above management staff obtained one hundred percent on the post-test. All post-tests were reviewed for compliance by the SCC.<br><br>11. The management staff which included, the Administrator, DON, ADON, RN Supervisor, MDS, Quality of Life (Activity) Director, HR staff, ESD, SSD, Admissions Director, Medical Records staff, or Chaplain, after completion of the | F 323 |  |  |
|-------|--|-------|--|--|

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

PRINTED: 11/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

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| F 323  | Continued From page 39<br>education, re-educated all facility staff on the facility's care plan policy, accident/incident policy and the revised "Outing Guidelines" process starting on 10/22/14. By 10/24/14, one hundred and twenty-six (126) of the facility's one hundred and eighty-nine (189) staff had been re-educated. All employees who had not received the education were sent a certified letter on 10/27/14, providing notification to staff not to return to work until education was completed, with no staff allowed to work until education was provided. All staff provided the re-education completed an abuse post-test and a one-hundred percent score had to be obtained, or the staff were immediately re-educated and the post-test was re-administered. This process was to continue until staff obtained a score of one hundred percent on the post-test. This education was to be included during orientation for all newly hired staff who would not be allowed to work until the education was provided, the post-test administered and a score of one hundred percent obtained. The facility does not employ or utilize agency staffing.<br><br>12. A nurse from the facility's regional or corporate office was onsite beginning 10/22/14, and was to remain in the facility daily until the Immediate Jeopardy (IJ) was lifted. These nurses assisted with investigations, observed staff treatment of residents, performed chart audits, observed environment safety, observed care delivery to ensure it was provided as per residents' care plans and provided oversight and consultation. The facility's corporate Vice President (VP) of Operations, the Special Projects Administrator or the Director of Clinical Programs was to be in daily contact with the SCC and were to review allegations until the IJ was | F 323  |   |                      |   |

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

PRINTED: 11/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

|  |  |  |   |   |
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| F 323  | Continued From page 40 lifted.<br><br>13. Per the AOC, the DON, ADON, SDC or Nursing Supervisor would observe the care delivery for five (5) different residents on different units for a total of fifteen (15) residents for any concerns daily until removal of the IJ, then would perform the observations weekly for four (4) weeks. Results of the care delivery/observation audits were to be reported to the facility's Quality Assurance (QA) Committee weekly to determine the need for continued staff education or revision of plan. Concerns identified would be corrected immediately and reported to the Administrator to ensure investigations were completed and, if necessary reported as per the facility's guidelines. The Administrator, DON, or member of the facility's regional staff were to review all the resident care delivery audits daily to identify any concerns. Investigations of any concerns were to be initiated upon receipt of the concern starting on 10/23/14. The Administrator and one (1) of the following: VP of Operations; Special Projects Administrator; or SCC would review the investigations daily to ensure the above areas were covered. All the above was to continue until removal of the IJ.<br><br>14. The VP of Operations, SCC or Special Projects Administrator would provide administrative oversight of the facility daily until removal of the IJ beginning 10/22/14, after removal of the IJ administrative oversight by the above would continue weekly for four (4) weeks, then monthly. A QA meeting would be held weekly for four (4) weeks beginning 10/22/14, then monthly afterwards for recommendations and further follow up regarding the AOC. The QA Committee would determine at what frequency | F 323  |   |   |

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

PRINTED: 11/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

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| F 323  | Continued From page 41<br>any ongoing audits would need to continue. The Administrator had the oversight to ensure an effective plan was in place to meet residents' well-being, as well as, an effective plan to identify facility concerns and implement a plan of correction to involve all staff of the facility. Corporate Administrative oversight of the QA Committee meeting would be completed by the Special Projects Administrator, Regional VP of Operations, or member of the regional staff daily until removal of the IJ beginning 10/22/14, then weekly for four (4) weeks, then monthly thereafter.<br><br>The State Agency validated the implementation of the facility's AOC as follows:<br><br>1. Review of the facility's investigation report revealed: it was initiated 10/10/14 by the DON; Resident #1 was assessed by the ADON on 10/10/14, witness statements of staff and residents on the van had been obtained by the Administrator, DON, ADON and SSD; and per the Plant Operations Director (POD) written statement, the "wheelchair placement area" on the van with the "failed seat belt function" had been placed "out of service" as per the AOC.<br><br>Interview with the SCC on 11/04/14 at 10:30 AM, revealed the van had not transported residents since the incident involving Resident #1 on 10/03/14, and he verified the facility's investigation completion as above.<br><br>2. Review of the statement signed by the Administrator, undated, revealed she contacted an officer with the KSP, who agreed to offer training regarding safety on the van. Continued review of the Administrator's written statement | F 323  |   |                      |   |

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

PRINTED: 11/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

|  |  |  |   |                      |   |
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| F 323  | <p>Continued From page 42</p> <p>revealed the KSP officer provided the training on 10/24/14 at 10:30 AM.</p> <p>Review of the In-Service sign-in sheets, dated 10/24/14, revealed the officer provided instruction on "Outing Education and Safety" for twenty-four (24) facility staff who signed the in-service sheets.</p> <p>Observation on 11/05/14 at approximately 1:00 PM, revealed the Quality of Life (Activity) Director and the Chaplain performed a demonstration of what they had been trained on by the KSP officer.</p> <p>Interview on 11/05/14 with the Human Resources (HR) staff person at 11:07 AM, Activity Aide Assistant #1 at 1:56 PM, Activity Aide Assistant #2 at 2:08 PM and on 11/06/14 with the Activities Director at 12:19 PM and the DON at 12:47 PM revealed they had all received the training provided by the KSP officer on 10/24/14, completed return demonstration and had taken a post-test on which they had to score one hundred percent. Per the DON, any new staff designated to assist with outings would go through the same education, return demonstration and post-testing.</p> <p>3. Review of the facility's, "Outing Guidelines Form", undated, revealed the facility had implemented the use of a the "Pre-Trip Vehicle Safety Form" which was to be completed by staff to double check the security of all residents and their wheelchairs when on the van. Continued review of the Form revealed a copy of residents' CNA care guides were to brought on each outing for every resident attending. The Form noted staff members were secure empty wheelchairs on the bus to ensure safety of residents.</p> <p>Interview on 11/05/14 with the HR staff person at</p> | F 323  |   |                      |   |

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

PRINTED: 11/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

|  |   |  |   |                      |   |
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| F 323  | Continued From page 43<br>11:07 AM, Activity Assistant Aide #1 at 1:56 PM, Activity Assistant Aide #2 at 2:08 PM and on 11/06/14 with the Activities Director at 12:19 PM revealed they had all been educated on the new process for transportation of residents on outings. They all reported being educated on the updated "Pre-Trip Vehicle Safety Form" between 10/22/14 and 10/24/14. Interview on 11/06/14 at 12:47 PM with the DON revealed: she had also been educated on the updated "Pre-Trip Vehicle Safety Form"; Resident #1 was provided a wheelchair which had a self-releasing seat belt for outings; and she had completed a thorough investigation of the 10/03/14 incident involving Resident #1 on 10/15/14, which was sent to the State Survey Agency.<br><br>Review of Resident #1's medical record revealed the resident was assessed by Occupational Therapy (OT) and was provided a transport wheelchair with a self-releasing seat belt on 10/23/14.<br><br>Interview with the SCC on 11/06/14 at 1:58 PM, revealed revisions were made to the facility's, "Outings Guidelines" as per the AOC. He stated the "Outings Guidelines" process was a check off system for to ensure safety of residents on the facility's van. Continued interview revealed changes were made to the process to address vehicle safety and to ensure all residents were secure restrained in their seat belts, including residents in wheelchairs. He revealed the "Pre-Trip Vehicle Safety Form" was revised and the "Outings Guidelines" were revised to include the addition of bringing the residents' CNA care cards on outings.<br><br>4. Review of the facility's, "Outing Guidelines" | F 323  |   |                      |   |

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

PRINTED: 11/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

|  |   |   |   |   |
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| F 323  | <p>Continued From page 44</p> <p>Form", undated, revealed the facility had implemented the use of a the "Pre-Trip Vehicle Safety Form" which was a check-off sheet to be completed by staff to double check the security of all residents and their wheelchairs when on the van, and noted a copy of each residents' CNA care guides was to brought on each outing for every resident attending.</p> <p>Review of the in-service titled, "Outing Guidelines" revealed the training was conducted by the SCC on 10/22/14.</p> <p>Interview on 11/05/14 with the Director of Housekeeping and Laundry at 2:27 PM and on 11/06/14 with the Activities Director at 11:19 AM and with the DON at 12:47 PM, revealed they had all been educated on the new "Outing Guidelines" process on 10/22/14.</p> <p>Interview with the SCC on 11/06/14 at 1:08 PM, revealed he provided the in-service training on 10/22/14 at 8:00 PM as per the AOC. The SCC revealed the in-service was completed with all of the department managers as per the AOC, who in turn provided the education to staff in their departments regarding the new "Outing Guidelines".</p> <p>5. Review of the facility's "Census Board" Report dated 10/22/14, revealed residents were assessed for use of electric wheelchairs. Resident #1 and Resident #4 were determined to have the electric wheelchairs during the assessment.</p> <p>Interview on 11/05/14 with OT #1 at 11:43 AM and OT #2 at 1:47 PM revealed they assessed Resident #1 and Resident #4 and determined the</p> | F 323   |   |   |

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

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FORM APPROVED  
OMB NO. 0938-0391

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| F 323  | <p>Continued From page 45</p> <p>residents needed special transport chairs for outings which the residents were provided with and their care plans updated to include this information.</p> <p>Review of Resident #1's and Resident #4's care plans revealed the care plans were updated to reflect the new transport chairs provided by OT.</p> <p>Interview with the SCC on 11/06/14 at 1:58 PM revealed the assessment of all resident's who had electric wheelchairs was performed as per the AOC on 10/22/14. He revealed Resident #1 and Resident #4 were assessed by OT to require special transport wheelchairs for outings. Per interview, Resident #1's transport wheelchair was equipped with a self-releasing seat belt as per the resident's care plan.</p> <p>6. Review of the facility's interviews conducted with residents who had a BIMS score greater than eight (8) revealed the residents were asked to answer questions on a questionnaire regarding any concerns. Continued review of the resident interviews revealed the DON, ADON and SSD questioned the residents on 10/22/14. Review of the CNA Skin Care Alert for residents with a BIMS of less than eight (8) revealed physical assessments of those residents were completed by the DON, ADON, Unit Managers or RN Supervisor.</p> <p>Interview with the SCC on 11/06/14 at 1:58 PM, revealed resident interviews were conducted as per the AOC for residents with a BIMS of eight (8) or greater. The SCC revealed as per the AOC, residents with a BIMS of less than eight (8) were physically assessed for injury. Per interview, staff were also asked if they were aware of any</p> | F 323   |   |                      |

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

PRINTED: 11/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

|  |   |  |   |   |
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| F 323  | Continued From page 46 concerns regarding residents.<br><br>7. Review of the facility's personnel file audits revealed all files were audited by the Chaplain, HR Director and LPN #5, Unit Manager, who signed and dated the completion of the review of the files on 10/23/14. The State Survey Agency reviewed five (5) personnel records with no concerns identified.<br><br>Review of the facility's "Healthcare-Event" Incident/Accident Report audit sheet revealed it included review of all incidents from 07/22/14 through 10/22/14, with no concerns identified.<br><br>Interview with the HR Director on 11/05/14 at 11:07 AM, revealed she, along with the Chaplain and LPN #5 reviewed all employee personnel files.<br><br>Interview with the SCC on 11/06/14 at 1:08 PM, revealed all staffs' personnel files were checked as per the AOC with no concerns identified. Continued interview revealed the audits of the Incident/Accident forms were performed as per the AOC, with no concerns identified. Per interview, the audits would continued and the clinical team would address any issues. The SCC revealed the audits would also be performed on weekends and holidays. If any concerns were noted during the audits of the Incident/Accident Reports staff would notify the Administrator and DON.<br><br>8. Review of the facility's audits of residents' care plans and CNA Care Plans, which began on 10/22/14 with a completion date of 10/29/14, revealed all the residents' care plans and CNA Care Plans were reviewed and/or updated and | F 323  |   |   |

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

PRINTED: 11/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

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| F 323 | <p>Continued From page 47</p> <p>revised as necessary to show the resident's current care needs. revisions in the comprehensive care plans, as well as, the Certified Nursing Assistance Care Plans.</p> <p>Interview, on 11/06/14 at 12:47 PM, with the DON revealed the ADON, Nursing Supervisor, MDS Nurse and herself had performed the care plan reviews and ensured the care plans reflected each resident's assessed needs.</p> <p>Interview with the SCC on 11/06/14 at 1:08 PM, revealed all residents' care plans and CNA Care Plans (care cards) were audited and reviewed by the DON, ADON, Nursing Supervisor or MDS Nurse to ensure they were correct according to the resident's assessed needs. He reported he along with the other Corporate Consultants looked over the completed care plans after the audit to ensure they were correct.</p> <p>9. Review of the "Environmental Rounds" check sheet revealed the facility's department heads would be responsible for conducting the environmental rounds of the facility which began on 10/22/14. Review of the 10/22/14 "Environmental Rounds" check sheet revealed the rounds were completed by the Housekeeping Director, Activity Director or Administrator. Review of the "Environmental Rounds" schedule revealed department head managers were assigned to check the facility's environment for accident and safety hazards.</p> <p>Interview with the Director of Environmental Services, on 11/06/14 at 3:04 PM, revealed he had been assigned to conduct the "Environmental Rounds" checking for concerns related to safety of residents. We reported that if he noticed a</p> | F 323 |  |  |
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

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| F 323  | <p>Continued From page 48</p> <p>concern while conducting the environmental tour, he would repair the problem himself.</p> <p>Interview with the Administrator on 11/06/14 at 3:35 PM, revealed the "Environmental Rounds" were completed by the Housekeeping Director, Activity Director or herself on 10/22/14 as per the AOC. She stated these continued to be performed by the facility's department head managers.</p> <p>10. Review of the in-service sign-in sheets dated 10/22/14 revealed signatures for the Administrator, DON, ADON, RN Supervisor, MDS Nurse, Activity Director, HR Director, ESD, SSC, Admissions Director, Medical Records staff person and Chaplain. Continued review revealed the in-service was conducted by the SCC regarding the facility's care plan policies, incident/accident policy and the revised "Outing Guidelines" process. Review of the post-tests taken by the above staff revealed all had scored one hundred percent as per the AOC.</p> <p>Interview on 11/05/14 with the HR Director at 11:07 AM, the Director of Environmental Services at 3:04 PM and on 11/06/14 with the Activity Director at 12:20 PM, with the DON at 12:47 PM, with the SSD at approximately 1:15 PM, with the SDC at 1:35 PM, with the Administrator at 3:35 PM, revealed they were all in-serviced by the SCC on 10/22/14, regarding the facility's care plan policy, revised "Outing Guidelines" process and accident/incident policy prior to returning to work that day. They reported having to receive a score of one hundred percent on the post-test.</p> <p>11. Review of the in-service sign-in sheets and documentation revealed all the in-services began</p> | F 323   |   |

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

PRINTED: 11/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

|  |   |  |   |                      |   |
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| F 323  | Continued From page 49<br>on 10/22/14 and were completed by 11/03/14. Review of the certified mail receipts, dated for 10/27/14, revealed letters were mailed to staff who were not scheduled to work during the in-services. Review of staffs' post-tests revealed scores of one-hundred percent.<br><br>Interview on 11/05/14 with the HR Director at 11:07 AM, the Director of Environmental Services at 3:04 PM and on 11/06/14 with the Activity Director at 12:20 PM, with the DON at 12:47 PM, with the SSD at approximately 1:15 PM, with the SDC at 1:35 PM, with the Administrator at 3:35 PM, revealed they all had assisted with in-servicing staff after their training on 10/22/14, regarding the facility's care plan policy, accident/incident policy and revised "Outings Guidelines" process. They stated post-tests were administered to all the staff after the in-service training with staff having to score one hundred percent or be re-educated until the score was obtained. Per interview, no staff person was allowed to work until they had received the in-service and scored one hundred percent on the post-test.<br><br>Interview on 11/05/14 with Certified Nursing Assistant (CNA) #1 at 10:45 AM, with CNA #2 at 11:26 AM, with Activity Aide Assistant #1 at 1:56 PM, with Activity Aide Assistant #2 at 2:08 PM and the Director of Housekeeping and Laundry at 2:27 PM, and on 11/06/14 with CNA #3 at 8:57 AM, with CNA #4 at 9:17 AM, with CNA #5 at 9:30 AM, with the Activities Director at 11:19 AM, with CNA #7 at 12:10 PM, revealed they all reported having been in-serviced on the care plan policy, accidents/incidents policy and the revised "Outing Guidelines" process. They stated they had not been allowed to work until they had received the | F 323  |   |                      |   |

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

PRINTED: 11/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

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|--|--|--|---|----------------------|---|
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| F 323  | Continued From page 50<br><br>in-services. Further interview with the above staff revealed they all took a post-test in which they had to score one hundred percent or re-take the test. They all reported receiving the required one hundred percent on the post-test.<br><br>12. Interview with the SCC on 11/06/14 at 1:58 PM, revealed he had been onsite since the IJ was called 10/22/14. He reported he worked a minimum of eight (8) hours a day to ensure staff understood the facility's inservices and revised "Outing Guidelines" process, assisted with any investigations, performed observations of staff providing care to ensure residents received care as per their care plan, assisted with chart audits and provided oversight and consultation as necessary. He stated he made rounds on all shifts to ensure the facility's policies were implemented and followed.<br><br>13. Review of the facility's "Care Delivery Audits" revealed the DON, ADON, SDC, or Nursing Supervisor observed care delivery for five (5) different residents on different units for a total of fifteen (15) residents for any suspected neglect concerns of residents as per the AOC.<br><br>Interview on 11/06/14 with the DON at 12:47 PM and SDC at 1:35 PM, revealed they both had assisted with performing the "Care Delivery Audits" on five (5) different residents on different units.<br><br>Interview on 11/06/14 at 3:35 PM with the Administrator revealed the "Care Delivery Audits" had been performed on five (5) different residents on different units since 10/22/14 as per the AOC. She stated the results of the audits were being reviewed by the DON, corporate staff or herself | F 323  |   |                      |   |

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

PRINTED: 11/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

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| F 323  | Continued From page 51<br>daily, and were being taken to the facility's QA Committee weekly.<br><br>Interview with the SCC on 11/06/14 at 1:58 PM, revealed the care delivery audits were being performed for five (5) different residents on different units as per the AOC. He stated the audit began on 10/23/14 and the last listed audit was on 10/29/14. He reported the audit would continue for four (4) weeks and the results of the care audits would be reported to the facility's QA Committee weekly to determine the further need for continued staff education. The SCC revealed no concerns had been identified at the time, but if there were concerns, an investigation would be immediately initiated.<br><br>14. Interview with the SCC on 11/06/14 at 1:58 PM, revealed he was providing daily oversight of the facility until the IJ was lifted. Then he would provide weekly oversight which would continue for four (4) weeks, then monthly thereafter. Continued interview revealed the QA Committee meeting would be held weekly, beginning 10/22/14, and for four (4) weeks total to discuss any concerns regarding the processes implemented, and to determine at what frequency any ongoing audits would need to continue. He stated the QA Committee meetings would then be performed monthly for continued follow up and monitoring. Per interview, the Administrator was responsible for oversight to ensure an effective plans were in place to meet each residents' needs, and ensure identification of concerns and implementation of plans involving all facility staff. | F 323  |  |                      |   |
| F 490<br>SS=J  | 483.75 EFFECTIVE<br>ADMINISTRATION/RESIDENT WELL-BEING   | F 490  | F490<br><br>1. On 10/22/14 the SCC educated all the facility's administration, including the Administrator, DON, ADON, Nursing | 12/01/14             |   |

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

PRINTED: 11/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

|  |  |  |   |
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| NAME OF PROVIDER OR SUPPLIER<br><br>FOUNTAIN CIRCLE CARE & REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE<br>200 GLENWAY ROAD<br>WINCHESTER, KY 40391 |
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|--------------------|--|---------------|---|----------------------|

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| F 490 | Continued From page 52<br>A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview, record review, review of the facility's policies, Administrator job description, and Incident Reports, it was determined the facility's Administration failed to have an effective system in place to ensure policies and procedures were implemented to ensure the residents' environment remained as free from accident hazards as possible, ensure staff were trained and knowledgeable regarding the process for ensuring safety of residents on facility outings and ensure staff implemented residents' care plans. (Refer to F-282, F-323)<br><br>Resident #1 was to attend a facility outing on 10/03/14, and was assisted out of his/her motorized wheelchair with a self-releasing seat belt, for which he/she was care planned to have for security, into a manual wheelchair, without a self-releasing seat belt. Staff assisted Resident #1 onto the facility's van; however, did not ensure the resident was securely restrained with a seat belt prior to the van moving. During the transportation at approximately 2:15 PM, the van suddenly stopped for a traffic light and Resident #1 "flew" out of the manual wheelchair onto the van floor. Registered Nurse (RN) #1, who was present on the van, immediately assessed Resident #1 and he/she was transported to the hospital Emergency Room where he/she was | F 490 | Supervisors, MDS Coordinators, QOL Director, HR Director, Environmental Services Director, Social Services Director, Admissions Director, Medical Records, SDC, and Chaplain on the care plan policy, including following care plans, accident and incident policy, including ensuring an environment free of accident and hazards, and the revised outing guidelines with new monitoring process to ensure resident safety during outings.<br><br>Administrative oversight of the facility was completed by the VP of Operations, Signature Care Consultant or Special Projects Administrator daily until removal of immediacy beginning on 10/22/14, then weekly for 4 weeks.<br><br>2. Starting on 10/22/2014 and was completed on 10/24/2014, all the facility staff was educated on the facility's care plan policy, including following care plans, accident and incident policy, including ensuring an environment free of accident |  |
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

|  |  |  |  |                      |   |
|--|--|--|--|----------------------|---|
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| F 490  | Continued From page 53<br>diagnosed with a large Hematoma to the right forehead area. The resident returned to the facility at 4:52 PM on 10/03/14.<br><br>The facility's Administrator's failure to have an effective system in place to ensure policies and procedures were implemented to ensure the residents' environment remained as free from accident hazards as possible, ensure staff were trained and knowledgeable regarding the process for ensuring safety of residents on facility outings, and ensure staff implemented residents' care plans was likely to cause risk for serious injury, harm, impairment, or death. Immediate Jeopardy was identified on 10/22/14 and determined to exist on 10/03/14. The facility was notified of the Immediate Jeopardy on 10/22/14.<br><br>The facility provided an acceptable credible Allegation of Compliance (AOC) on 10/29/14, alleging removal of the Immediate Jeopardy on 10/25/14. The Immediate Jeopardy was verified to be removed on 10/25/14, as alleged, with remaining non-compliance at 42 CFR 483.75 Administration, F-490 at a Scope and Severity (S/S) of a "D", while the facility develops and implements a Plan of Correction (POC), and the facility's Quality Assurance continues to monitor to ensure compliance with systemic changes.<br><br>The findings include:<br><br>Review of the Administrator's Job Description, updated December 2011, revealed the Administrator was responsible for leading and directing the overall operations of the facility in accordance with residents' needs, government regulations and company policies. Continued review revealed the Administrator's management | F 490  | and hazards, and the revised outing guidelines with new monitoring process to ensure resident safety during outings by the SDC, DON, Administrator, ADON, Nursing Supervisors, QOL Director, HR Director, Environmental Services Director, MDS Coordinators, Social Services Director, Admissions Director, Medical Records, and Chaplain.<br><br>3. On 10/22/14 the SCC educated all the facility's administration, including the Administrator, DON, ADON, Nursing Supervisors, MDS Coordinators, QOL Director, HR Director, Environmental Services Director, Social Services Director, Admissions Director, Medical Records, SDC, and Chaplain on the care plan policy, including following care plans, accident and incident policy, including ensuring an environment free of accident and hazards, and the revised outing guidelines with new monitoring process to ensure resident safety during outings. |                      |   |

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

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|  |  |  |   |
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|--------------------|--|---------------|---|----------------------|
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| F 490 | Continued From page 54<br>duties included, but were not limited to, hiring, training and developing, coaching, counseling and terminating facility staff as deemed necessary. In addition, the Job Description revealed the Administrator's duties included monitoring delivery of nursing care and ensuring residents' needs were addressed. Per the Job Description, the Administrator was responsible for the facility's Quality Assurance (QA) program and to maintain a working knowledge of and confirm compliance with all governmental regulations.<br><br>Review of the facility's, "Safety Precautions for Activities" policy, revised January 2009, revealed the facility was to provide supervision, safety and a safe environment for all residents during any facility activities.<br><br>Review of the facility's, "Outing Guidelines", undated, revealed the facility was to ensure the safety and well-being of residents, and staff were to "double check" residents' security for both residents who were ambulatory and residents who were being transported in a wheelchair on the facility's van. Per the Guidelines, staff should "not assume" residents had been secured properly on the van.<br><br>Review of the "Accidents and Incidents-Investigating and Reporting" policy, revised April 2013, revealed the Nurse Supervisor/Charge Nurse and/or Department Director or Supervisor was to "promptly" initiate an investigation of an accident or incident and document the investigation. Per the Policy, all accidents involving residents were to be investigated and reported to the Administrator.<br><br>Review of the facility's "Care | F 490 | Administrative oversight of the facility was completed by the VP of Operations, Signature Care Consultant or Special Projects Administrator daily until removal of immediacy beginning on 10/22/14, then weekly for 8 weeks, then monthly.<br><br>Starting on 10/22/2014 and was completed on 10/24/2014, all the facility staff was educated on the facility's care plan policy, including following care plans, accident and incident policy, including ensuring an environment free of accident and hazards, and the revised outing guidelines with new monitoring process to ensure resident safety during outings, by the SDC, DON, Administrator, ADON, Nursing Supervisors, QOL Director, HR Director, Environmental Services Director, MDS Coordinators, Social Services Director, Admissions Director, Medical Records, and Chaplain.<br><br>The new Pre-Trip Vehicle Safety form was implemented on 10/3/14 and was revised on |  |
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

|  |  |  |  |   |
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| F 490  | <p>Continued From page 55</p> <p>Plans-Comprehensive" policy, revised October 2010, revealed care plan development was to include developing interventions which were targeted and meaningful to each resident.</p> <p>Review of the facility's Incident Report dated 10/03/14, revealed Resident #1 was in a wheelchair on his/her way to a facility outing when the resident fell out of the wheelchair into the aisle of the facility van, hitting his/her head on the van floor. According to the Incident Report, one (1) of the contributing factors Resident #1 fell out of the wheelchair was the resident had difficulty maintaining his/her sitting balance, related to diagnoses of Cerebrovascular Accident (CVA) with right-sided Hemiplegia and a Right Above the Knee Amputation (AKA).</p> <p>Review of the hospital Emergency Room (ER) record dated 10/03/14 at 2:52 PM, revealed Resident #1 had sustained an injury to his/her head after a fall on the facility van. Review of the ER record revealed the ER Physician diagnosed Resident #1 with a large Hematoma to the right forehead area.</p> <p>Record review revealed Resident # 1 was totally dependent on assistance of two (2) staff for all transfers and, had an Physician's Order for a self-releasing seat belt when up in wheelchair related to resident's sense of security related to the diagnosis of Right AKA. Review of Resident #1's Comprehensive Care Plan revealed the facility care planned the resident to have a self-releasing seat belt when up in a wheelchair.</p> <p>However, staff interviews revealed even though they were aware Resident #1 required a self-releasing seat belt when in a wheelchair, they</p> | F 490  | <p>10/22/14 to be completed on any facility outing. The Administrator will sign off on all Pre-Trip Vehicle Safety Forms completed.</p> <p>On 10/24/14 Officer Tinsley with the KY State Police Vehicle Enforcement provided education and training related to vehicle safety and pre-trip inspection and properly securing passengers with a return demonstration to the nursing administration, nursing staff, medical records staff, quality of life staff, chaplain, administrative staff, housekeeping staff, and the rehab services manager.</p> <p>Any new transport staff will have to demonstrate to the Administrator the proper safety belt application prior to going on an outing with the residents. In the absence of the Administrator, the D.O.N., A.D.O.N., or Staff Development Coordinator may educate and sign off on the return demonstration of proper safety belt application.</p> |   |

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

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| F 490 | Continued From page 56<br>had not ensured the resident was properly restrained with any type of seat belt prior to movement of the facility van on 10/03/14. Staff failed to "double check" residents' security and "not assume" residents had been secured properly on the van per the facility's guidelines for resident outings. Staff interviews revealed the facility had not formally trained them on assisting residents who were attending outings and ensuring residents' safety while on the outings. Staff interviews also revealed staff thought the resident's self releasing seatbelt was only for use when Resident #1 was in his/her motorized wheelchair.<br><br>Interview with the Director of Nursing (DON) on 10/21/14 at 2:00 PM and on 10/22/14 at 4:05 PM, revealed the Activity Director "informally" went over the facility's "Outing Guidelines" with staff before each outing. According to the DON, she was aware of Resident #1's ordered and care planned self-releasing seat belt when in a wheelchair. However, she reported she thought the self-releasing seat belt was for only when Resident #1 was in his/her motorized wheelchair, not when he/she was in a manual wheelchair. The DON revealed the facility had no policy specific to staff following residents' care plans; however, it was the expectation staff would do so.<br><br>Interview and record review revealed the facility failed to conduct an investigation related to the incident per the facility's policy which stated staff would "promptly" initiate an investigation of an accident or incident and document the investigation. Record review revealed the investigation of the accident was not initiated until 10/10/14, seven (7) days later. | F 490 | 4. Administrative oversight of the facility was completed by the VP of Operations, Signature Care Consultant or Special Projects Administrator daily until removal of immediacy beginning on 10/22/14, then weekly for 8 weeks, then monthly.<br><br>All Pre-Trip Vehicle Safety Forms will be signed off by the Administrator.<br><br>DON, ADONs, SDC or Nursing Supervisor will observe the care delivery, per the care plan for any concerns on 5 different residents/unit for a total of 15 residents daily beginning on 10/22/14 until removal of immediacy 10/25/14 and then on 5 different residents per unit 3 days a week for 4 weeks, then weekly for 4 weeks. Results of the care delivery audits will be reported to the QA committee weekly to determine the further need of continued education or revision of plan. At that time, based on evaluation, the QA committee will determine at what frequency the audits will need to continue. Concerns |  |
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/21/2014  
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| F 490 | Continued From page 57<br>Continued interview with the Director of Nursing (DON) on 10/21/14 at 2:00 PM and on 10/22/14 at 4:05 PM, revealed when the facility first learned of the accident involving Resident #1 it was unclear what had happened on the van for the resident to fall out of the wheelchair. She stated she thought Resident #1 had possibly removed both (shoulder and lap) seat belts by himself/herself after the van started moving, and did not know until later staff had not ensured the seat belts were in place prior to the van moving. Per interview, on 10/03/14 after Resident #1's accident, the facility completed an Incident Report; however, an investigation was not initiated until 10/10/14, to determine the cause of the fall. Even though the facility's policy stated facility staff were to "promptly" initiate an investigation of an accident. The DON indicated the facility did not conduct an investigation on 10/03/14 because staff thought the incident involving Resident #1's fall was not abuse or neglect and was just an accident. However, the facility's policy was specific to investigating accidents and incidents, not abuse or neglect. Continued interview with the DON revealed the nurse completing the facility's "Event Manager", the computer system used for accidents/incidents, determined the "contributing factor" for the fall on 10/03/14 was the resident having difficulty maintaining his/her sitting balance. However, the DON indicated she did not know how this was determined by the nurse.<br><br>Interview with the Administrator on 10/21/14 at 2:45 PM revealed she first became aware of the incident involving Resident #1 on 10/03/14 when the Activity Director called her from the ER. She stated she thought Resident #1's seat belts had possibly malfunctioned, and when the van | F 490 | identified will be corrected immediately and reported to Director of Nursing or Administrator.<br><br>Daily, Monday thru Friday all accident and incidents will be reviewed by the DON, ADON, or Nursing Supervisors to ensure all current care needs were implemented and a thorough investigation was completed.<br><br>The ongoing processes 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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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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| F 490 | Continued From page 58<br>returned to the facility all the seat belts on the van were inspected and found to be intact and functioning properly. She stated after learning of the incident involving Resident #1's fall on the bus, an Incident Report was completed. The Administrator indicated on 10/03/14, she was aware an investigation had not been initiated that day to determine the cause of Resident #1's fall, as per the policy, as it was not abuse or neglect and just an accident. However, the facility's policy was specific to investigating accidents and incidents, not abuse or neglect. She stated the facility's management team met on 10/03/14, after learning of Resident #1's accident, and developed a new form titled, "Outing Safety Checklist" to be used for all residents' outings to ensure safety of the residents. The Administrator stated the management team felt that they needed to put a system in place to ensure all residents' seat belts were fastened prior to movement of the van, other than the current system of the Activity Director verbally asking if the seat belts were fastened. She reported eight (8) staff members were in-serviced on the new form on 10/03/14; however, no further in-services had been performed until Corporate's approval of the new checklist was received. The Administrator acknowledged her duties and responsibilities located in her Job Description; however, stated she did not feel her staff were not trained and educated regarding the care of residents during transport to ensure their safety.<br><br>The facility provided an acceptable, credible Allegation of Compliance (AOC) on 10/29/14, with alleged removal of Immediate Jeopardy (IJ), effective 10/25/14. Review of the AOC revealed the facility implemented the following: | F 490 |  |  |
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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| F 490 | <p>Continued From page 59</p> <p>1. The initial investigation of Resident #1's fall was started by the Director of Nursing (DON) on 10/10/14. The investigation included: Resident #1 was assessed by the Assistant Director of Nursing (ADON) on 10/10/14; staff statements were obtained 10/10/14 through 10/14/14 by the Administrator, Director of Nursing (DON), Social Services Director (SSD) and ADON; resident's statements were obtained 10/10/14 through 10/14/14 by the Administrator, DON, ADON, or SSD, from the residents who were on the van when the 10/03/14 incident involving Resident #1 occurred; "the wheelchair placement area" on the van with the "failed seat belt function", was placed out of service on 10/10/14 by the Maintenance Director.</p> <p>2. Contacts, which started on 10/03/14 by the Administrator, were made to several agencies to get all seat belts on the van assessed for proper function and safety. An officer with the Kentucky State Police (KSP) Vehicle Enforcement provided education/training on 10/24/14 for eight (8) nursing administration staff, two (2) nursing staff, one (1) Medical Records staff person, three (3) Quality of Life (Activity) Staff, the Chaplain, seven (7) administrative staff, two (2) housekeeping staff, and the Rehabilitation (Rehab) Services Manager, who were all designated transport staff, regarding pre-trip vehicle inspection and properly securing resident passengers on the van. Return demonstration was completed by these staff at the training that was held on 10/24/14. All the designated transport staff were to complete a demonstration to the Administrator prior to going on another outing to ensure understanding of proper safety belt function. Any new designated transport staff will demonstrate to the Administrator proper safety belt application prior</p> | F 490 |  |  |
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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| F 490  | Continued From page 60<br>to going on an outing with the residents.<br><br>3. A new process was put in place to ensure residents' safety while on the van which included a safety check off sheet implemented on 10/3/14 by the Administrator. The facility also implemented changes to the "Outings Guidelines" which included: staff utilizing the "Pre-Trip Vehicle Safety Form", which was revised 10/22/14, prior every outing to ensure safety of residents; and a copy of the Certified Nursing Assistant (CNA) "care guide" for each resident would be taken on every outing to ensure residents' care plans were followed. The designated transport staff and two (2) van drivers received education/training on the new process on 10/03/14, by the ADON. The designated transport staff was educated on the updated "Pre-Trip Vehicle Safety Form", which began on 10/22/14 and was completed on 10/24/14. Resident #1 was provided with a transport wheelchair, to include a self-release seat belt, on 10/23/14 that met resident care needs and ensured the residents safety during transport in the facility van. An investigation of the 10/03/14 incident involving Resident #1 was completed by the DON on 10/15/14.<br><br>4. The new "Outing Guidelines" process which included the "Pre-Trip Vehicle Safety Form" and copy of the CNA "care guide" for each resident, that were to be taken and followed on all outings, would also ensure residents' care plans were followed on the outing when the residents were on the van. All Department Managers received education/training on 10/22/14, regarding the new "Outing Guidelines" process provided by the SCC.<br><br>5. All residents were assessed by the DON, | F 490  |   |                      |   |

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

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FORM APPROVED  
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| F 490  | Continued From page 61<br>ADON, or Registered Nurse (RN) Supervisor on 10/22/14, for electric wheelchair usage, to determine if residents' safety needs were met, along with any care planned safety devices for safety needs during transport in the facility van, as outlined by residents' care plans.<br><br>6. All residents were assessed. Residents with a Brief Interview Mental Status (BIMS) score greater than eight (8), were interviewed beginning 10/22/14 and completed on 10/23/14, by the Administrator, DON, ADON, SSD, Registered Dietician (RD), Chaplain or Medical Records staff for any concerns. Residents with a BIMS score less than eight (8) were physically assessed by the DON, ADON, Unit Managers, or RN supervisor. The assessments, interviews and questionnaires were reviewed by the Administrator or Signature Care Consultant (SCC) on 10/23/14.<br><br>7. All personnel files were audited 10/22/14 by Human Resources staff, Chaplain or Nursing Supervisor for any concerns, with results given to the SCC on 10/23/14, for review. Additionally, all accident/incident reports from July to 10/22/14 were reviewed on 10/23/14 by the DON, ADON, SDC or SCC to identify any concerns and ensure incident reports and a thorough investigation was completed, with no concerns identified.<br><br>8. All residents' care plans and CNA care plans were reviewed and updated as needed to include residents' wheelchair safety devices, on 10/22/14 by the DON, ADON, Nursing Supervisor or Minimum Data Set (MDS) Nurses to ensure each resident's care plan and CNA care plan reflected the current care needs of the resident. | F 490  |   |                      |   |

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

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| F 490 | Continued From page 62<br>9. Facility environmental rounds were completed by the Housekeeping Director, Activity Director or Administrator on 10/22/14, to ensure the residents' environment was free of accidents and hazards.<br><br>10. On 10/22/14, the SCC educated the facility's management staff which included the Administrator, DON, ADON, RN Supervisors, MDS, Quality of Life (Activity) Director, HR staff, Environmental Services Director (ESD), SSD, Admissions Director, Medical Records and Chaplain on the facility's care plan policy, accident/incident policy and the revised "Outing Guidelines" process. These staff could not return to work until the education was provided, post-test administered and a score of one hundred percent was obtained. If they did not score one hundred percent on the post-test, the staff person was immediately re-educated and post-test re-administered. The process continued until all the above management staff obtained one hundred percent on the post-test. All post-tests were reviewed for compliance by the SCC.<br><br>11. The management staff which included, the Administrator, DON, ADON, RN Supervisor, MDS, Quality of Life (Activity) Director, HR staff, ESD, SSD, Admissions Director, Medical Records staff, or Chaplain, after completion of the education, re-educated all facility staff on the facility's care plan policy, accident/incident policy and the revised "Outing Guidelines" process starting on 10/22/14. By 10/24/14, one hundred and twenty-six (126) of the facility's one hundred and eighty-nine (189) staff had been re-educated. All employees who had not received the education were sent a certified letter on 10/27/14, | F 490 |  |  |
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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| F 490 | Continued From page 63<br>providing notification to staff not to return to work until education was completed, with no staff allowed to work until education was provided. All staff provided the re-education completed an abuse post-test and a one-hundred percent score had to be obtained, or the staff were immediately re-educated and the post-test was re-administered. This process was to continue until staff obtained a score of one hundred percent on the post-test. This education was to be included during orientation for all newly hired staff who would not be allowed to work until the education was provided, the post-test administered and a score of one hundred percent obtained. The facility does not employ or utilize agency staffing.<br><br>12. A nurse from the facility's regional or corporate office was onsite beginning 10/22/14, and was to remain in the facility daily until the Immediate Jeopardy (IJ) was lifted. These nurses assisted with investigations, observed staff treatment of residents, performed chart audits, observed environment safety, observed care delivery to ensure it was provided as per residents' care plans and provided oversight and consultation. The facility's corporate Vice President (VP) of Operations, the Special Projects Administrator or the Director of Clinical Programs was to be in daily contact with the SCC and were to review allegations until the IJ was lifted.<br><br>13. Per the AOC, the DON, ADON, SDC or Nursing Supervisor would observe the care delivery for five (5) different residents on different units for a total of fifteen (15) residents for any concerns daily until removal of the IJ, then would perform the observations weekly for four (4) | F 490 |  |  |
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 490 Continued From page 64

weeks. Results of the care delivery/observation audits were to be reported to the facility's Quality Assurance (QA) Committee weekly to determine the need for continued staff education or revision of plan. Concerns identified would be corrected immediately and reported to the Administrator to ensure investigations were completed and, if necessary reported as per the facility's guidelines. The Administrator, DON, or member of the facility's regional staff were to review all the resident care delivery audits daily to identify any concerns. Investigations of any concerns were to be initiated upon receipt of the concern starting on 10/23/14. The Administrator and one (1) of the following: VP of Operations; Special Projects Administrator; or SCC would review the investigations daily to ensure the above areas were covered. All the above was to continue until removal of the IJ.

14. The VP of Operations, SCC or Special Projects Administrator would provide administrative oversight of the facility daily until removal of the IJ beginning 10/22/14, after removal of the IJ administrative oversight by the above would continue weekly for four (4) weeks, then monthly. A QA meeting would be held weekly for four (4) weeks beginning 10/22/14, then monthly afterwards for recommendations and further follow up regarding the AOC. The QA Committee would determine at what frequency any ongoing audits would need to continue. The Administrator had the oversight to ensure an effective plan was in place to meet residents' well-being, as well as, an effective plan to identify facility concerns and implement a plan of correction to involve all staff of the facility. Corporate Administrative oversight of the QA Committee meeting would be completed by the

F 490

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

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| F 490 | <p>Continued From page 65</p> <p>Special Projects Administrator, Regional VP of Operations, or member of the regional staff daily until removal of the IJ beginning 10/22/14, then weekly for four (4) weeks, then monthly thereafter.</p> <p>The State Agency validated the implementation of the facility's AOC as follows:</p> <ol style="list-style-type: none"> <li>1. Review of the facility's investigation report revealed: it was initiated 10/10/14 by the DON; Resident #1 was assessed by the ADON on 10/10/14, witness statements of staff and residents on the van had been obtained by the Administrator, DON, ADON and SSD; and per the Plant Operations Director (POD) written statement, the "wheelchair placement area" on the van with the "failed seat belt function" had been placed "out of service" as per the AOC.</li> <li>Interview with the SCC on 11/04/14 at 10:30 AM, revealed the van had not transported residents since the incident involving Resident #1 on 10/03/14, and he verified the facility's investigation completion as above.</li> <li>2. Review of the statement signed by the Administrator, undated, revealed she contacted an officer with the KSP, who agreed to offer training regarding safety on the van. Continued review of the Administrator's written statement revealed the KSP officer provided the training on 10/24/14 at 10:30 AM.</li> <li>Review of the In-Service sign-in sheets, dated 10/24/14, revealed the officer provided instruction on "Outing Education and Safety" for twenty-four (24) facility staff who signed the in-service sheets.</li> </ol> | F 490 |  |  |
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/21/2014  
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|--------------------|--|---------------|---|----------------------|
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F 490 Continued From page 66

Observation on 11/05/14 at approximately 1:00 PM, revealed the Quality of Life (Activity) Director and the Chaplain performed a demonstration of what they had been trained on by the KSP officer.

Interview on 11/05/14 with the Human Resources (HR) staff person at 11:07 AM, Activity Aide Assistant #1 at 1:56 PM, Activity Aide Assistant #2 at 2:08 PM and on 11/06/14 with the Activities Director at 12:19 PM and the DON at 12:47 PM revealed they had all received the training provided by the KSP officer on 10/24/14, completed return demonstration and had taken a post-test on which they had to score one hundred percent. Per the DON, any new staff designated to assist with outings would go through the same education, return demonstration and post-testing.

3. Review of the facility's, "Outing Guidelines Form", undated, revealed the facility had implemented the use of a the "Pre-Trip Vehicle Safety Form" which was to be completed by staff to double check the security of all residents and their wheelchairs when on the van. Continued review of the Form revealed a copy of residents' CNA care guides were to brought on each outing for every resident attending. The Form noted staff members were secure empty wheelchairs on the bus to ensure safety of residents.

Interview on 11/05/14 with the HR staff person at 11:07 AM, Activity Assistant Aide #1 at 1:56 PM, Activity Assistant Aide #2 at 2:08 PM and on 11/06/14 with the Activities Director at 12:19 PM revealed they had all been educated on the new process for transportation of residents on outings. They all reported being educated on the updated "Pre-Trip Vehicle Safety Form" between 10/22/14 and 10/24/14. Interview on 11/06/14 at 12:47 PM

F 490

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

PRINTED: 11/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

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| F 490  | Continued From page 67<br>with the DON revealed: she had also been educated on the updated "Pre-Trip Vehicle Safety Form"; Resident #1 was provided a wheelchair which had a self-releasing seat belt for outings; and she had completed a thorough investigation of the 10/03/14 incident involving Resident #1 on 10/15/14, which was sent to the State Survey Agency.<br><br>Review of Resident #1's medical record revealed the resident was assessed by Occupational Therapy (OT) and was provided a transport wheelchair with a self-releasing seat belt on 10/23/14.<br><br>Interview with the SCC on 11/06/14 at 1:58 PM, revealed revisions were made to the facility's, "Outings Guidelines" as per the AOC. He stated the "Outings Guidelines" process was a check off system for to ensure safety of residents on the facility's van. Continued interview revealed changes were made to the process to address vehicle safety and to ensure all residents were secure restrained in their seat belts, including residents in wheelchairs. He revealed the "Pre-Trip Vehicle Safety Form" was revised and the "Outings Guidelines" were revised to include the addition of bringing the residents' CNA care cards on outings.<br><br>4. Review of the facility's, "Outing Guidelines Form", undated, revealed the facility had implemented the use of a the "Pre-Trip Vehicle Safety Form" which was a check-off sheet to be completed by staff to double check the security of all residents and their wheelchairs when on the van, and noted a copy of each residents' CNA care guides was to brought on each outing for every resident attending. | F 490  |   |   |

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

PRINTED: 11/21/2014  
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| F 490 | Continued From page 68<br><br>Review of the in-service titled, "Outing Guidelines" revealed the training was conducted by the SCC on 10/22/14.<br><br>Interview on 11/05/14 with the Director of Housekeeping and Laundry at 2:27 PM and on 11/06/14 with the Activities Director at 11:19 AM and with the DON at 12:47 PM, revealed they had all been educated on the new "Outing Guidelines" process on 10/22/14.<br><br>Interview with the SCC on 11/06/14 at 1:08 PM, revealed he provided the in-service training on 10/22/14 at 8:00 PM as per the AOC. The SCC revealed the in-service was completed with all of the department managers as per the AOC, who in turn provided the education to staff in their departments regarding the new "Outing Guidelines".<br><br>5. Review of the facility's "Census Board" Report dated 10/22/14, revealed residents were assessed for use of electric wheelchairs. Resident #1 and Resident #4 were determined to have the electric wheelchairs during the assessment.<br><br>Interview on 11/05/14 with OT #1 at 11:43 AM and OT #2 at 1:47 PM revealed they assessed Resident #1 and Resident #4 and determined the residents needed special transport chairs for outings which the residents were provided with and their care plans updated to include this information.<br><br>Review of Resident #1's and Resident #4's care plans revealed the care plans were updated to reflect the new transport chairs provided by OT. | F 490 |  |  |
|-------|---|-------|--|--|

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

PRINTED: 11/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

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| F 490  | Continued From page 69<br><br>Interview with the SCC on 11/06/14 at 1:58 PM revealed the assessment of all resident's who had electric wheelchairs was performed as per the AOC on 10/22/14. He revealed Resident #1 and Resident #4 were assessed by OT to require special transport wheelchairs for outings. Per interview, Resident #1's transport wheelchair was equipped with a self-releasing seat belt as per the resident's care plan.<br><br>6. Review of the facility's interviews conducted with residents who had a BIMS score greater than eight (8) revealed the residents were asked to answer questions on a questionnaire regarding any concerns. Continued review of the resident interviews revealed the DON, ADON and SSD questioned the residents on 10/22/14. Review of the CNA Skin Care Alert for residents with a BIMS of less than eight (8) revealed physical assessments of those residents were completed by the DON, ADON, Unit Managers or RN Supervisor.<br><br>Interview with the SCC on 11/06/14 at 1:58 PM, revealed resident interviews were conducted as per the AOC for residents with a BIMS of eight (8) or greater. The SCC revealed as per the AOC, residents with a BIMS of less than eight (8) were physically assessed for injury. Per interview, staff were also asked if they were aware of any concerns regarding residents.<br><br>7. Review of the facility's personnel file audits revealed all files were audited by the Chaplain, HR Director and LPN #5, Unit Manager, who signed and dated the completion of the review of the files on 10/23/14. The State Survey Agency reviewed five (5) personnel records with no | F 490  |   |                      |   |

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

PRINTED: 11/21/2014  
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OMB NO. 0938-0391

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| F 490  | Continued From page 70 concerns identified.<br><br>Review of the facility's "Healthcare-Event" Incident/Accident Report audit sheet revealed it included review of all incidents from 07/22/14 through 10/22/14, with no concerns identified.<br><br>Interview with the HR Director on 11/05/14 at 11:07 AM, revealed she, along with the Chaplain and LPN #5 reviewed all employee personnel files.<br><br>Interview with the SCC on 11/06/14 at 1:08 PM, revealed all staffs' personnel files were checked as per the AOC with no concerns identified. Continued interview revealed the audits of the Incident/Accident forms were performed as per the AOC, with no concerns identified. Per interview, the audits would continued and the clinical team would address any issues. The SCC revealed the audits would also be performed on weekends and holidays. If any concerns were noted during the audits of the Incident/Accident Reports staff would notify the Administrator and DON.<br><br>8. Review of the facility's audits of residents' care plans and CNA Care Plans, which began on 10/22/14 with a completion date of 10/29/14, revealed all the residents' care plans and CNA Care Plans were reviewed and/or updated and revised as necessary to show the resident's current care needs. revisions in the comprehensive care plans, as well as, the Certified Nursing Assistance Care Plans.<br><br>Interview, on 11/06/14 at 12:47 PM, with the DON revealed the ADON, Nursing Supervisor, MDS Nurse and herself had performed the care plan | F 490  |   |                      |   |

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

PRINTED: 11/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

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| F 490 | Continued From page 71<br>reviews and ensured the care plans reflected each resident's assessed needs.<br><br>Interview with the SCC on 11/06/14 at 1:08 PM, revealed all residents' care plans and CNA Care Plans (care cards) were audited and reviewed by the DON, ADON, Nursing Supervisor or MDS Nurse to ensure they were correct according to the resident's assessed needs. He reported he along with the other Corporate Consultants looked over the completed care plans after the audit to ensure they were correct.<br><br>9. Review of the "Environmental Rounds" check sheet revealed the facility's department heads would be responsible for conducting the environmental rounds of the facility which began on 10/22/14. Review of the 10/22/14 "Environmental Rounds" check sheet revealed the rounds were completed by the Housekeeping Director, Activity Director or Administrator. Review of the "Environmental Rounds" schedule revealed department head managers were assigned to check the facility's environment for accident and safety hazards.<br><br>Interview with the Director of Environmental Services, on 11/06/14 at 3:04 PM, revealed he had been assigned to conduct the "Environmental Rounds" checking for concerns related to safety of residents. We reported that if he noticed a concern while conducting the environmental tour, he would repair the problem himself.<br><br>Interview with the Administrator on 11/06/14 at 3:35 PM, revealed the "Environmental Rounds" were completed by the Housekeeping Director, Activity Director or herself on 10/22/14 as per the AOC. She stated these continued to be | F 490 |  |  |
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/21/2014  
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| F 490 | <p>Continued From page 72 performed by the facility's department head managers.</p> <p>10. Review of the in-service sign-in sheets dated 10/22/14 revealed signatures for the Administrator, DON, ADON, RN Supervisor, MDS Nurse, Activity Director, HR Director, ESD, SSC, Admissions Director, Medical Records staff person and Chaplain. Continued review revealed the in-service was conducted by the SCC regarding the facility's care plan policies, incident/accident policy and the revised "Outing Guidelines" process. Review of the post-tests taken by the above staff revealed all had scored one hundred percent as per the AOC.</p> <p>Interview on 11/05/14 with the HR Director at 11:07 AM, the Director of Environmental Services at 3:04 PM and on 11/06/14 with the Activity Director at 12:20 PM, with the DON at 12:47 PM, with the SSD at approximately 1:15 PM, with the SDC at 1:35 PM, with the Administrator at 3:35 PM, revealed they were all in-serviced by the SCC on 10/22/14, regarding the facility's care plan policy, revised "Outing Guidelines" process and accident/incident policy prior to returning to work that day. They reported having to receive a score of one hundred percent on the post-test.</p> <p>11. Review of the in-service sign-in sheets and documentation revealed all the in-services began on 10/22/14 and were completed by 11/03/14. Review of the certified mail receipts, dated for 10/27/14, revealed letters were mailed to staff who were not scheduled to work during the in-services. Review of staffs' post-tests revealed scores of one-hundred percent.</p> <p>Interview on 11/05/14 with the HR Director at</p> | F 490 |  |  |
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/21/2014  
FORM APPROVED  
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|--------------------|--|---------------|---|----------------------|
|--------------------|--|---------------|---|----------------------|

F 490 Continued From page 73

11:07 AM, the Director of Environmental Services at 3:04 PM and on 11/06/14 with the Activity Director at 12:20 PM, with the DON at 12:47 PM, with the SSD at approximately 1:15 PM, with the SDC at 1:35 PM, with the Administrator at 3:35 PM, revealed they all had assisted with in-servicing staff after their training on 10/22/14, regarding the facility's care plan policy, accident/incident policy and revised "Outings Guidelines" process. They stated post-tests were administered to all the staff after the in-service training with staff having to score one hundred percent or be re-educated until the score was obtained. Per interview, no staff person was allowed to work until they had received the in-service and scored one hundred percent on the post-test.

Interview on 11/05/14 with Certified Nursing Assistant (CNA) #1 at 10:45 AM, with CNA #2 at 11:26 AM, with Activity Aide Assistant #1 at 1:56 PM, with Activity Aide Assistant #2 at 2:08 PM and the Director of Housekeeping and Laundry at 2:27 PM, and on 11/06/14 with CNA #3 at 8:57 AM, with CNA #4 at 9:17 AM, with CNA #5 at 9:30 AM, with the Activities Director at 11:19 AM, with CNA #7 at 12:10 PM, revealed they all reported having been in-serviced on the care plan policy, accidents/incidents policy and the revised "Outing Guidelines" process. They stated they had not been allowed to work until they had received the in-services. Further interview with the above staff revealed they all took a post-test in which they had to score one hundred percent or re-take the test. They all reported receiving the required one hundred percent on the post-test.

12. Interview with the SCC on 11/06/14 at 1:58 PM, revealed he had been onsite since the IJ was

F 490

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

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| NAME OF PROVIDER OR SUPPLIER<br><br>FOUNTAIN CIRCLE CARE & REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE<br>200 GLENWAY ROAD<br>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 490 | Continued From page 74<br>called 10/22/14. He reported he worked a minimum of eight (8) hours a day to ensure staff understood the facility's inservices and revised "Outing Guidelines" process, assisted with any investigations, performed observations of staff providing care to ensure residents received care as per their care plan, assisted with chart audits and provided oversight and consultation as necessary. He stated he made rounds on all shifts to ensure the facility's policies were implemented and followed.<br><br>13. Review of the facility's "Care Delivery Audits" revealed the DON, ADON, SDC, or Nursing Supervisor observed care delivery for five (5) different residents on different units for a total of fifteen (15) residents for any suspected neglect concerns of residents as per the AOC.<br><br>Interview on 11/06/14 with the DON at 12:47 PM and SDC at 1:35 PM, revealed they both had assisted with performing the "Care Delivery Audits" on five (5) different residents on different units.<br><br>Interview on 11/06/14 at 3:35 PM with the Administrator revealed the "Care Delivery Audits" had been performed on five (5) different residents on different units since 10/22/14 as per the AOC. She stated the results of the audits were being reviewed by the DON, corporate staff or herself daily, and were being taken to the facility's QA Committee weekly.<br><br>Interview with the SCC on 11/06/14 at 1:58 PM, revealed the care delivery audits were being performed for five (5) different residents on different units as per the AOC. He stated the audit began on 10/23/14 and the last listed audit | F 490 |  |  |
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>185146 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br>C<br>11/06/2014 |
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| NAME OF PROVIDER OR SUPPLIER<br><br>FOUNTAIN CIRCLE CARE & REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE<br>200 GLENWAY ROAD<br>WINCHESTER, KY 40391 |
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| F 490 | <p>Continued From page 75</p> <p>was on 10/29/14. He reported the audit would continue for four (4) weeks and the results of the care audits would be reported to the facility's QA Committee weekly to determine the further need for continued staff education. The SCC revealed no concerns had been identified at the time, but if there were concerns, an investigation would be immediately initiated.</p> <p>14. Interview with the SCC on 11/06/14 at 1:58 PM, revealed he was providing daily oversight of the facility until the IJ was lifted. Then he would provide weekly oversight which would continue for four (4) weeks, then monthly thereafter. Continued interview revealed the QA Committee meeting would be held weekly, beginning 10/22/14, and for four (4) weeks total to discuss any concerns regarding the processes implemented, and to determine at what frequency any ongoing audits would need to continue. He stated the QA Committee meetings would then be performed monthly for continued follow up and monitoring. Per interview, the Administrator was responsible for oversight to ensure an effective plans were in place to meet each residents' needs, and ensure identification of concerns and implementation of plans involving all facility staff.</p> | F 490 |  |  |
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