

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

PRINTED: 08/02/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES NO PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186140	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 08/19/2011
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NAME OF PROVIDER OR SUPPLIER  FOUNTAIN CIRCLE HEALTH AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 200 GLENWAY ROAD WINCHESTER, KY 40391
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS  An Abbreviated Survey investigating #KY00016837, #KY00016900, KY00016895, KY00016898 and KY00016864 was initiated on 08/12/11 and concluded on 08/19/11. #KY00016900 was unsubstantiated with no deficiencies cited, #KY00016837 was unsubstantiated with related deficiencies cited, KY00016895 was unsubstantiated with related deficiencies cited, KY00016838 was unsubstantiated with related deficiencies cited and KY00016864 was unsubstantiated with no deficiencies cited. The highest 8/8 cited was a "D".	F 000	<i>This Plan of Correction is the center's credible allegation of compliance.</i>  <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>	
F 240 S6=D	483.16 CARE AND ENVIRONMENT PROMOTES QUALITY OF LIFE  A facility must care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life.	F 240	F240  Resident #13 was notified of the reason for one to one supervision on 8/17/11. Resident #13 was downgraded from 1:1 supervision on 8/18/11 to every 15 minute checks.  Effective 8/22/11, all residents who are observed to have inappropriate contact or conversation with another resident will be interviewed to determine the specifics surrounding the situation. The licensed nurse, Social Worker (SW), Director of Nursing Services (DNS), Reflections Program Director (RPD) or the Executive Director (ED) will conduct and document the interview in the Resident Progress Notes. The licensed nurse, SW, DNS or ED will also notify the resident, in a language they can understand, of the reason for 1:1 supervision, if applicable, and will document the notification in the Resident Progress Notes.	9/4/11
	This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of care for one (1) of thirteen (13) sampled residents (Resident #13). It was determined the facility failed to create and sustain an environment that humanizes and individualizes each resident as evidenced by the facility failing to interview and inform Resident #13, after an allegation was			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Robert Hillman</i>	TITLE Executive Director	(X6) DATE 9/8/11
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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 240	<p>Continued From page 1</p> <p>made that he/she had touched Resident #12's breast. The facility failed to inform Resident #13 why he/she was being placed on one (1) on one (1) observation.</p> <p>The findings include:</p> <p>Record review revealed the facility admitted Resident #13 on 07/15/08, with diagnoses which included Gastroesophageal Reflux Disease (GERD, acid reflux), Hypertension (high blood pressure), Coronary Artery Disease, and Type Two (2) Diabetes. Review of the facility's Roster Matrix revealed the facility assessed Resident #13 as interviewable, with no cognitive impairment.</p> <p>Review of the facility's investigation revealed Resident #13 allegedly touched another resident inappropriately on 08/12/11. The facility placed Resident #13 on one (1) to one (1) observation. However, further review of the facility's investigation revealed no documented evidence that Resident #13 was interviewed as part of the facility's investigation until 08/17/11, five (5) days later.</p> <p>Interview with CNA (Certified Nursing Assistant) #3, on 08/18/11 at 3:50 PM, revealed he came around the corner to the day room on 08/12/11 and saw Resident #13 with his/her hand on Resident #12's breast. He further stated he asked Resident #13 what he/she was doing. Resident #13 stated Resident #12 was bothering him/her and he/she just wanted to be left alone. CNA #3 further stated he was not sure if Resident #13 was just trying to push Resident #12 away, but he saw Resident #13's hand on Resident</p>	F 240	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>On 8/22/11, the Staff Development Coordinator (SDC), RPD, SW, ED, DNS and/or Assistant Director of Nursing Services (ADNS) initiated education with all licensed staff on informing resident's of their health status, to include, but no limited to, interviewing residents when observed to have inappropriate contact or conversation with another resident, notifying the resident, in a language they can understand, of the reason for 1:1 supervision, if applicable, and the requirement to document the interview and notification in the Resident Progress Notes. Education was completed on 9/3/11. Any direct care staff having not attended the education by 9/3/11, will not be allowed to provide direct care until they attend.</p> <p>The ADNS, Unit Manager (UM) and/or WS will audit the Resident Progress Notes within 24 hours of the initiation of 1:1 supervision to</p>	9/4/11

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F 240	Continued From page 2 #12's breast.  Observation, on 08/17/11 at 3:00 PM, revealed Resident #13 was laying in his/her bed with staff sitting in the hallway in a chair, observing Resident #13.  Interview with Resident #13, on 08/17/11 at 4:50 PM, revealed staff never talked to him/her about the accusation he/she had touched another resident's breast. He/she stated he/she was on the porch smoking when another resident approached him/her the next day and stated they had heard he/she had touched another resident's breast. Resident #13 also stated staff came to his/her bedroom door on 08/12/11, with a chair and sat outside his/her room looking into the room. He/she stated he/she asked staff why they were sitting in front of his/her room and staff stated the Doctor had written the order. He further stated it was upsetting to have a staff person stare at him/her all the time, when he/she had not done anything wrong.	F 240	<i>This Plan of Correction is the center's credible allegation of compliance.</i>  <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>  validate that the resident was interviewed, notified of the 1:1 supervision and that the interview and notification were documented. Any area identified as not completed will be corrected at the time of the audit.  The DNS will track and trend audits on a monthly basis through the Performance Improvement Committee (PIC). The PIC members include, but are not limited to the ED, Assistant Executive Director (AED), DNS, Assistant Director of Nursing (ADNS), RPD, Social Worker (SW), Registered Dietician (RD), Maintenance Director (MD), Nutrition Services Manager (NSM), Recreational Services Director (RSD) and the Medical Director. Action plans will be developed and implemented as indicated. The audits will be reviewed in the monthly PIC for three months and as needed thereafter.	9/4/11
	Interview with Social Services Director, on 08/19/11 at 10:00 AM, revealed she had conducted the investigation of the alleged abuse starting on 08/13/11 but failed to interview Resident #13 until 08/17/11.  Interview with LPN #3, on 08/19/11 at 2:00 PM, revealed she did not speak with Resident #13 about the allegation of abuse made by CNA #3 nor had she explained the order for one (1) on one (1) observation to Resident #13. She further stated she thought Registered Nurse (RN) #1 had spoken to Resident #13 about the allegation and the one (1) on one (1) observation. LPN #3			

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F 240	<p>Continued From page 3</p> <p>further stated staff should have interviewed Resident #13 the night the allegation occurred and staff should have explained to Resident #13 why he/she was being placed on a one (1) on one (1) observation.</p> <p>Interview with RN #1, on 08/18/11 at 12:20 PM, revealed RN #1 thought LPN #3 had spoken to Resident #13 about the allegation and the reason for the one (1) on one (1) observation. Further interview with RN #1 revealed, "We dropped the ball on this one". She continued to say staff should have interviewed Resident #13 the night the allegation occurred and staff should have explained the reason for the one (1) on one (1) observation to the resident on 08/12/11.</p> <p>Interview with the Executive Director, on 08/19/11 at 10:50 AM, revealed per the facility's policy staff should have interviewed Resident #13 the night the allegation was made and staff should have explained to Resident #13 why he/she was being placed on one (1) on one (1) observation with staff.</p>	F 240	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p>	9/4/11
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F 315 88-D	<p>483.26(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p>	F 315	<p>Resident # 8 was provided incontinent care on 8/19/11.</p> <p>All residents receive timely care and services, to include, but not limited to, incontinent care. Any identified concern is addressed immediately on an ongoing basis.</p> <p>On 8/22/11, the Staff Development Coordinator (SDC), SW, ED, DNS and/or Assistant Director of Nursing Services (ADNS) initiated education with all direct care staff on Quality of</p>	
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F 315	<p>Continued From page 4</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to ensure incontinent residents received appropriate treatment and services to prevent urinary tract infections and maintain skin integrity for one (1) of thirteen (13) sampled residents (Resident #8). Observation on 08/19/11, revealed Resident #8 was lying on urine-soaked linens.</p> <p>The findings include:</p> <p>Review of the facility's Incontinence/Perineal Care Policy, dated 11/02/10 R, revealed cleanliness of the perineum helps to prevent infection, skin breakdown and odor by removing irritating and odorous secretions that collect on the inner surface of the labia or under the foreskin of the penis. Perineal care is to be provided to the resident who needs assistance to maintain perineal cleanliness.</p> <p>Review of the facility's Adult Brief or Underpad Policy, dated 10/31/09 R, revealed the incontinent adult may wear briefs or underpads to protect their clothing. Changing the brief or underpad after an incontinent episode provides cleanliness and comfort to the resident and prevents skin breakdown.</p> <p>Record review revealed the facility admitted Resident #8 on 08/28/11, with diagnoses which included Generalized Pain, Altered Mental Status, Failure to Thrive, Heart Disease, Dementia, Bradycardia and Hypertension.</p>	F 315	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>Care and the provision of care, to include, but not limited to, incontinent care. Education included implementation of the resident Care Plan and Certified Nursing Assistant (CNA) Assignment Sheet as these guide the provision of care and services. Education was completed on 9/3/11. Any direct care staff having not attended the education by 9/3/11, will not be allowed to provide direct care until they attend.</p> <p>The SDC, DNS, ADNS, Unit Manager (UM), Shift Supervisor (SS), licensed nurse and/or WS will conduct 3 observations per week of a licensed staff and/or a CNA during the provision of care to validate that all residents are receiving care and services in accordance with their Care Plan and CNA Assignment Sheet, to include, but not limited to, appropriate incontinent care. Any concerns identified will be corrected immediately.</p>	9/4/11

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F 315	<p>Continued From page 6</p> <p>Review of the Minimum Data Set (MDS), dated 07/05/11, revealed the facility assessed the resident to always be incontinent of urine and to have severely impaired cognitive status.</p> <p>Review of the Comprehensive Care Plan, dated 07/09/11, revealed Resident #8 was to wear adult briefs and staff was to change the briefs as soon as possible after incontinence episodes and perineal care was to be performed after each incontinence episode.</p> <p>Observation during a skin assessment, on 08/19/11 at 10:15 AM revealed Resident #8 was wet through his/her adult brief, gown, turn sheet, bottom sheet and top of mattress cover. A dark yellow/brown ring and strong odor were noted.</p> <p>Interview, on 08/19/11 at 10:55 AM, with State Registered Nurse Aide (SRNA) #9 revealed residents were checked every two (2) hours and were changed if incontinent. She stated the aides were making check and change rounds at that time.</p> <p>Interview, on 08/19/11 at 10:30 AM, with Licensed Practical Nurse (LPN) #4 revealed aides were to check residents for incontinence every two (2) hours. Further interview revealed the urine was soaked through the draw sheet, bottom sheet and the mattress was also wet. She stated the urine was strong smelling and appeared to have been there awhile.</p> <p>Interview, on 08/19/11 at 10:40 AM, with Registered Nurse (RN) #4 revealed the "ton" of dark urine had a strong odor, she didn't know when the resident was changed. Further</p>	F 315	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>The DNS will track and trend audits on a monthly basis through the Performance Improvement Committee (PIC). Action plans will be developed and implemented as indicated. The audits will be reviewed in the monthly PIC for three months and as needed thereafter.</p>	9/4/11

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F 315	Continued From page 6 interview revealed the urine appeared to have been there for a "little bit".  Interview, on 08/19/11 at 6:40 PM, with the Regional Director of Nursing revealed the aides were to check and change residents every two (2) hours and as needed. She stated it would be unusual for a resident to be so wet if they were checked/changed within two (2) hours unless the resident was on a diuretic.	F 315	<i>This Plan of Correction is the center's credible allegation of compliance.</i>  <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>	
F 323 88-D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323	F323  The bleach wipes and germicidal disposable cloths were removed from room #129 on 8/19/11.	9/4/11
	This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the Material Safety Data Sheets (MSDS) it was determined the facility failed to ensure the residents' environment remained as free from accident hazards as was possible as evidenced by observation of hazardous chemicals stored in a resident's room. The facility failed to ensure a safe environment when a container of Dispatch Hospital Cleaner Disinfectant Towels with Bleach and a container of Sani-Cloth Plus Germicidal Disposable Cloths were observed in Resident Room #129.		A facility wide observational audit was conducted 8/24/11 by the ED, AED, MD and Housekeeping Supervisor to validate the resident environment was free from all accident hazards and to validate appropriate supervision was provided. Any identified accident hazards or supervision concerns were corrected on 8/24/11.	

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F 323	<p>Continued From page 7 The findings include:</p> <p>Observation on 08/19/11 at 10:15 AM, revealed Licensed Practical Nurse (LPN) #4, Registered Nurse (RN) #4 and a State Surveyor, entered Resident Room #129 to perform a head to toe skin assessment on Resident #8. During the skin assessment, it was noted that a container of Dispatch Hospital Cleaner Disinfectant Towels with Bleach (Caution: Keep out of reach of children, Avoid contact with eyes, skin and clothing as this product may produce irritation) was on the countertop and a container of Sani-Cloth Plus Germicidal Disposable Cloths (Caution: Keep out of reach of children, Avoid contact with eyes and skin, Not for use on skin, Not a baby wipe) was on the over-bed table in the resident's room.</p> <p>Review of the MSDS sheet revealed Dispatch Hospital Cleaner Disinfectant Towels with Bleach cautions were as follows: Avoid contact with eyes, skin and clothing as this product may produce irritation. Do not allow this product to contact acidic materials as hazardous chlorine gas may be released. Causes moderate eye irritation, gloves are recommended, use safety glasses with protective side shields to avoid eye contact.</p> <p>Review of the MSDS sheet revealed Sani-Cloth Plus Germicidal Disposable Cloths cautions were as follows: Causes moderate eye irritation, avoid contact with eyes and skin, wash thoroughly with soap and water after handling and before eating, drinking, chewing gum, using tobacco or using toilet, this product maybe harmful if absorbed through skin, prolonged or repeated dermal exposure can cause drying, defatting and</p>	F 323	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>On 8/22/11, the Staff Development Coordinator (SDC), SW, ED, DNS and/or Assistant Director of Nursing Services (ADNS) Initiated education with all facility staff on resident environment, safety hazards, to include, but not limited to, bleach wipes. Education was completed on 9/3/11. Any staff having not attended the education by 9/3/11, will not be allowed to work until they attend.</p> <p>The ED, Assistant Executive Director (AED), DNS, ADNS, UM, WS, SS and/or Administrative Staff (Maintenance Director (MD), Business Office Manager (BOM), Medical Records Director (MRD), Reflections Program Director (RPD), Case Manager (CM), Transitional Care Unit Program Director (TCUPD), Recreational Services Director (RSD) and/or SW will conduct 3 observational audits per week of the resident environment to</p>	9/4/11

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F 323	Continued From page 8 dermatitis, symptoms may include headache, dizziness, tiredness, nausea and vomiting. Wear protective clothing, keep out of reach of children, not for use on skin, not a baby wipe.  Interview, on 08/19/11 at 10:55 AM, with State Registered Nurse Aide (SRNA) #9 revealed she brought the Gani-Cloths in the room on 08/18/11. She stated she used the wipes to clean surfaces after a resident vomited in the room. Further interview revealed the cloths towels should have been locked in the Biohazard Room, not in a resident's room. She did not know when the Dispatch Towels were brought in the room.  Interview, on 08/19/11 at 11:10 AM, with LPN #4 revealed the cleaning towels and cloths should have been locked up, not in a resident's room.  Interview, on 08/19/11 at 6:40 PM, with the Regional Director of Nursing revealed it was not normal practice to keep the cleaning towels/cloths in a resident's room. Hazardous chemicals for cleaning were usually kept in the Biohazard Room which was kept locked. Dispatch towels were also kept in a locked drawer on the medication cart.	F 323	<i>This Plan of Correction is the center's credible allegation of compliance.</i>  <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>  ensure the resident environment is free from accident hazards and to ensure appropriate supervision.  The ED and/or DNS will track and trend audits on a monthly basis through the Performance Improvement Committee (PIC). Action plans will be developed and  implemented as indicated. The audits will be reviewed in the monthly PIC for three months and as needed thereafter.	9/4/11
F 441 SS=D	483.66 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program The facility must establish an Infection Control	F 441	F441  Appropriate incontinent/perineal care and bed cleaning/making was provided to Residents #1, #2 and #4 on 8/19/11. All soiled linens were removed from the floor on 8/19/11.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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PRINTED: 08/02/2011  
FORM APPROVED  
OMB NO. 0938-0381

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  105146	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 08/19/2011
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NAME OF PROVIDER OR SUPPLIER  FOUNTAIN CIRCLE HEALTH AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 200 GLENWAY ROAD WINCHESTER, KY 40301
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F 441	<p>Continued From page 9</p> <p>Program under which it -</p> <p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(a) Linens</p> <p>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, record review and review of facility's Incontinence/Perineal Care Policy and the Adult Brief or Underpad Policy it was determined the facility failed to provide a safe, sanitary and comfortable environment and to help prevent the development and</p>	F 441	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>All residents receive appropriate infection control techniques, to include, but not limited to, incontinence/perineal care, to include appropriate bed cleaning and appropriate handling of dirty linen. Any identified concern is corrected immediately on an ongoing basis.</p> <p>On 8/22/11, the Staff Development Coordinator (SDC), SW, ED, DNS and/or Assistant Director of Nursing Services (ADNS) initiated education</p> <p>with all direct care staff on appropriate infection control techniques, to include, but not limited to, incontinence/perineal care, bed cleaning and handling of dirty linen. In addition, the SDC, DNS and/or ADNS will conduct competency evaluations of all licensed nurses and all CNAs on perineal care and handwashing.</p> <p>Education/competency was completed on 9/3/11. Any direct</p>	
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NAME OF PROVIDER OR SUPPLIER  FOUNTAIN CIRCLE HEALTH AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 200 GLENWAY ROAD WINCHESTER, KY 40391
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F 441	<p>Continued From page 10 transmission of disease and infection.</p> <p>Observations revealed staff cleaned Resident #2 from dirty to clean, aides did not change gloves/wash hands per the facility's policy and a State Registered Nurse Aide (SRNA) was observed putting soiled linens on the floor and failed to clean a soiled mattress before applying clean sheets.</p> <p>The findings include:</p> <p>Review of the facility's Incontinence/Perineal Care Policy, revised 11/02/10, and the facility's Adult Brief or Underpad Policy, revised 10/31/09, revealed gloves should be removed, hands washed and gloves reapplied between cleaning the perineal/perianal areas and clean brief reapplied. Further review revealed a clean washcloth/wipe should be used for each swipe for the pubic/anal areas, and the anal area to be cleaned last.</p> <p>1. Observation during initial tour, on 08/12/11 at 3:45 PM, revealed State Registered Nurse Aide (SRNA) #10 performed perineal care on Resident #4. The resident was soiled with diarrhea-like stool from mid back to mid thigh. The stool had soaked through the brief, chux, turn sheet, bottom sheet, the resident's shirt and on the mattress. Observation revealed the SRNA threw the soiled linen on the floor. She partially cleaned the resident, put a clean sheet on the bed without cleaning the mattress or removing the resident's soiled shirt and didn't change gloves/wash hands between cleaning the resident and putting the clean sheet on the bed. The resident's buttocks were reddened and the SRNA applied skin barrier</p>	F 441	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>care staff having not attended the education or having not demonstrated competency by 9/3/11, will not be allowed to provide direct care until they attend and demonstrate competency.</p> <p>The SDC, DNS, ADNS, UM, SS and/or WS will conduct 3 observations per week of a licensed staff and/or a CNA during the provision of care to validate that infection control techniques are</p> <p>implemented. Any concerns identified will be corrected immediately.</p> <p>The DNS will track and trend the observations on a monthly basis through the Performance Improvement Committee (PIC). Action plans will be developed and implemented as indicated. The audits will be reviewed in the monthly PIC for three months and as needed thereafter.</p>	
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F 441	<p>Continued From page 11.</p> <p>to the resident's buttocks using the same gloves that were used during the complete procedure.</p> <p>Interview, on 08/12/11 at 4:26 PM, with the SRNA #10 revealed she had worked at the facility approximately two (2) months and was nervous having a Surveyor watch her. She stated she always washed her hands and wore gloves when she performed personal care and removed the gloves and washed her hands prior to exiting the resident's room. She stated she wasn't aware she should change gloves/wash her hands during procedures. Further interview revealed she was aware that the mattress should have been cleaned prior to putting the sheet on it however, she didn't have the wipes with her. The SRNA stated she threw the soiled linen on the floor because she didn't have another place to put it.</p> <p>Interview, on 08/12/11 at 4:50 PM, with Licensed Practical Nurse (LPN) #6, revealed the SRNA should have changed gloves and washed her hands during the procedure, when going from dirty to clean. She should have changed gloves and washed her hands prior to the application of the skin barrier. Further interview revealed the SRNA should not have thrown the soiled linen on the floor, she should have put the linen in a dirty linen cart. The SRNA should have thoroughly cleaned the mattress prior to putting a clean sheet on the bed.</p> <p>2. Observation, on 08/19/11 at 11:22 AM, revealed Registered Nurse (RN) #1 performed perineal care on Resident #2 and used the same wipe to clean the resident's pubic area and the anal area.</p>	F 441	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p>	

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F 441	<p>Continued From page 12</p> <p>Interview, on 08/19/11 at 2:25 PM, with RN #1 revealed she should have used a wipe to clean the pubic area and used another wipe to clean the anal area. She stated she knew that but just wasn't thinking.</p> <p>3. Observation, on 08/19/11 at 2:30 PM, of perineal care on Resident #1 revealed SRNA #11 and SRNA #12 did not change gloves and wash hands after cleaning the resident and prior to putting the clean brief on the resident.</p> <p>Interview, on 08/19/11 at 3:00 PM, with SRNA #11 revealed she was taught to put gloves on, clean the resident, complete the procedure, remove the gloves and wash hands prior to leaving the room. She stated she always washed her hands after she removed gloves. Further interview revealed she never thought about contaminating the clean supplies. She thought that since she wore gloves the supplies were still clean.</p> <p>Interview, on 08/19/11 at 3:10 PM, with SRNA #12 revealed she always washed her hands after she removed gloves; however, she wasn't taught to remove gloves/wash hands during procedures. She stated she was taught to wash her hands, put gloves on, perform the procedure, remove the gloves and wash her hands prior to leaving the resident's room. Further interview revealed she never thought that clean supplies would become dirty if they were touched with dirty gloves.</p> <p>Interview, on 08/19/11 at 6:40 PM, with the Director of Nursing revealed perineal care should be performed as follows: gather supplies, get a basin of warm water, use a clean washcloth with soap and water (preferred method, wipes are also</p>	F 441		

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F 441	Continued From page 13 allowed) for each swipe, wash from clean to dirty, ensure all folds are cleaned, wash from front to back, change gloves/wash hands in between cleaning the resident and putting a clean brief on the resident. She stated the SRNA should have cleaned the mattress thoroughly before putting a sheet on it. Further interview revealed the staff above did not follow policy. She stated Infection Control was important and it was evident the staff needed inservice regarding Infection Control.	F 441		
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