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

PRINTED: 07/27/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	185146		R 07/14/2012

NAME OF PROVIDER OR SUPPLIER: KINDRED TRANSITIONAL CARE & REHAB-FOUNTAIN CIRCLE

STREET ADDRESS, CITY, STATE, ZIP CODE: 200 GLENWAY ROAD, WINCHESTER, KY 40391

RECEIVED AUG - 1 2012 BY:

(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 A Revisit Survey was conducted 07/11/12 through 07/14/12 to determine if the facility was in substantial compliance on 06/18/12 as alleged. The following deficiencies were not corrected on 06/18/12 as alleged: F-281, F-282, F-315, F-431 and F-441. Two new deficiencies were cited at F-490 and F-520 with the highest scope and severity of an "E".	{F 000}	*This Plan of Correction is the center's credible allegation of compliance.* *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.*	
{F 281} SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility's policies it was determined the facility failed to ensure services being provided met professional standards of quality for two (2) of the fifteen (15) sampled residents (Residents #49 and #50). The facility failed to develop an Initial Care Plan on admission to direct the care for Resident #49 related to his/her oxygen needs. The resident was admitted and had a Physician's order for oxygen at two (2) liters per minute for shortness of air. Review of the initial plan of care revealed no respiratory care plan was developed for the resident's respiratory needs to include the use of oxygen. The facility failed to follow Physician's orders for wound care treatment and Enteral Nutrition for Resident #50. The resident had a wound	{F 281}	**F281** A care plan was developed for Resident #49 related to Oxygen use on 7/17/12. Resident #50 received the appropriate wound care and dressing change on 7/14/12, in accordance with the physician's order. Resident #50 received the enteral feeding of Suplena on 7/13/12, in accordance with the physician's order. On 7/24/12, the Minimum Data Set Coordinators (MDSCs) conducted an audit of all residents admitted/readmitted to the facility from 7/14/12 through 7/23/13 to ensure all appropriate care plans were developed. Any revisions needed were made as indicated.	7/25/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Walt Smith (X6) DATE: 7-31-12

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 281)	Continued From page 1 treatment order to clean the wound (back of the left thigh) with soap and water daily. Observation revealed the nurse used normal saline to clean the wound site. In addition, review of a Physician's order revealed the facility was to discontinue the enteral tube feeding formula Nepro when the formula Suplena was available. Observation and Interview revealed the facility failed to change the formula when the Suplena was delivered to the facility on 07/11/12. The findings include: 1. Review of the facility's policy entitled "Initial Plan of Care", dated 05/28/08, revealed the Initial Care Plan would be developed within twenty-four (24) hours of admission to address the resident's initial and immediate needs until the interdisciplinary team finalized the comprehensive plan of care. Review of Resident #49's medical record revealed the facility admitted the resident on 07/05/12, with diagnoses which included Hypertension, Diabetes, Hyperlipidemia, Urinary Tract Infection, and Peri-Ventricular Ischemic Infarct. Review of Physician's Orders for Respiratory/Pulmonary Care, dated 07/05/12, revealed the facility was to administer humidified oxygen continuously at two (2) liters/minute via nasal cannula due to shortness of air. Review of Resident # 49's Initial Care Plan, dated 07/05/12, revealed no documented evidence an initial care plan was developed to address the respiratory needs of the resident related to Resident #49 being on continuous oxygen for shortness of air.	(F 281)	*This Plan of Correction is the center's credible allegation of compliance.* *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.* On 7/24/12, the Registered Dietician (RD) conducted an audit of all residents who receive enteral feeding to ensure all enteral feedings were administered in accordance with physician orders. No concerns were identified. The Staff Development Coordinator (SDC), Assistant Director of Nursing Services (ADNS) and Weekend Supervisor (WS) initiated inservices on 7/18/12, with the licensed nurses on developing initial care plans as indicated by the resident's current needs. In addition, education consisted of implementing physician orders to include, but not limited to, wound treatments and enteral feedings. No licensed nurse was allowed to work after 7/24/12 without having attended the inservice.	7/25/12

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(F 281)	Continued From page 2 Interview, on 07/13/12 at 7:25 PM, with Licensed Practical Nurse (LPN) #10 revealed the admitting nurse developed the Initial Care Plans and it was to be developed within twenty-four (24) hours after admission. She stated the Initial Care Plan should address resident's needs, such as the resident being administered oxygen. LPN #10 stated, after review of the Initial Care Plan, it did not address all of the resident's care needs. Interview, on 07/14/12 at 9:55 AM, with Registered Nurse (RN) #2/Unit Manager revealed the day after a resident was admitted the resident's chart was reviewed in the clinical morning meeting to determine the resident's needs and review to ensure all components of the admission was complete, such as ensuring the initial care plan was developed. She indicated Initial Care Plans were developed based on the the resident's diagnoses, nursing judgement, and acute problems. Interview, on 07/14/12 at 11:15 AM, with the Director of Nursing (DON) revealed the Initial Care Plan was completed by the Unit Manager or the Weekend Supervisor within twenty-four (24) hours of the admission. She stated if a resident was on continuous oxygen they should have completed an Initial Care Plan. Further interview revealed the care plan directed the care and the expectation was the oxygen would have been addressed on the Initial Plan of Care. Further interview with the DON, on 07/14/12 at 2:05 PM, revealed Initial Care Plans were reviewed by the Interdisciplinary Team weekly. She stated the team missed the fact the oxygen had not been put on the Initial Care Plan. Additionally she	(F 281)	*This Plan of Correction is the center's credible allegation of compliance.* *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.* The Director of Nursing (DNS), ADNS, Unit Manager (UMs) and/or WS will conduct an audit of initial care plans for accuracy and completeness on the day following admission/readmission. In addition, the MDSCs will audit the of initial care plans for accuracy and completeness two days following admission/readmission. The RD will audit all enteral feedings weekly to ensure the appropriate enteral feeding is administered in accordance with physician's orders. The audits will be brought to the Performance Improvement Committee (PIC) which includes the Executive Director (ED), Assistant Executive Director (AED), DNS, ADNS, UMs, Social Service Director (SS), RD,	7/25/12

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{F 281}	Continued From page 3 stated it was not identified during the Quality Assurance Audit. 2. Review of the facility's policy entitled "Pressure Ulcer Care", dated 05/28/08, revealed a resident who had a pressure ulcer received the necessary treatment and services to promote healing. Further review of the policy revealed to consult with the Physician to obtain an appropriate treatment and follow appropriate Physician's orders for cleansing to minimize colonization. Review of the medical record for Resident #50 revealed the resident was admitted by the facility, on 06/29/12, with diagnoses which included Anxiety Disorder, Anoxic Brain Damage, Chronic Kidney Disease Stage III, Peripheral Vascular Disease, Gastrostomy Status, and Diabetes. Review of Physician's Telephone Orders, dated 07/12/12, revealed the facility was to perform the following procedure, daily and as needed, to a wound area located on the back of the resident's left thigh: cleanse with soap and water, pat dry, apply triple antibiotic ointment, and cover with Mepilex dressing. Review of the July 2012 Treatment Record revealed the area of the back of the left thigh was to be cleansed with soap and water, patted dry, apply triple antibiotic ointment, and cover with Mepilex dressing. Observation of wound care to the back of Resident #50's left thigh site, on 07/13/12 at 10:20 AM, revealed the nurse cleansed the site with a gauze soaked with normal saline, applied triple antibiotic ointment, and covered with Mepilex.	{F 281}	*This Plan of Correction is the center's credible allegation of compliance.* *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.* Activities Director (AD) Maintenance Director, SDC, Dietary Manager, Certified Dementia Practitioner (CDP), Medical Director (MD) and Case Manager (CM) every month for the next three months, and as needed thereafter. The PIC will determine if further action is needed. **F282** The nurse providing care to Resident #48 on 7/13/12, did not work on 7/24/12 and received appropriate education on 7/25/12, prior to being allowed to work, related to hand hygiene. Resident #2 was evaluated by therapy services on 7/12/12 and deemed to be appropriate to require assist of one staff. Resident #2's comprehensive care plan was revised to reflect	7/25/12

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{F 281}	Continued From page 4 During an interview with LPN #13, on 07/13/12 at 2:10 PM, regarding her wound care, on 07/12/12, she stated she cleansed the site to the back of the left thigh with normal saline. After review of the Physician's Telephone Order and the Treatment Record related to the wound care procedure, the LPN stated the wound should have been cleansed with soap and water as ordered and not normal saline. She stated she should have followed the Physician's order. She indicated the facility normally used saline to cleanse wounds, but she should have called the Physician if she needed clarification prior to performing the wound care. Interview with RN #2/Unit Manager, on 07/14/12 at 9:30 AM, revealed using normal saline to cleanse wounds is the facility's standard of practice. She stated the nurse should be aware of what was ordered to cleanse the wound, soap and water, and provide the treatment according to the order. She indicated if LPN #13 had a question about the treatment she should have clarified the order with the Physician. Interview with the DON, on 07/14/12 at 11:15 AM, revealed if the order, for the wound treatment, said to use soap and water, the nurse should have followed the wound treatment order. She indicated the nurses should be aware of the treatment needs prior to doing the procedure and nurses were expected to follow Physician's orders. Further review of the medical chart for Resident #50 revealed a Physician Telephone order to discontinue the gastrointestinal tube (tube going into the stomach) feeding formula Nepro, given at	{F 281}	*This Plan of Correction is the center's credible allegation of compliance.* *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.* assist of one staff on 7/12/12. The nurse providing care to Resident #2 on 7/11/12 received appropriate education on 7/12/12 related to incontinence care. Resident #2 received appropriate incontinence care on 7/11/12. On 7/12/12, the SDC, ADNS and/or WS initiated education and return demonstration competencies for all direct care staff, to include licensed nurses and Certified Nursing Assistants (CNAs) on transfer, hand hygiene and incontinence care. The SDC, ADNS and/or WS, initiated inservice on 7/18/12 for all CNAs and licensed staff on providing resident care per the Nursing Assistant assignment sheets and following the care plan.	7/25/12

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{F 281}	Continued From page 5 fifty (50) cubic centimeters (cc) per hour for twenty-two (22) hours, when the formula Suplena was available and provide this formula at sixty (60) milliliters an hour for twenty-two (22) hours. Observation of Resident #50, on 07/11/12 at 3:40 PM; 07/12/12 at 10:15 AM, and 07/13/12 at 9:25 AM. revealed Nepro tube feeding formula was infusing at 50 cc per hour. Continued interview with the DON, on 07/14/12 at 11:15 AM, revealed the Suplena formula was in house on 07/11/12 and was available to staff in the tube feeding supply room. However, it came in cans when normally tube feeding products came in ready to hang containers, and was not in the tube feeding section of the supply room. Therefore it was put in with the nutritional supplements. Interview with the Registered Dietitian (RD), on 07/14/12 at 11:00 AM, revealed she recommended the Suplena formula after assessing the resident's protein needs. Further interview revealed although Resident #50 had been on Nepro at the hospital, she wanted a tube feeding formula which was lower in protein because the resident had chronic renal failure. She stated the facility did not keep the formula onsite and Central Supply had ordered the Suplena. Additional interview revealed once the Suplena was delivered, the RD expected the Nepro to be replaced with the Suplena by the nurses. She indicated the nurses should have been watching for it to see when it was available and followed the Physician's order to replace the formula.	{F 281}	*This Plan of Correction is the center's credible allegation of compliance.* *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.* No direct care staff was allowed to work after 7/24/12 without having attended education and demonstrated competency. The MDSCs will audit three (3) residents each week to validate implementation of care plan. In addition, the UMs will audit (5) residents each month to validate implementation of the care plan. The DNS, ADNS, UM, SDC, CM and/or MDSC will conduct 10 direct observations per week of the provision of care to validate appropriate hand hygiene and incontinent care is implemented in accordance with the care plan. The audits will be brought to the Performance Improvement Committee (PIC) which includes the ED, AED, DNS, ADNS, UM, SS, RD, AD, Maintenance Director, SDC, Dietary Manager,	7/25/12

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{F 281}	Continued From page 6 Interview with LPN #13, on 07/13/12 at 4:00 PM, revealed she knew a different tube feeding formula (the Suplena) had been ordered, but was not aware the supply was available in the tube feeding storage area. LPN #13 stated she was unfamiliar with this type of formula and did not realize it came in a can. She stated tube feeding products normally came in ready to hang containers and she looked at those containers to see if the Suplena came in and did not see the formula. She indicated cans normally contained nutritional supplements not tube feeding formula. Interview with RN/Unit Manager #2, on 07/14/12 at 9:30 AM, revealed she was not familiar with the Suplena formula. She stated the Dietitian had informed them this product wound be a better formula for Resident #50 because of Resident #50's renal failure. She indicate it was important for the resident to get this formula when it became available. The RN stated staff should have been checking to see if it was available. She indicated it was one of those things which got overlooked because staff was unfamiliar with the product and did not realize it came in cans. Further interview with the DON, on 07/14/12 at 11:15 AM, revealed the nurses should have looked in the tube feeding room for the formula. She stated it was on the Medication Administration Record to replace the Nepro with the Suplena when available. She indicated if the nurses did not see it, they should have checked to see if the product had been delivered. She stated the nurses could have checked with the Supply Coordinator or asked their Unit Manager to follow-up.	{F 281}	*This Plan of Correction is the center's credible allegation of compliance.* *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.* CDP, Medical Director (MD) and CM every month for the next three months, and as needed thereafter. The PIC will determine if further action is needed. **F315** The nurse providing care to Resident #2 on 7/11/12 received appropriate education on 7/12/12 related to incontinence care. Resident #2 received appropriate incontinence care on 7/11/12. On 7/12/12, the SDC, ADNS and/or WS initiated education and return demonstration competencies for all direct care staff, to include licensed nurses and CNAs on transfer, hand hygiene and incontinence care. The SDC, ADNS and/or WS initiated inservice on 7/18/12 for	7/25/12
{F 282}	483.20(k)(3)(ii) SERVICES BY QUALIFIED	{F 282}		

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{F 282} SS=D	Continued From page 7 PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility's policy it was determined the facility failed to ensure care was provided in accordance with the written plan of care for two (2) of fifteen (15) sampled residents (Resident #2 and #48). Observation revealed a nurse completed a skin assessment and exited the room without washing or sanitizing her hands as per the Plan of Care for Resident #48 who was in contact isolation for Methicillin Resistant Staphylococcus Aureus (MRSA) of the Right Great Toe. Observation revealed Resident #2 was not transferred from the broda chair to the bed and from the bed to the broda chair by the assistance of two (2) as per the Plan of Care. In addition, observation of a skin assessment revealed Resident #2 did not receive incontinence care although the brief was saturated with urine. After the skin assessment, the soiled brief was re-applied and the resident was transferred from the bed to the chair. The findings include: Review of the facility's policy entitled	{F 282}	*This Plan of Correction is the facility's credible allegation of compliance.* *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.* all CNAs and Licensed staff on providing resident care per the Nursing Assistant assignment sheets and following the care plan. No direct care staff was allowed to work after 7/24/12 without having attended education and demonstrated competency. The DNS, ADNS, UM, SDC, CM and or MDSC will conduct 10 direct observations per week of the provision of care to validate appropriate hand hygiene and incontinent care is implemented in accordance with the care plan. The UMs and DNS will report, track and trend audit findings to the PIC which includes the ED, AED, DNS, ADNS, UM, SS, RD, AD, Maintenance Director, SDC, Dietary Manager, CDP, Medical Director (MD) and CM three	7/25/12

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{F 282}	Continued From page 8 "Comprehensive Plan of Care", dated 05/28/08, revealed the facility would communicate new or changed care plans to caregivers and ensure any care cues were placed appropriately to remind caregivers of the resident's special needs. 1. Medical record review revealed the facility admitted Resident #48, on 01/27/12 with diagnoses which included Methicillin Resistant Staphylococcus Aureus (MRSA) of the Right Great Toe. Review of the Significant Change Minimum Data Set (MDS) Assessment, dated 04/26/12, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) of fifteen (15) indicating no cognitive impairment. Review of the Physician's Orders, dated 07/10/12, revealed orders for Contact Precautions related to MRSA of the Right Great Toe. Review of the Comprehensive Plan of Care, dated 07/10/12, revealed the resident had a wound to the Right Great Toe related to an ingrown toenail with a goal that the infection would be contained and not spread to other areas or to other resident's, family, or staff. Interventions included contact precautions and specified the following: place an infection control bag outside of the door and place an infection control sign on the resident's door; Personal Protective Equipment (PPE) to be available from the isolation bag on the resident's door; hand hygiene to be performed before and after contact with the patient; their environment or equipment, and on leaving the isolation room; and gloves to be used to prevent hand contamination and after	{F 282}	*This Plan of Correction is the center's credible allegation of compliance.* *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.* months and thereafter as needed. Appropriate corrective action will be taken as indicated. **F431** No resident was identified as having been affected. On 7/24/12, the DNS, ADNS and/or UM conducted an audit of all treatment carts to validate no expired or undated treatments were in the facility. Any area in need of correction was corrected immediately. The SDC initiated education with licensed nurses on 7/18/12 on proper procedures for dating treatments, and removing expired/undated treatments from the facility. No licensed nurse staff was allowed to work after 7/24/12	7/25/12

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{F 282}	Continued From page 9 glove removal hands must be decontaminated. Observation of a skin assessment, on 07/13/12 at 2:00 PM, revealed Licensed Practical Nurse (LPN) #18 completed a head to toe skin assessment and lifted the resident's right foot to assess the heel area. Continued observation after the skin assessment revealed the nurse removed the gown and gloves and placed them in a plastic bag and a red biohazard bag. She was observed to open the resident room door, and while holding her hands up in the air, walk down the hall to the nurse's station, opened the nurse's station door, and washed her hands in the sink at the nurse's station. The nurse was not observed to wash her hands or sanitize her hands prior to exiting the resident's room. Additional observation revealed there was no sink in the resident's room in which to wash hands; however there was a bottle of hand sanitizer over the bed of the resident's room-mate. Interview, on 07/13/12 at 2:10 PM and 07/14/12 at 9:00 AM; with LPN #18 revealed it was the first time she had cared for Resident #48 since he/she had moved to the room with no sink. She confirmed she had to touch the resident's door knob and the nurse's station door knob and touch the nurse's station sink prior to washing her hands. She stated she had not brought up the concern of having no sink in this resident's room with management. Further interview revealed she carried her own hand sanitizer in her pocket; however, was unsure if she had used it prior to exiting the resident's room. Interview, on 07/13/12 at 6:00 PM, with LPN #11/Unit Manager for the C-Wing, revealed LPN	{F 282}	*This Plan of Correction is the center's credible allegation of compliance.* *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.* without having attended education. The UMs will conduct audits of the treatment carts weekly to validate no expired and/or undated treatments. The UMs and the DNS will report, track and trend audit findings to the PIC which includes the ED, AED, DNS, ADNS, UM, SS, RD, AD, Maintenance Director, SDC, Dietary Manager, CDP, Medical Director (MD) and CM for three months and thereafter as needed. Appropriate corrective action will be taken as indicated. **F441** The nurse providing care to Resident #48 on 7/13/12, did not work on 7/24/12 and received appropriate education on 7/25/12 prior to being allowed to work,	7/25/12

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	186146		R 07/14/2012

NAME OF PROVIDER OR SUPPLIER: KINDRED TRANSITIONAL CARE & REHAB-FOUNTAIN CIRCLE

STREET ADDRESS, CITY, STATE, ZIP CODE: 200 GLENWAY ROAD, WINCHESTER, KY 40391

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{F 282}	Continued From page 10 #18 should have sanitized her hands in the resident's room and then washed her hands once exiting the room. She stated she had been auditing staff on hand washing which included ensuring the correct process of washing hands at the sink. She further stated when she made routine rounds she monitored staff to ensure staff washed or sanitized their hands before entering resident rooms and prior to exiting resident rooms and prior to peri care. However, she had not been routinely auditing this and had not been routinely observing staff during care to ensure proper hand hygiene. Interview, on 07/13/12 at 3:00 PM and 6:30 PM, with the Director of Nursing (DON) revealed the staff on C-Wing knew to sanitize their hands with the hand gels located on the wall because several of the rooms did not have sinks. Further interview revealed she thought the Unit Managers were watching to ensure correct hand hygiene during care and not just ensuring the correct process of hand washing at the sinks. 2. Review of Resident #2's medical record revealed diagnoses which included Dementia, Anxiety, Parkinson's Disease and a History of Falls. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 06/25/12, revealed the facility assessed the resident as having severe impairment in cognitive skills for decision making and as requiring extensive assist of two (2) staff for transfers. Review of the Care Area Assessment Summary (CAAS), dated 04/09/12, revealed the resident was non-ambulatory, was recently admitted to Hospice, and was at risk for further decline.	{F 282}	*This Plan of Correction is the center's credible allegation of compliance.* *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.* related to hand hygiene. The nurse providing care to Resident #2 on 7/11/12 received appropriate education on 7/12/12 related to incontinence care and skin assessments. Resident #2 received appropriate incontinence care on 7/11/12 and wound treatment on 7/12/12. The nurse administering medications on 7/11/12 received education related to medication administration and hand hygiene on 7/18/12. The nurse providing care to Resident #47 on 7/12/12, received appropriate education on 7/13/12 related to hand hygiene and skin assessment. Resident #47 received appropriate skin assessment on 7/19/12.	7/25/12

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{F 282}	Continued From page 11 Review of the Comprehensive Plan of Care, dated 01/30/09, revealed Resident #2 had an alteration in mobility, positioning, ambulation related to poor balance, nonambulatory status, and weakness. The goal with a target date of 10/01/12 revealed the resident would continue to transfer with the assistance of two (2). The interventions revealed the resident required the assistance of two (2) staff for transfers. Observation, on 07/11/12 at 4:25 PM, revealed Certified Nursing Assistant (CNA) #40 transferred the resident using a gait belt from the broda chair to the bed. CNA #40 then performed incontinence care, and transferred the resident from the bed to the broda chair using the gait belt. The broda chair was not right next to the bed during the transfer and the CNA assisted the resident to ambulate backwards to the broda chair. Interview, on 07/11/12 at 4:45 PM, with CNA #40 revealed Resident #2 was a one (1) person transfer and had always been a 1 person transfer. She stated she had received a recent inservice related to following the care plan and the CNA Assignment Sheet. She further stated she did not have the CNA Assignment with her and would check it at the nurse's station. Record review of the CNA Assignment Sheet with CNA #40 revealed Resident #2 was to have two (2) staff for transfers. Interview, on 07/12/12 at 12:00 PM, with Licensed Practical Nurse (LPN) #3/Unit Manager of the D-Wing, revealed the CNAs were to read the CNA Assignment Sheet and carry it in their pocket as a reference related to resident care	{F 282}	*This Plan of Correction is the center's credible allegation of compliance.* *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.* On 7/12/12, the SDC, ADNS' and/or WS initiated education and return demonstration competencies for all direct care staff, to include licensed nurses and CNAs on hand hygiene, incontinence care. On 7/18/12, the SDC, ADNS' and/or WS initiated education for all direct care staff to include skin assessment and medication administration. No direct care staff was allowed to work after 7/24/12 without having attended education and demonstrated competency. The DNS, ADNS, UM, SDC, CM and or MDSC will conduct 10 direct observations per week of the provision of care to validate appropriate hand hygiene and incontinent care is implemented in accordance with the care plan.	7/25/12

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(F 282)	Continued From page 12 including transfers. Continued interview revealed she audited to ensure the Comprehensive Care Plan matched the CNA Assignment Sheets, and ensured the Care Plans were appropriate for the residents. She further stated she also ensured interventions were implemented such as alarms and devices. She indicated she had not conducted any audits related to transfers to ensure the residents were being transferred correctly as per the Care Plan. Interview, on 07/14/12 at 2:10 PM, with the Director of Nursing (DON) and the Administrator revealed the staff was not auditing to ensure residents were being transferred correctly although audits had been completed related to ensuring the care plans were followed. Further review of the Quarterly Minimum Data Set (MDS) Assessment, dated 06/26/12, for Resident #2 revealed the facility assessed Resident #2 as being occasionally incontinent of urine and frequently incontinent of bowel. Review of the Care Area Assessment Summary (CAAS), dated 04/09/12, revealed the resident required assistance with toileting and was frequently incontinent of bladder. Review of the Comprehensive Plan of Care, dated 01/30/09, revealed Resident #2 had an alteration in elimination, was frequently incontinent of urine and required assistance with toileting secondary to decreased mobility and impaired cognitive status. The interventions included observing the resident for any incontinence and providing pericare after any noted incontinent episode.	(F 282)	*This Plan of Correction is the center's credible allegation of compliance.* *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.* The SDC will conduct 2 medication administration audits per week to validate appropriate hand hygiene. The UMs and Rehab Director will report, track and trend audit findings to the PIC which includes the ED, AED, DNS, ADNS, UM, SS, RD, AD, Maintenance Director, SDC, Dietary Manager, CDP, Medical Director (MD) and CM for three months and thereafter as needed. Appropriate corrective action will be taken as indicated. **F490** Refer to F281, F282, F315, F431 and F441. The ED chairs the facility PIC and will validate that systems are implemented and maintained as specified in this Plan of	7/25/12

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{F 282}	Continued From page 13 Observation of a skin assessment for Resident #2, on 07/11/12 at 4:00 PM, revealed Licensed Practical Nurse (LPN) #17 and Certified Nursing Assistant (CNA) #40 untaped the residents briefs, checked the genital area and buttocks, and then retaped the brief which was saturated with urine. The resident's pants were pulled up, and the resident was transferred to the broda chair and taken to the dayroom in the urine saturated briefs. Interview, on 07/11/12 at 4:15 PM, with LPN #17 revealed it would be a "good idea" to change to clean attends but she knew they would be doing rounds soon. Interview, on 07/11/12 at 4:20 PM, with CNA #40 revealed she normally provided incontinence care for someone who she knew was wet, but she was following the nurse who was completing the skin assessment. Interview, on 07/12/12 at 12:00 PM, with Licensed Practical Nurse (LPN) #3/Unit Manager of the D-Wing revealed staff should have provided incontinence care to Resident #2 prior to transferring the resident out of the bed. Interview, on 07/14/12 at 2:10 PM, with the Director of Nursing (DON) and the Administrator revealed although the staff was monitored to ensure the care plan was being followed, the staff was not being audited related to incontinence care.	{F 282}	*This Plan of Correction is the center's credible allegation of compliance.* *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.* Correction through weekly PIC meetings until substantial compliance is achieved. The Committee, chaired by the ED, will review the findings of the audits completed for F281, F282, F315, F431 and F441. By reviewing the findings, the Committee will monitor the effectiveness and compliance with the plan and update and develop plans of action related to any and all problems identified. The results of the above will be tracked and trended with follow up actions or education for staff completed as necessary. The Medical Director if unavailable in person will review the progress by phone with the Executive Director on a monthly basis.	7/25/12
{F 315} SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a	{F 315}		

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(F 315)	Continued From page 14 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of facility policies, it was determined the facility failed to ensure that a resident who was incontinent received appropriate treatment and services to prevent urinary tract infections function as possible for one (1) of fifteen (15) sampled residents (Resident #2). Observation of a skin assessment for Resident #2 revealed the resident did not receive the appropriate treatment and services related to incontinence. The resident was observed to have a urine saturated brief during the skin assessment; however, after the skin assessment, the soiled brief was re-applied and the resident was transferred out of the bed and into a chair. The findings include: Review of the facility's Incontinence/Perineal Care Policy, revised 11/02/10, revealed, "Cleanliness of the perineum helps 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 provided to	(F 315)	*This Plan of Correction is the center's credible allegation of compliance.* *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.* The facility PIC members include but are not limited to, ED, AED, DNS, ADNS, UM, SS, RD, AD Maintenance Director, SDC, Dietary Manager, CDP, Medical Director (MD) and CM. The PIC will meet weekly until substantial compliance is achieved. Once the Committee determines compliance has been sustained, the PIC will meet monthly there after. **F520** Refer to F281, F282, F315, F431 and F441. The ED chairs the facility PIC and will validate that systems are implemented and maintained as specified in this Plan of Correction through weekly PIC meetings until substantial compliance is achieved.	7/25/12

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{F 315}	Continued From page 15 the resident who needs assistance to maintain perineal cleanliness". Review of Resident #2's medical record revealed diagnoses which included Dementia, Anxiety, Parkinson's Disease and Incontinence of Bowel and Bladder. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 06/25/12, revealed the facility assessed Resident #2 as being occasionally incontinent of urine and frequently incontinent of bowel. Review of the Care Area Assessment Summary (CAAS), dated 04/09/12, revealed the resident required assistance with toileting and was frequently incontinent of bladder. Review of the Patient Nursing Evaluation, dated 06/27/12, revealed the section titled "Bladder Status/Bowel Status Screening" revealed the resident was always incontinent and was unable to participate in a toileting program. Review of the Flow Sheet Record, dated 06/12, revealed the resident was incontinent each day and each shift. Review of the Comprehensive Plan of Care, dated 01/30/09, revealed a problem which stated the resident had an alteration in elimination, was frequently incontinent of urine and required assistance with toileting related to decreased mobility and impaired cognitive status. The approaches included observing for any incontinence, providing perineal care after any noted incontinent episode and to observe for any signs and symptoms of Urinary Tract Infections. Observation, of a skin assessment for Resident #2 on 07/11/12 at 4:00 PM revealed Licensed	{F 315}	*This Plan of Correction is the center's credible allegation of compliance.* *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.* The Committee, chaired by the ED, will review the findings of the audits completed for F281, F282, F315, F431 and F441. The ED convened a meeting with the PIC on July 24, 2012 to review the findings, address the quality issues, and formalize corrective action plans. This meeting included the ED, DNS and ADNS. By reviewing the findings, the Committee will monitor the effectiveness and compliance with the plan and update and develop plans of action related to any and all problems identified. The results of the above will be tracked and trended with follow up actions or education for staff completed as necessary. The Medical Director, if unavailable in person, will review the progress by phone with the ED on a weekly	7/25/12

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{F 315}	Continued From page 16 Practical Nurse (LPN) #17 and Certified Nursing Assistant (CNA) #40 untaped Resident #2's briefs, checked the perineal area and buttocks, and then retaped the soiled brief which was saturated with urine. The resident was then transferred to the "Broda" chair and taken to the dayroom in the soiled briefs. Interview, on 07/11/12 at 4:15 PM with LPN #17, revealed it would be a "good idea" to change the resident to clean attends but she knew they would be doing rounds soon". She indicated that wearing soiled attends could possibly contribute to a Urinary Tract Infection. Interview, on 07/11/12 at 4:20 PM, with CNA #40 revealed she normally provided incontinence care for someone who was known to be wet; however, she was following the nurse who was completing the skin assessment. Interview, on 07/12/12 at 12:00 PM, with Licensed Practical Nurse (LPN) #3/Unit Manager of the D-Wing revealed staff should have provided incontinence care to Resident #2 during the skin assessment when they noted he/she was wet and prior to transferring the resident out of the bed. Interview, on 07/14/12 at 2:10 PM, with the Director of Nursing (DON) and the Administrator revealed staff was auditing to ensure Bowel and Bladder Assessments were being completed per the MDS schedule; however, staff was not auditing to ensure incontinence care was provided.	{F 315}	*This Plan of Correction is the center's credible allegation of compliance.* *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.* basis. The facility PIC members include, but are not limited to, ED, AED, DNS, ADNS, UM, SS, RD, AD, Maintenance Director, SDC, Dietary Manager, CDP, Medical Director (MD) and CM. The PIC will meet weekly until substantial compliance is achieved. Once the Committee determines compliance has been sustained, the PIC will meet monthly there after.	7/25/12
{F 431} SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	{F 431}		

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{F 431}	Continued From page 17 The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's policies, it was determined the facility	{F 431}		

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{F 431}	Continued From page 18 failed to ensure drugs and biologicals were labeled, stored and dated in accordance with currently accepted professional principles, and discarded after the expiration date. Observation of the treatment carts on the B,C and D-Wings revealed medications that were improperly stored or labeled. Further observations revealed medications that were not dated or had expired. The findings include: 1. Review of the facility's policy entitled "Storage of Medications", dated 02/23/11, revealed eye medications were to be stored separate and medications and biologicals should be stored under proper conditions of sanitation. Review of the facility's policy entitled " Medication Labels and Packaging", dated 10/31/09, revealed medications were to be discarded by the expiration date. A review of the facility's policy entitled "Medication Administration", dated 08/31/11, revealed staff was required to dispose of any medication that was prepared but not administered. 1. Observation, on 07/13/12 at 10:15 AM, of the treatment cart in the Medication room on the B-Wing revealed Tobrex Ophthalmic ointment was stored in a compartment with topical medication, and a tube of Mupirocin ointment was stored with the top off and an illegible label in the same drawer. A bottle of Normal Saline solution was opened with no date or label on the bottle. Further observation revealed a Santyl and	{F 431}		

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(F 431)	Continued From page 19 Mupironcin topical ointment mixture was noted to have an expiration date of 03/07/12 and a Dakins one-half (½) strength solution bottle with an expiration date of 07/05/12. Interview, on 07/13/12 at 10:15 AM, with Licensed Practical Nurse (LPN) #14 revealed the eye ointment should not have been stored with the topical ointments, and the Mupirocin ointment should have had the top replaced. She stated, the Normal Saline should have had the date that the bottle was open because it was only good for thirty (30) days. She further stated the expired medications should have been discarded . Interview, on 07/13/15 at 1:50 PM, with the B-Wing Unit Manager (UM) revealed the medications should have been stored in the appropriate separate compartments, the Mupirocin ointment tube should have had the top replaced or the tube discarded and the bottle of Normal Saline should have been dated when opened. Further interview revealed the expired medications should have been removed from the cart and discarded according to the facility's policy. 2. Observation, on 07/13/12 at 1:00 PM, of the treatment cart in the Medication Room on the D-Wing revealed a bottle of Normal Saline which was opened with no date, and there was a bottle of Nystatin Powder 100,000 Unit/GM to be applied twice a day for fourteen (14) days with an issue date of 03/15/12. Interview, on 07/13/12 at 1:00 PM, at the time of the observation with the D-Wing UM, revealed there was no one assigned to clean out the	(F 431)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	185146		R 07/14/2012

NAME OF PROVIDER OR SUPPLIER
KINDRED TRANSITIONAL CARE & REHAB-FOUNTAIN CIRCLE

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{F 431}	Continued From page 20 treatment cart; however, the nurses should discard expired medications. She further stated the bottle of Normal Saline should have been dated when opened because it was only good for twenty-four (24) hours. 3. Observation, on 07/13/12 at 1:25 PM, of the treatment cart in the Medication room on the C-Wing revealed an aerosol can of Granulex with an illegible label was stored in the bottom drawer. Further observation revealed an open bottle of Dakins ½ strength solution in the same drawer with an expiration date of 06/15/12. Interview, on 07/13/12 at 1:25 PM, with the C-Wing UM revealed the illegible can should have been thrown away and expired medications should be discarded. Interview with the DON and Administrator, on 07/14/12 at 2:10 PM, revealed each nurse was responsible to ensure opened medications were dated and expired medications were discarded. During the interview the facility was unable to provide evidence weekly audits of the medication carts were conducted by the Unit Managers after 05/16/12 per the facility's Plan of Correction, dated 06/18/12.	{F 431}		
{F 441} SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program	{F 441}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
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{F 441}	Continued From page 21 The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility policies, it was determined the facility failed to establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and	{F 441}		

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{F 441}	Continued From page 22 to help prevent the development and transmission of disease and infection for three (3) sampled residents (Resident #46, #2 and #47) and two (2) unsampled resident (Unsampled Resident B and Unsampled Resident C). Resident #46 was in contact isolation related to a diagnosis of MRSA (Methicillin Resistant Staphylococcus Aureus) of the Right Great Toe which required dressing changes; however, this resident was in a room which did not have a sink in which staff could wash their hands. Observation revealed a staff member performed a skin assessment, removed her gloves, and gown, and exited the room without washing or sanitizing her hands. Observation of a skin assessment and perineal care for Resident #2 revealed staff used poor infection control technique. In addition, although the resident was noted to have a urine saturated brief which was untaped during the skin assessment, the soiled brief was re-applied and the resident was transferred to a Broda chair after the skin assessment. Observation of a skin assessment for Resident #47 revealed poor infection control technique. Observation of medication pass on the C-Wing revealed staff failed to wash their hands after administration of medication to Unsampled Resident B, and prior to setting up medications for Unsampled Resident C. The findings included: Review of the facility's policy entitled	{F 441}		

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(F 441)	Continued From page 23 "Transmission Based Precautions", revised 03/12/12, revealed staff was to determine the type of transmission based precautions to be initiated; contact, droplet, or airborne. "Place and maintain an adequate supply of antiseptic soap and paper towels in the room; use running water and anti-septic soap for handwashing. Waterless hand sanitizers were not an appropriate substitute for running water". Further review of the Transmission Based Precautions Policy Reference, revised 10/31/09, revealed hands should be immediately washed, after removing gloves, with an antimicrobial agent. Review of the facility's policy entitled "Hand Hygiene/Handwashing", revised 08/31/11, revealed handwashing was the single most important procedure for preventing spread of infection. If soap and water were not available and hands were not visibly soiled, an alcohol based hand rub may be used for routine decontamination of hands in clinical situations. When hands were visibly dirty or contaminated with proteinaceous material or were visibly soiled with blood or other body fluids, wash hands with either a non-antimicrobial soap and water or an antimicrobial soap and water. Review of the facility's policy entitled "Oral Medication Administration", revised October 2010, revealed staff was to verify Physician's Orders and patient's identity, wash hands, check label on medication, elevate head of bed, pour the correct number of tablets or capsules into the medication cup, if administering a unit dose medication, check the label for a final time at the patient's bedside, administer medications in accordance with manufacturer's specifications,	(F 441)		

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	185146		R 07/14/2012

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{F 441}	Continued From page 24 verify the medication was taken, and wash hands. 1. Review of Resident #48's clinical record revealed diagnoses which included Methicillin Resistant Staphylococcus Aureus (MRSA) of the Right Great Toe. Review of the Physician's Orders dated 06/28/12, revealed orders to cleanse the right great toe with Normal Saline, pat dry around nail bed, apply Triple Antibiotic Ointment, cover with gauze and secure with tape tid and prn (three times a day and as needed). Review of the Physician's Orders dated 06/30/12 revealed orders to culture the Right Great Toe, clean the Right Great Toe with Normal Saline, apply a dry dressing daily and Doxycycline (Antibiotic medication) 100 milligrams (mg) by mouth twice a day for seven (7) days. Further review revealed Physician's Orders, dated 07/06/12, for Levaquin (antibiotic medication) 500 mg by mouth daily for ten (10) days for a diagnosis of MRSA. Physician's Orders dated 07/10/12, revealed orders for Contact Precautions related to MRSA of the Right Great Toe. Observation, on 07/13/12 at 2:00 PM, of Resident #48's door revealed a sign which stated "Stop-visitors and personnel please speak to nurse before entering". The other side of the sign stated, contact precautions: Gloves: if anticipate contact with blood or other potentially infectious material, mucous membranes, non-intact skin or potentially contaminated intact skin is likely. Gown: appropriate to the task to prevent soiling	{F 441}		

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	185146		R 07/14/2012

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{F 441}	Continued From page 25 or contamination of clothing during procedures and patient care activities when contact with blood, body fluids, secretions or excretions is anticipated. "Before exiting room, remove gloves and gown and wash hands". Observation, of a skin assessment for Resident #48, performed on 07/13/12 at 2:00 PM, by Licensed Practical Nurse (LPN) #18, revealed the nurse completed a head to toe skin assessment and lifted the resident's right foot to assess the heel area. Continued observation revealed, after the skin assessment the nurse removed her gown and gloves and placed them into a plastic bag and a red biohazard bag. LPN #18 was observed to open the resident's door, and while holding her hands up in the air, walk down the hall to the nurse's station, open the nurse's station door, and wash her hands at the sink at the nurse's station. LPN #18 was not observed to wash her hands or sanitize her hands prior to exiting Resident #48's room. Further observation revealed there was no sink in the resident's room in which to wash hands; however, there was a bottle of hand sanitizer over the bed of the resident's room mate. Interview, on 07/13/12 at 2:10 PM and on 07/14/12 at 9:00 AM, with LPN #18 revealed this was the first time she had been assigned to Resident #48 since he/she had moved to the room with no sink. She sated she had touched the resident's door knob, the nurse's station door knob, and the nurse's station sink prior to washing her hands. She indicated she had not brought up the concern of having no sink in this resident's room with management. Continued interview revealed she carried her own hand	{F 441}		

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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB-FOUNTAIN CIRCLE		STREET ADDRESS, CITY, STATE, ZIP CODE 200 GLENWAY ROAD WINCHESTER, KY 40391	

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{F 441}	Continued From page 26 sanitizer in her pocket. However she was unsure if she had used it prior to exiting Resident #48's room after the skin assessment. Interview on 07/13/12 at 6:00 PM with LPN #11/Unit Manager for the "C" Unit, revealed LPN #18 should have sanitized her hands in the resident's room and then washed her hands once exiting the room and explained there were sinks in the hall. She stated she had been auditing staff on hand washing which included ensuring staff knew how to properly wash their hands at the sink. Continued interview, revealed she did observe staff at times to ensure staff washed or sanitized their hands before entering resident rooms and prior to exiting resident rooms, and prior to perineal care. However she had not been routinely audited this and had not been routinely observing staff during care to ensure proper hand hygiene. Interview, on 07/11/12 at 3:30 PM with the Staff Development Coordinator, revealed she inserviced all staff on isolation precautions and the Transmission Based Precautions Policy to include how the precautions were communicated to staff, PPE, signage, and handwashing prior to exiting the rooms. Continued interview revealed it was not ideal to place a resident with contact precautions in a room without a sink. Interview, on 07/13/12 at 3:00 PM and 6:30 PM, on 07/14/12 at 9:00 AM, with the Director of Nursing (DON)/Infection Control Nurse, revealed the staff on C-Wing knew they were to sanitize their hands with the hand gels located on the wall because several of the rooms did not have sinks. She stated the resident was moved to room	{F 441}		

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{F 441}	Continued From page 27 304B, on 06/07/12, prior to the diagnosis of MRSA; however, she was aware the resident was in the room without a sink and felt the hand gel was sufficient for staff for decontaminating. She further stated that in the past all residents on precautions were placed in rooms with sinks. Continued interview revealed she thought the Unit Managers were watching to ensure correct hand hygiene during care and not just ensuring the correct process of hand washing at the sinks. 2. Review of the facility's policy entitled "Incontinence/Perineal Care", revised 11/02/10, revealed, "Cleanliness of the perineum helps 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 provided to the resident who needs assistance to maintain perineal cleanliness". Review of Resident #2's medical record revealed diagnoses which included Dementia, Anxiety, Parkinson's Disease. The facility assessed Resident #2 as being occasionally incontinent of urine and frequently incontinent of bowel, and as having a feeding tube. Observation of a skin assessment for Resident #2, on 07/11/12 at 4:00 PM, performed by Licensed Practical Nurse (LPN) #17 with Certified Nursing Assistant (CNA) #40 assisting, revealed the nurse donned gloves and removed the resident's gastric tube dressing. LPN #17 changed her gloves, but did not wash her hands prior to changing her gloves. She then palpated the gastric tube site, untaped the resident's brief, checked the vaginal area and then checked	{F 441}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185146	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED R 07/14/2012
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB-FOUNTAIN CIRCLE		STREET ADDRESS, CITY, STATE, ZIP CODE 200 GLENWAY ROAD WINCHESTER, KY 40391	

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{F 441}	Continued From page 28 between the resident's buttocks. The nurse retaped the brief although the brief was saturated with urine. LPN #17 then removed her gloves. However she did not wash hands and checked behind the resident's ears. She then washed her hands and the resident was transferred to the Broda chair and taken to the dayroom in the urine saturated briefs. Interview, on 07/11/12 at 4:15 PM with LPN #17, revealed she did not wash her hands after removing the soiled gastric tube dressing and prior to donning new gloves because she was not going to clean the site and change the dressing right then. She agreed she had palpated the gastric tube area and then palpated the vaginal area and buttocks with the same gloves. Further interview revealed she thought she had washed her hands prior to checking behind the resident's ears. Continued interview, revealed, it would be a "good idea" to clean and change the resident's attends. However, she knew they would be doing rounds soon thereafter. Interview, on 07/11/12 at 4:20 PM with CNA #40, revealed she agreed the resident was wet with urine and she normally provided incontinence care for someone who was known to be wet, but she was following the nurse who was completing the skin assessment. Interview, on 07/12/12 at 12:00 PM, with Licensed Practical Nurse (LPN) #3/Unit Manager of the D-Wing revealed the nurse should have washed her hands after removing the soiled gastric tube dressing and prior to checking the vaginal area, and should have washed her hands prior to checking behind the resident's ears. Further	{F 441}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
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{F 441}	Continued From page 29 interview revealed staff should have provided incontinence care to Resident #2 prior to transferring the resident out of the bed. Observation of perineal care for Resident #2, on 07/11/12 at 4:26 PM, revealed Certified Nursing Assistant (CNA) #40 cleansed the buttocks with perineal spray and a dry wash cloth and with the same soiled gloves opened a tube of Remedy Cream and applied it to the buttocks. The CNA then changed gloves and did not wash hands. She positioned the brief under the resident's buttocks. She then, with the same gloves, sprayed a dry cloth with perineal spray and cleansed the vaginal area. With the same soiled gloves, she picked up the Remedy cream and applied it to the resident's inner thighs. Interview, on 07/11/12 at 4:45 PM with CNA #40, revealed she should have washed her hands after cleansing the resident's buttocks and prior to performing perineal care. She further indicated that she contaminated the Remedy Cream and the Peri-Spray by handling it with soiled gloves. Further interview revealed she should have washed her hands after the incontinence care. Interview on 07/11/12 at 1:15 PM with Licensed Practical Nurse (LPN) #3/Unit Manager of the D-Wing revealed she had been lining staff up at the sink and observing to ensure they were using proper technique for handwashing; however, she had not audited to ensure staff used proper hand hygiene while performing care during perineal care or skin assessments. Further interview on 07/12/12 at 12:00 PM, revealed the CNA should have washed her hands after cleaning the resident's buttocks and prior to handling the	{F 441}		

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{F 441}	Continued From page 30 Remedy Cream and Peri-spray. She further stated the CNA should have washed her hands prior to completing perineal care for this resident and prior to exiting the resident's room. 3. Observation of a medication pass on, 07/11/12 at 5:05 PM, performed by LPN #20, on the C-Unit revealed the nurse handed Unsampled Resident B a cup of pills and a glass of water and waited for the resident to take the medication. The nurse then retrieved the cup from the resident and discarded it and exited the room without washing or sanitizing her hands. Further observation revealed LPN #20 went to the medication cart and without washing or sanitizing her hands, started setting up medications for Unsampled Resident C. Interview, on 07/11/12 at 5:10 PM, with LPN #20 revealed she had just handed Unsampled Resident B the medications and did not touch the resident's mouth or any objects in the resident's room so she did not feel she needed to wash or sanitizer her hands after the medication administration. Continued interview revealed she only washed or sanitized her hands every three (3) residents during medication pass unless she had to touch the resident. Interview, on 07/14/12 at 2:10 PM, with the Director of Nursing (DON) and the Administrator, revealed the staff was to wash or sanitize their hands during medication pass between residents. 4. Review of Resident #47's medical record revealed diagnoses which included Dementia and Diabetes Mellitus.	{F 441}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ___ B. WING ___	(X3) DATE SURVEY COMPLETED
	185146		R 07/14/2012

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{F 441}	Continued From page 31 Observation of a skin assessment on 07/12/12 at 11:00 AM performed by LPN #19, revealed the nurse untaped the resident's briefs and checked the vaginal area; the resident's legs and feet and then turned the resident to the side and checked between the resident's buttocks. The nurse with the same soiled gloves, checked the resident's breast, hands, left heel, and checked behind the resident's ears. Interview, on 07/12/12 at 11:15 AM with LPN #19, revealed she did not directly touch the resident's vagina and only touched the resident's hips, not between the buttocks. She stated she did not feel there was a concern with the skin assessment. Interview on 07/13/12 at 11:00 AM with Licensed Practical Nurse (LPN) #3/Unit Manager of the "D" Wing revealed a skin assessment should be performed head to toe, washing hands after checking perineal area and buttocks. 5. Observation of a medication pass on, 07/11/12 at 5:05 PM, performed by LPN #20, on the C-Unit revealed the nurse handed Unsampled Resident B a cup of pills and a glass of water and waited for the resident to take the medication. The nurse then retrieved the cup from the resident and discarded it and exited the room without washing or sanitizing her hands. Further observation revealed LPN #20 went to the medication cart and without washing or sanitizing her hands, started setting up medications for Unsampled Resident C. Interview, on 07/11/12 at 5:10 PM, with LPN #20	{F 441}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185146		R 07/14/2012

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STREET ADDRESS, CITY, STATE, ZIP CODE: 200 GLENWAY ROAD, WINCHESTER, KY 40391

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(F 441)	Continued From page 32 revealed she had just handed Unsampled Resident B the medications and did not touch the resident's mouth or any objects in the resident's room so she did not feel she needed to wash or sanitizer her hands after the medication administration. Continued interview revealed she only washed or sanitized her hands every three (3) residents during medication pass unless she had to touch the resident. Interview, on 07/14/12 at 2:10 PM, with the Director of Nursing (DON) and the Administrator, revealed the staff was to wash or sanitize their hands during medication pass between residents.	(F 441)		
F 490 SS=E	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility's policies and Plan of Correction, it was determined the facility's Administration failed to ensure the facility was administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable, physical, or psychosocial well-being of each resident. The facility's Administration failed to have an effective system in place to ensure programs, policies and procedures, and the facility's Plan of Correction	F 490		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	195146		R 07/14/2012

NAME OF PROVIDER OR SUPPLIER
KINDRED TRANSITIONAL CARE & REHAB-FOUNTAIN CIRCLE

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F 490	Continued From page 33 were implemented to correct deficiencies cited during the recertification survey concluded on 05/11/12. This failure resulted in continued non-compliance at 483.20 Resident Assessment (F281, F282), 483.25 Quality of Care (F315), 483.60 Pharmacy Services (F431), and 483.65 Infection Control (F441). The findings include: The facility's Administration failed to have an effective system in place to ensure there was evidence of assessment and care planning sufficient to meet the needs of newly admitted residents prior to the completion of the first comprehensive assessment and comprehensive care plan. The facility admitted Resident #49 on 07/05/12 with Physician's Orders for continuous oxygen; however, the facility failed to develop an Initial Care Plan to address this resident's respiratory status and need for oxygen. (Refer to F281) The facility failed to have an effective system to ensure Physician's Orders were carried out. Observations, of a treatment on 07/13/12, revealed the nurse used Normal Saline to cleanse the wound instead of soap and water as per Physician's Orders. In addition, observation, on 07/12/12 revealed the facility failed to ensure the correct tube feeding formula was administered as per Physicians's Orders. (Refer to F281) The facility failed to have an effective system to ensure care was provided in accordance with the written Plan of Care. Observation, on 07/13/12, revealed the Comprehensive Plan of Care for	F 490		

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F 490	Continued From page 34 Resident #48 was not followed related to handwashing and isolation precautions. Observation on 07/11/12 revealed Resident #2 was transferred from the "Broda" chair to the bed and from the bed to the "Broda" chair with the assistance of one (1) staff, although the Comprehensive Plan of Care stated two (2) staff was to transfer the resident. In addition, observation of a skin assessment on 07/11/12 revealed staff did not follow the Comprehensive Plan of Care for Resident #2 and the resident did not receive appropriate care and services related to incontinence care. (Refer to F282 and F316) The facility failed to have an effective system to ensure proper storage of drugs and biologicals related to the treatment carts containing medications and biologicals that were labeled and/or stored improperly, and observation revealed discontinued and expired medications. (Refer to F431) The facility failed to have an effective system to 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. Resident #48 was in contact isolation related to a diagnosis of MRSA. Observation on 07/13/12, revealed a staff member performed a skin assessment, removed her gloves, and gown, and exited the room without washing or sanitizing her hands. Also, observation of a skin assessment for Resident #2 on 07/11/12 and Resident #47 on 07/12/12 revealed staff used poor infection control technique. In addition, improper infection control technique was observed on 07/11/12 for Resident #2 related to	F 490		

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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB-FOUNTAIN CIRCLE		STREET ADDRESS, CITY, STATE, ZIP CODE 200 GLENWAY ROAD WINCHESTER, KY 40391	

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F 490	Continued From page 35 perineal care. Additionally, although Resident #2 was noted to have a urine saturated brief, which was untaped during the skin assessment on 07/11/12, the soiled brief was re-applied and the resident was transferred to a "Broda" chair after the skin assessment. Also, observation on 07/11/12 of the medication pass revealed the nurse failed to wash her hands after administration of medications to Unsampled Resident B. (Refer to F441) Interview with the Administrator and the Director of Nursing (DON), 07/14/12 at 2:10 PM, revealed observations/audits conducted were not all inclusive to ensure implementation of all Physician orders, care plan interventions, provision of incontinence care, and monitoring of treatment carts. Further interview revealed even though medication pass observation by the Staff Development Coordinator was detailed in the Plan of Correction, this had not been completed. In addition, the facility failed to detail the audit expectation related to infection control and hand washing with the Unit Managers which resulted in skin assessments, incontinence care and perineal care not being observed.	F 490		
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance	F 520		

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	185146		R 07/14/2012

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F 520	Continued From page 36 committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, review of the facility's policies and review of the facility's Plan of Correction (POC) with a compliance date of 06/18/12, it was determined the facility failed to maintain a Quality Assessment and Assurance (QA) Program that developed and implemented appropriate plans of action to correct quality deficiencies. This was evidenced by repeat deficiencies cited during the Revisit Survey conducted on 07/14/12 at 483.20 Resident Assessment (F281, F282), 483.25 Quality of Care (F315), 483.60 Pharmacy Services (F431), and 483.65 Infection Control (F441). The findings include: 1. Review of the facility's POC, with a	F 520		

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F 520	Continued From page 37 compliance date of 06/18/12, revealed the Unit Managers would conduct an audit of the initial care plans for accuracy and completeness weekly for three (3) months and the audits would be brought to the Performance Improvement Committee (PIC) every month for three (3) months. Based on interview, and record review it was determined the facility failed to develop an Initial Care Plan on admission for Resident #49 related to his/her oxygen needs. Although the resident was admitted with Physician's order for oxygen at two (2) liters per minute for shortness of air, there was no documented evidence the initial plan of care addressed the resident's need of oxygen. Interview, on 07/14/12 at 11:15 AM, and 2:05 PM with the Director of Nursing (DON), revealed the Initial Care Plans were completed by the Unit Manager or the Weekend Supervisor within twenty-four (24) hours of the admission. She stated, if a resident was on continuous oxygen this should have been addressed on an Initial Care Plan. Continued interview revealed the Initial Care Plans were also reviewed by the Interdisciplinary Team weekly and they missed the fact the oxygen had not been put on the Initial Care Plan or the Interim Care Plan. She further stated, this was also missed during the audit. 2. Review of the facility's POC, with a compliance date of 06/18/12, revealed the Assistant Director of Nursing (ADON) would conduct a weekly audit of three (3) Medication Administration Records (MARs) per unit, to validate the timely administration of medications with new Physician's Orders and the Staff	F 520		

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F 520	Continued From page 38 Development Coordinator (SDC) would conduct a weekly audit of a medication pass to validate administration of medications. These audits would be reported to the PIC monthly for three (3) months and thereafter, as needed. Based on observation, interview, and record review, it was determined the facility failed to ensure Physician's Orders were followed for Resident #50 related to wound care treatment and Enteral Nutrition. Although the resident had a wound treatment order dated 07/12/12 to clean the wound (back of the left thigh) with soap and water daily, observation on 07/13/12 at 10:20 AM revealed the nurse used Normal Saline to clean the wound site. Also, review of a Physician's order, dated 07/06/12, revealed the Enteral formula Nepro was to be discontinued when the formula Suplena was available. However, observation on 07/12/12, and interview with staff revealed the facility failed to change the formula when the Suplena was available and delivered to the facility on 07/11/12. Interview on 07/14/12 at 2:10 PM with the DON and the Administrator, revealed the facility initially audited all MARs for timeliness of medications and checked the Physician's Orders to ensure the Care Plans matched the orders. However, there were no observations/audits completed to ensure the residents were receiving the correct tube feedings or treatments as per Physician's Orders. Further interview revealed the SDC was to observe medication pass; however this was not done as per the POC and there were no medication pass observations except for one (1) completed by pharmacy in 05/2012. Review of the Audits revealed there was no audit related to	F 520		

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F 520	Continued From page 39 observation of medication pass. 3. Review of the facility's POC, with a compliance date of 06/18/12, revealed the Minimum Data Set (MDS) Coordinators would audit three (3) residents each week to validate accuracy of care plans and the audits would be brought to the PIC every month for three (3) months and as needed thereafter. Based on observation, interview, and record review, it was determined the facility failed to ensure care was provided in accordance with the written plan of care. Observation on 07/13/12 at 2:00 PM revealed a nurse performed a skin assessment for Resident #48 who was in contact isolation for Methicillin Resistant Staphylococcus Aureus (MRSA) of the Right Great Toe. The nurse exited the resident's room without washing or sanitizing her hands as per the Plan of Care. In addition, observation on 07/11/12 at 4:26 PM, revealed Resident #2 was transferred from the "Broda" chair to the bed and from the bed to the "Broda" chair by the assistance of one (1) staff, although the Plan of Care specified two (2) staff was to assist with transfers. Also, observation of a skin assessment for Resident #2 on 07/11/12 at 4:00 PM revealed the resident did not receive incontinence care although the brief was saturated with urine. Following the skin assessment, the soiled brief was re-applied and the resident was transferred from the bed to the chair. Interview on 07/12/12 at 12:00 PM with the Unit Manager/Licensed Practical Nurse (LPN) for the "D" Wing, where Resident #2 resided, revealed she was unaware of any audits being done on her	F 520		

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	185146		R 07/14/2012

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F 520	Continued From page 40 unit related to transfers, incontinence care, or skin assessments, although she did audits to ensure the care plans were appropriate for the residents and ensure interventions were implemented such as devices and alarms. Interview, on 07/13/12 at 4:00 PM, with MDS Coordinator #1 and MDS Coordinator #2, and on 07/14/12 at 2:10 PM with the Director of Nursing and the Administrator, revealed there was a continued audit three (3) times a week for nine (9) residents to ensure staff was following the care plan. However, transfers were not audited as residents were screened quarterly by Physical Therapy related to transfers. In addition, incontinence care and skin assessments were not being audited. 4. Review of the facility's POC, with a compliance date of 06/18/12, revealed Unit Managers would conduct audits of Bowel and Bladder Assessments per the MDS schedule weekly for three (3) months, to validate completion of the assessments. Based on observation, interview, and record review, it was determined the facility failed to ensure residents received the appropriate care and services related to incontinence care. Observation of a skin assessment for Resident #2 on 07/11/12 at 4:00 PM, revealed the resident had a urine saturated brief during the skin assessment; however, after the skin assessment, the soiled brief was re-applied and the resident was transferred out of the bed and into a chair. Interview on 07/11/12 at 1:15 PM with the Unit Manager/ LPN #3 for the "D" Wing where	F 520		

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F 520	Continued From page 41 Resident #2 resided, revealed she was completing audits to ensure the Bowel and Bladder Assessments were completed as per the MDS schedule; however, she was not auditing incontinence care to ensure it was completed as per the Bowel and Bladder Assessments. Interview on 07/14/12 at 2:10 PM with the DON and the Administrator, revealed Resident #2's brief should have been changed and incontinence care performed at the time staff realized the resident was wet. Further interview revealed the Unit Managers were responsible to audit to ensure the Bowel and Bladder Assessments were completed timely; however,they were not auditing to ensure incontinence care was performed as per the Assessments. 5. Review of the facility's POC, with a compliance date of 06/18/12, revealed the Unit Managers would conduct audits of the medication carts and medication room weekly, for three (3) months to validate multi-dose vials were labeled, no expired medications were present and that no medications were set up and the audits would be brought to the PIC every month for three (3) months, and as needed thereafter. Based on observation, interview, and review of the facility's policies, it was determined the facility failed to ensure drugs and biologicals were labeled, stored and dated in accordance with currently accepted professional principles, and discarded after the expiration date. Observation, on 07/13/12 at 10:16 AM, of the "B" Wing treatment cart revealed Tobrex Ophthalmic ointment (eye) was stored in the topical drawer	F 520		

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F 520	Continued From page 42 with other topical medications. There was Mupirocin topical ointment in the same drawer which had a missing cap and an illegible label. Medications including Santyl and Mupirocin topical ointment mixture, a bottle of Dakins ½ strength solution, Nystatin Powder, and Santyl topical ointment were noted to be expired. Also, there was an unlabeled can of Granulex in the bottom drawer of the treatment cart , and an open bottle of Normal Saline irrigation with no date or label on top of the treatment cart. Observation, on 07/13/12 at 1:00 PM, of the "D" Wing treatment cart revealed a bottle of Normal Saline which was open undated, and a bottle of Nystatin Powder 100,000 Unit/GM with a label which stated, to be applied twice a day for fourteen days with an issue date of 03/15/12. Observation on 07/13/12 at 1:25 PM, of the "C" Wing treatment cart revealed an aerosol can of Granulex with an illegible label was stored in the bottom drawer. Also, there was an expired bottle of Dakins ½ strength solution in the same drawer. Interview, on 07/13/12 at 1:00 PM, with the Unit Manager of the "D" Wing/LPN #3, revealed she was auditing the medication carts and medication rooms; however, she did not think about auditing the treatment carts. Interview, on 07/13/12 at 1:40 PM, with the DON and the Administrator, revealed the Unit Managers were auditing the medication rooms and medication carts; however, they did not instruct them to check the treatment carts. 6. Review of the facility's POC, with a compliance date of 06/18/12, revealed the Unit Managers and Rehabilitation Director conducted	F 520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
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F 520	Continued From page 43 audits of proper hand washing techniques being demonstrated by staff and monitored medications carts weekly, for three (3) months to validate staff was following hand washing procedures and the audits would be brought to the PIC every month for three (3) months, and as needed thereafter. Based on observation, interview, record review, and review of facility policies, it was determined the facility failed to 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. Observation of a skin assessment for Resident #48 on 07/13/12 at 2:00 PM revealed a staff member performed the skin assessment, removed her gloves, and gown, and exited the room without washing or sanitizing hands although this resident was in contact isolation related to a diagnosis of MRSA of the Right Great Toe. In addition, although this resident required dressing changes to the affected site (Right Great toe), there was no sink in the room in which staff could wash their hands. Other observations related to deficient practice in infection control included; poor infection control technique related to a skin assessment for Resident #2 on 07/11/12 at 4:00 PM; Resident #47 on 07/12/12 at 11:00 AM; and, poor infection control technique for perineal care for Resident #2 on 07/11/12 at 4:25 PM. In addition, although Resident #2 was noted to have a urine saturated brief which was untaped during a skin assessment on 07/11/12 at 4:00 PM, the soiled brief was re-applied and the resident was transferred to a "Broda" chair after the skin assessment. Also, observation on the "C" Unit of medication pass on 07/11/12 at 5:05 PM revealed	F 520		

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F 520	Continued From page 44 staff failed to wash their hands after administration of medication to Unsampled Resident B, and prior to setting up medications for Unsampled Resident C. Interview on 07/11/12 at 1:15 PM with Licensed Practical Nurse (LPN) #3/Unit Manager of the "D" Wing revealed she had been lining staff up at the sink and observing to ensure they were using proper technique for handwashing; however, she had not audited to ensure staff used proper hand hygiene while performing care during perineal care or skin assessments. Interview on 07/13/12 at 6:00 PM with LPN #11/Unit Manager for the "C" Unit, revealed she had been auditing staff on hand washing which included ensuring staff knew how to properly wash their hands at the sink; however, she had not been routinely auditing staff for hand hygiene during care. Interview on 07/13/12 at 3:30 PM with the Staff Development Coordinator revealed she inserviced all staff on isolation precautions and the "Transmission Based Precautions" Policy to include handwashing prior to exiting the rooms. She verified that according to the "Transmission Based Precautions" Policy in which she inserviced staff there was to be an adequate supply of antiseptic soap and paper towels in the room and staff were to use running water and anti-septic soap for handwashing. Interview on 07/13/12 at 3:00 PM, 5:30 PM and 6:30 PM, and on 07/14/12 at 9:00 AM with the Director of Nursing (DON)/Infection Control Nurse, revealed she thought the Unit Managers	F 520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185146	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED R 07/14/2012
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F 520	Continued From page 46 were watching to ensure correct hand hygiene during care and not just ensuring the correct process of hand washing at the sinks. "I did not spell out how to do hand washing observations". Interview, on 07/14/12 at 2:10 PM with the DON and the Administrator, revealed the audit expectation related to infection control and hand washing should have been clarified with the Unit Managers to audit staff while performing care with an emphasis on skin assessments, incontinence care, and perineal care. Further interview revealed there was no medication pass audits done per the SDC, as per the POC and if the audits had been completed the problem with staff not washing hands between residents on medication pass may have been caught.	F 520		

PRINTED: 05/25/2012
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
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F 000	INITIAL COMMENTS A Recertification/Abbreviated Survey investigating KY#00018037, KY#00018083, KY#00018162 and KY#00018163 was initiated on 03/27/12. KY#00018083 was substantiated with no deficiencies. KY#00018037 was substantiated with deficiencies. After Supervisory review by the State Agency, the survey was re-opened on 04/16/12 to gather additional information. During this survey, KY#00018163 was substantiated with no deficiencies and KY#00018162 was unsubstantiated with no deficiencies. Deficiencies were cited with the highest scope and severity of a "G" at 42 CFR 483.15 Quality of Life (F-241). After quality review conducted by the State Agency it was determined the highest scope and severity was an "H" with Substandard Quality of Care at 42 CFR 483.15 Quality of Life (F-241). An extended survey was conducted 05/07/12 through 05/11/12 and based on additional information it was determined the highest scope and severity was a "G" at 42 CFR 483.15 Quality of Life (F-241).	F 000	Please see Attachment 6.18.12	
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of	F 166	RECEIVED JUN - 6 2012 BY:	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE 6-4-12

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 166	Continued From page 1 the facility's policy, it was determined the facility failed to ensure that after receiving a grievance, the facility actively sought a resolution for one (1) of forty-five (45) sampled residents (Resident #27). Resident #27 complained of having to toilet self due to staff not checking on him/her or answering his/her call bell on the night shift on 03/30/12. However, there was no documented evidence the grievance was acted on by the facility. The findings include: Review of the "Complaints/Concerns Policy", revised 04/28/09, revealed the resident may voice complaints/concerns without discrimination or reprisal. A complaints/concerns process was in place to address resident and/or family member/responsible party's concerns. A complaint/concern was acknowledged, investigated, and the complainant apprised of progress toward resolution. Review of Resident #27's medical record revealed the facility re-admitted the resident to the D-Wing Rehab Unit, on 02/09/12, with diagnoses which included Aftercare Trauma Fractured Bone, Muscle Weakness General, and Depressive Disorder. Review of the Significant Change Minimum Data Set (MDS) Assessment, dated 02/16/12, revealed the facility assessed Resident #27 as being cognitively intact, as requiring extensive assistance of two (2) people for toilet use, and as frequently incontinent of bowel and bladder. Review of the Urinary Incontinence Care Area	F 166	Please see Attachment 6.18.12	

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F 166	Continued From page 2 Assessment Summary (CAAS), dated 02/22/12, revealed Resident #27 was temporarily incontinent related to not being able to get to the toilet in time due to physical disability, external obstacles or problems thinking or communicating. Further review of the CAAS revealed the resident was expected to regain full control of his/her bladder when he/she was more mobile and self sufficient. Review of the Plan of Care as well as the Comprehensive Plan of Care, dated 02/24/12, revealed the resident was having frequent incontinence of bladder, and occasional incontinence of bowel since fracturing his/her foot. The interventions included ensuring the call light was within easy reach and reminding the resident to call for assistance at the first indication of the need to void rather than waiting until the urge was strong. Review of the Nurse's Notes, dated 03/31/12 at 2:45 PM, revealed when the nurse asked Resident #27 if he/she had a Certified Nursing Assistant (CNA) assist him/her to the toilet that morning the resident stated "No, I had my call light on for a long time and no one came to help me so I put myself on the toilet". Further review of the Nurse's Notes revealed the CNA had come once during the night to help, but no one had come that morning. Interview with Resident #27, on 03/29/12 at 1:15 PM, revealed he/she "sometimes" had to wait thirty (30) minutes for staff to respond to his/her call light, and that he/she had incontinent episodes "about every couple of weeks" while waiting on staff to respond. He/she further	F 166	Please see Attachment 6.18.12	

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

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F 166	Continued From page 3 revealed his/her longest wait had been on the three (3) to eleven (11) shift, usually around 10:00 PM, and that he/she felt embarrassed with him/her self and upset with staff when he/she was incontinent. Interview, on 05/10/12 at 3:00 PM, with Licensed Practical Nurse (LPN) #14 who wrote the Nurse's Notes, dated 03/31/12 at 2:45 PM, revealed Resident #27 complained of the call bell not being answered and of not being checked on for a long period of time on the night shift 03/30/12. The LPN stated she did not think she mentioned the call bell issue to the Director of Nursing (DON) or Assistant Director of Nursing (ADON) and did not remember if she had filed a Grievance Form after the resident complained. Interview, on 05/09/12 at 3:20PM, with the ADON and DON, revealed they did not recall being notified of Resident #27's complaint of staff not answering the call bell and not checking on him/her through the night. Further interview revealed the complaint should have been entered on a Grievance Form which would have been given to the Social Worker to distribute to the appropriate department head for follow up. Continued interview, revealed if the concern was related to nursing, either the ADON, or DON would receive the Grievance Form and would have seventy-two (72) hours to follow up to resolve the problem. The ADON stated Social Services was then to follow up with the resident related to resolution of the problem. Interview, on 05/11/12 at 5:30 PM, with the Administrator, revealed he had checked with Social Services and there was no Grievance	F 166	Please see Attachment 6.18.12	

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F 166	Continued From page 4	F 166	Please see	
	Form filed related to Resident #27's complaint.		Attachment	
F 241 SS=G	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY	F 241	6.18.12	
	The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.			
	This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policies, it was determined the facility failed to provide care for residents that maintained or enhanced each resident's dignity and respect for five (5) of forty-five (45) sampled residents (Residents #2, #11, #27, #34 and #45). The facility's failure, caused a negative psychosocial outcome for these residents, which resulted in actual harm.			
	Resident #2 did not receive incontinence care in a timely manner after having loose stool on 02/23/12. The resident was noted to be crying and moaning during perineal care.			
	Resident #11 had a loose stool incontinent episode in February 2012 while waiting for staff to respond to his/her call bell. Interview with Resident #11 revealed it made him/her feel like a dog.			
	Interview with Resident #27 revealed he/she had incontinent episodes "about every couple of weeks" while waiting on staff to respond to the call bell and he/she felt "embarrassed".			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 241	Continued From page 5 Resident #34 received a bed bath instead of a shower on 04/15/12. Interview with the resident revealed he/she woke up and smelled something "rank". Resident #45 received bed baths instead of showers for four (4) of the scheduled six (6) shower days. Interview with the resident revealed he/she did not feel as clean unless he/she had a shower early in the morning and he/she felt "awful". The findings include: Review of the facility's policy entitled "Call Light, Use Of", dated 09/23/03, revealed staff was to identify the location of the light, and answer the resident promptly. Review of the facility's policy entitled "Activities of Daily Living", with a revision date of 01/04/12, revealed Activities of daily living include the resident's ability to bathe and toilet. Further review of the policy revealed a resident's abilities in activities of daily living should not diminish unless the deterioration was unavoidable. Continued review of the policy revealed a resident's preferences should be respected and reasonable accommodations should be made to maximize the resident's functional abilities. Review of the facility's policy entitled "Angel Care", dated 04/26/10, revealed the Angel Care Program was a proactive approach to address requests or concerns before they become a complaint or grievance. Further review of the policy revealed staff was assigned to be "Angels"	F 241	Please see Attachment 6.18.12	

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F 241	Continued From page 6 and responsible for assigned rooms. The "Angels" were to visit the assigned residents two (2) to three (3) times per week and document a note of the visit. In addition, during the visits the "Angel" should cover any concerns the resident had related to staff members or the facility's services. During a resident group meeting with six (6) alert and oriented residents, on 03/27/12 at 3:30 PM, Resident #27 indicated sometimes aides were slow answering call bells, especially on the 3:00 PM to 11:00 PM shift. Further interview revealed it took approximately twenty (20) minutes for call bells to be answered. 1. Review of Resident #2's medical record revealed the facility admitted the resident on 12/27/07, with diagnoses which included Personal History of Fall, Dementia without Behavioral Disturbance, Anxiety, and Parkinson's Disease. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 01/31/12, revealed the facility assessed the resident as moderately impaired in cognitive skills for decision making, as requiring extensive assistance of one staff for transfers and toileting, and as always continent of bowel and bladder. Review of the Bladder Evaluation, dated 02/17/12, revealed the resident was assessed to have Stress Incontinence and Functional Incontinence and was usually continent with occasional episodes of incontinence. Review of the Bowel Evaluation, dated 02/17/12, revealed the resident required two (2) to assist with transfers, was able to tell the need to defecate, and was to be toileted every two (2) hours and as	F 241	Please see Attachment 6.18.12	

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

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F 241	Continued From page 7 needed. Review of the Comprehensive Plan of Care, with a problem date of 01/30/09, revealed the resident had an alteration in elimination related to requiring assistance with toileting and had further declines in continence secondary to decreased mobility and impaired cognitive status. The goal stated the resident would have no more than seven (7) episodes of bladder incontinence a week and no more than two (2) episodes of bowel incontinence with interventions. The interventions included toileting Resident #2 every hour and as needed with the assistance of one person. Review of the facility's abuse investigation, dated 02/23/12, revealed Certified Nursing Assistants (CNA) #9 and CNA #10 were caring for another resident at the time Resident #2 needed incontinence care. Further review revealed Resident #2 became agitated when the CNAs explained they would be with her/him in a few minutes as they were providing care for an unsampled resident. The investigation stated Resident #2's agitation increased and the resident began mumbling, and the CNAs could not understand her/him. The CNAs provided incontinence care as well as toileted the resident and set the resident up for her/his lunch tray. Further review revealed the Speech Therapist came in to work with Resident #2 during the lunch meal and Resident #2 starting crying and stated "they were mean to me" and the Resident indicated it was CNA #9 and CNA #10. An interview was attempted with Resident #2 with the assistance of a CNA, on 03/27/12 at 12:40 AM, however Resident #2 had slurred speech.	F 241	Please see Attachment 6.18.12	

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F 241	Continued From page 8 Interview with CNA #9, on 03/29/12 at 9:15 AM, revealed Resident #2 was waiting with Licensed Practical Nurse (LPN) #3 in the hallway while he and CNA #10 finished giving a shower to an unsampled resident. CNA #9 further revealed Resident #2 had an incontinent episode with a loose stool. He stated the resident was moaning during incontinence care and upset as she/he was usually continent. Further interview with CNA #9, on 05/09/12 at 2:50 PM, revealed Resident #2 had to wait approximately ten (10) minutes for incontinence care. He stated there were two (2) CNAs on the unit at the time. Interview with CNA #10, on 03/29/12 at 12:50 PM, revealed she and CNA #9 were assisting an unsampled resident in the shower room and couldn't get to Resident #2 quick enough. She further stated, Resident #2 was crying when they finally got to him/her as he/she had a bowel movement. Further interview, on 05/10/12 at 3:00 PM, with CNA #10 revealed Kentucky Medication Aide (KMA) #1 was the staff member who informed her and CNA #9 of Resident #2 needing to be toileted. She stated it took approximately five (5) minutes before they were able to check on Resident #2 and the resident was incontinent of a diarrhea stool. Continued interview revealed Resident #2 needed two (2) to assist with transfer at that time due to her/his legs were wobbly. Interview, on 05/10/12 at 4:00 PM, with KMA #1 revealed Resident #2 told her, while she was administering medications, to "come here" and informed her that she/he either needed incontinence care or needed to go to the bathroom. She stated she informed CNA #9 and	F 241	Please see Attachment 6.18.12	

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F 241	Continued From page 9 CNA #10 who were both assisting an unsampled resident with a shower. Further interview revealed at that time, Resident #2 needed two (2) to assist with transfers and she was unable to find anyone to assist her with transferring Resident #2. She stated the only CNAs on the unit were giving a shower, LPN #3 was in a meeting, and although she went to the Reflections unit for help, all the staff was busy. She further stated she went to Resident #2's room to inform her/him they would be there soon when CNA #9 and CNA #10 arrived in the resident's room to assist. She stated she was unsure of exactly how long it took before help arrived after the resident's request for assistance; however, she thought it was one (1) to two (2) minutes. Interview with LPN #3/Unit Manager, on 03/28/12 at 2:05 PM, revealed she occasionally had complaints from residents about not getting to the bathroom in time, but it was infrequent. Further interview revealed she did not remember anything unusual or hectic on the day of the alleged incident. Interview, on 05/11/12 at 5:15 PM, with the Director of Nursing (DON) revealed if a resident indicated he/she needed to go to the bathroom or needed incontinence care they would need assistance in a timely manner. She stated ten (10) minutes would be too long to wait if a resident had an incontinent episode of stool and further stated KMA #1 could have gone to the "C" wing which was attached to the "D" wing for assistance. 2. Review of the medical record revealed the facility admitted Resident #11 to the A-Wing	F 241	Please see attachment 6.18.12	

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F 241	Continued From page 10 Rehab Unit, on 01/31/12, with diagnoses which included Diabetes Mellitus, Anemia, Anxiety, Atrial Fibrillation, Constipation, Motor Vehicle Accident with severe Blunt Trauma with multiple Fractures involving both Tibias, Right Arm, Spine and Pelvis, and Left Pneumothorax. Review of Resident #11's Admission MDS Assessment, dated 02/07/12, revealed the facility assessed the resident as being cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15/15, as being continent of bowel, utilizing a catheter for bladder, and requiring the total assistance of two (2) or more persons for toileting. Review of Resident #11's Comprehensive Plan of Care, dated 01/31/12, revealed Resident #11 had problems providing self care and was dependent upon others for daily care needs related to being in a car accident in December of 2011. Individualized approaches to the plan of care included catheter care for urine and monitor bowel movements related to being at risk for constipation due to decreased mobility and medications. Review of the Certified Nursing Assistant (CNA) assignment/flow sheet, with an origination date of 01/31/12, revealed Resident #11 was continent of bowel. Interview with Resident #11, on 03/29/12 at 2:00 PM and on 04/20/12 at 10:45 AM, revealed he/she rang the call light one evening about a month ago (sometime in February) and it took an hour and a half before anyone came to the room and his/her bowels had moved while waiting. Resident #11 stated he/she could not wait that long and he/she felt like a "dog, because a dog is locked up in a house and has to rely on someone	F 241	Please see attachment 6.18.12	

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F 241	Continued From page 11 to let it out to go to the bathroom and when that doesn't happen the dog has an accident and feels ashamed". Review of Resident #11's Flow Sheet Record, for 02/01/12 through 02/29/12, revealed Resident #11 was continent of bowel except for two (2) incontinent episodes where the resident had loose stool on 02/10/12 and 02/19/12 during the three (3) PM to eleven (11) PM shift. Interview with CNA #12, on 04/20/12 at 11:40 AM, revealed Resident #11, as well as other residents on the A-Wing were in their "right mind" and they knew what they needed so when they used the call bell they needed it answered right away. Further interview revealed one evening in February, Resident #11's call bell was going off but she was already in a room assisting another resident to the toilet. It was about thirty (30) minutes before she could get to the resident, and by the time she got to Resident #11, the resident had a large loose bowel movement. Further interview revealed when one staff person was on break that left only two people to answer call bells. Additional interview revealed if she was already in a room with a resident then she would have to complete that task and wait until there was another aide available to assist her with a resident who required a two person assistance to the toilet. Interview with CNA #28, on 04/20/12 at 4:00 PM, revealed there was one time during her evening shift in February when she responded to Resident #11's call bell in less then five (5) minutes but the resident had diarrhea prior to her getting to the resident's room. She indicated CNA #12 came to	F 241	Please see attachment 6.18.12	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185146		C 05/11/2012

NAME OF PROVIDER OR SUPPLIER
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F 241	Continued From page 12 assist her shortly after with incontinence care for Resident #11. Further interview revealed she was unaware of any other time when the resident had an incontinent episode. Interview with RN #2, on 05/08 at 2:15 PM, revealed she was the Unit Manager of the A-Wing Rehab Unit as well as Resident #11's "Angel". RN #2 indicated she made rounds on her unit daily as well as twice weekly talking with Resident #11 related to any concerns the resident might have. RN #2 stated Resident #11 was an outspoken person and if there had been any concerns the resident would definitely had let her know. A review of RN #2's documented visitations with Resident #11 revealed there were no documented concerns voiced by Resident #45 related to having an incontinent episode due to having to wait for staff to answer the call bell. 3. Review of the medical record revealed the facility re-admitted Resident #27 to the D-Wing Rehab Unit, on 02/09/12, with diagnoses which included Aftercare Trauma Fractured Bone, Muscle Weakness General, and Depressive Disorder. The facility assessed Resident #27, in a Significant Change MDS Assessment, dated 02/16/12, as being cognitively intact with a BIMS score of 15/15, as requiring extensive assistance of two (2) people for toilet use, and was frequently incontinent of bowel and bladder. Review of the Urinary Incontinence Care Area Assessment Summary (CAAS), dated 02/22/12, revealed Resident #27 was temporarily incontinent related to not being able to get to the toilet in time due to physical disability, external obstacles or problems thinking or communicating.	F 241	Please see attachment 6.18.12	

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F 241	Continued From page 13 Further review of the CAAS revealed Resident #27 was expected to regain full control of his/her bladder when he/she was more mobile and self sufficient. Additional review of the CAAS as well as the Comprehensive Plan of Care, dated 02/24/12, revealed Resident #27 was encouraged to call for help at the first indication of the need to void rather than waiting until the urge was strong. Review of Nurse's Notes, dated 03/31/12 at 2:45 PM, revealed when the nurse asked Resident #27 if he/she had a Certified Nursing Assistant (CNA) assist him/her to the toilet that morning the resident stated "No, I had my call light on for a long time and no one came to help me so I put myself on the toilet". Further review of the Nurse's Notes revealed the CNA had come once during the night to help, but no one had come that morning. Additional review of the Nurse's Notes revealed the nurse discussed with Resident #27 the importance of waiting for staff to come and assist him/her when needed. An interview conducted with Resident #27, on 03/29/12 at 1:15 PM, revealed he/she "sometimes" had to wait thirty (30) minutes for staff to respond to his/her call light, and that he/she had incontinent episodes "about every couple of weeks" while waiting on staff to respond. He/she revealed his/her longest waits had been on the three (3) to eleven (11) shift, usually around 10:00 PM, and that he/she felt embarrassed with him/her self and upset with staff when he/she was incontinent. Interview, on 05/10/12 at 3:00 PM, with LPN #14 who wrote the Nurse's Notes dated 03/31/12 at 2:45 PM, revealed Resident #27 complained	F 241	Please see attachment 6.18.12	

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	185146	A. BUILDING B. WING	C 05/11/2012

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WINCHESTER, KY 40391

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F 241	Continued From page 14 he/she had the call bell on and was not checked on for a long period of time on the night shift on 03/30/12. Further interview revealed CNA #9 was the CNA assigned to him/her. The LPN stated she did not think she mentioned the call bell issue to the DON or ADON. Interview, on 05/09/12 at 2:45 PM, with Certified Nursing Assistant (CNA) #9, who was assigned to Resident #27 on 03/30/12, during the night shift, revealed he had never witnessed Resident #27 to be incontinent as she/he used the bed pan during the time he/she had a fractured foot and the resident was always up out of the bed by 4:30 AM per his/her request. He denied not checking on the resident through the night and not anwering the call bell. He further stated, he was the only CNA when he worked the "D" Wing and he did rounds including incontinence care at 12:30 AM, 3:00 AM and 5:30 AM. Continued interview revealed he had to help with rounds on the Reflections Unit also nightly because there was only one CNA on the night shift on the Reflections Unit and the residents on that unit sometimes had behaviors. Continued interview revealed Licensed Practical Nurse (LPN) #13 usually worked when he was working and would not answer call bells when he was off the unit. He stated he could hear bells ringing when he was off the unit and did not think it was safe because the bed alarms and call bells were not answered promptly by this nurse. Further interview revealed he had taken this matter to the Assistant Director of Nursing (ADON) and Licensed Practical Nurse (LPN) #3/Unit Manager. Interview, on 05/10/12 at 7:00 PM, with LPN #13, who worked the night shift on 03/30/12 according	F 241	Please see attachment 6.18.12	

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	185146		C 05/11/2012

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F 241	Continued From page 15 to the schedule, revealed there was she and two (2) aides to cover the "D" wing for the Reflections Unit and rooms outside the Reflections Unit on the night shift. She stated Resident #27 had never complained to her about call bells not being answered and the resident was checked on more frequently than every two (2) hours at the time he/she fractured his/her foot and was unable to toilet self. She stated she did not do incontinence rounds with the CNAs; however, she would cover the Reflections Unit if the CNA from the Reflections Unit was needed to assist with a resident who required a two (2) person transfer or position in bed. She further stated she always answered call bells and did rounds every two (2) hours to ensure call bells were in reach, water was in reach and incontinence care had been completed. Interview, on 05/08/12 at 12:30 PM and on 05/09/12 at 4:15 PM, with LPN #3/Unit Manager where Resident #27 resided revealed she had not received complaints related to not being able to complete care or call bells not being answered, and she felt there was adequate staff on all three (3) shifts for the "D" Wing. Interview, on 05/09/12 at 3:20 PM, with the Assistant Director of Nursing, revealed there was sixteen (16) resident on the "D" Wing outside of the Reflections Unit, and there was one (1) nurse and one (1) aide on the night shift. He stated he did not remember being notified of any concerns related to staffing or call bells being answered for this unit. 4. Review of the medical record revealed the facility admitted Resident #34 to the A-Wing	F 241	Please see attachment 6.18.12	

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	185146	A. BUILDING B. WING	C 05/11/2012

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F 241	Continued From page 16 Rehab Unit, on 04/09/12, with diagnoses which included Recent Pneumonia, Morbid Obesity, Diabetes Mellitus, and Gout. Review of the Admission Nursing Evaluation, dated 04/09/12, revealed Resident #34 was alert and oriented and had a BIMS score of 15/15, required assistance of two (2) for transfer and bed mobility and needed physical help in part of bathing activity. Review of an initial plan of care, dated 04/09/12, revealed Resident #34 was to have a shower for personal hygiene. Review of the CNA Assignment/Flow sheet revealed Resident #34 was to have a shower on Wednesdays and Sundays during the 7 AM-3 PM shift. Interview with Resident #34, on 04/17/12 at 3:45 PM, revealed he/she had been at the facility for nine (9) days and had only had one (1) shower. Further interview revealed he/she should have had a shower two (2) days ago (Sunday) but there wasn't enough staff to get him/her up and take him/her to the shower. Resident #34 indicated he/she woke up this morning and smelled something "rank". He/she stated the CNAs were all nice to him/her and tried to do the best they could with how many people they had to take care of, and he/she didn't want to get the CNAs in trouble. Review of Resident #34's Nurse Aide Flow Sheet Record, from 04/09/12 through 04/20/12, revealed Resident #34 was given a shower during the 3 PM-11 PM shift on Wednesday (04/11/12) and a bed bath on Sunday (04/15/12). Interview with Resident #34's family while in the room with Resident #34, on 04/17/12 at 4:00 PM, revealed Resident #34 had bowel movements up	F 241	Please see attachment 6-18-12	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185146		C 05/11/2012

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F 241	Continued From page 17 and down the resident's back on Wednesday (04/11/12) at approximately 7:30 PM when they visited Resident #34 and staff stated they were going to give the resident a bed bath. The family indicated staff had told them the first shift did not have time to give the resident a shower and the resident was suppose to get a shower on the 3 PM-11 PM shift, but they didn't have time to have two (2) CNAs get him/her up with the mechanical lift and take him/her to the shower. The family stated they went to the nurse's station and had to argue with staff and demand to give Resident #34 a shower because he/she "smelled rank and like shit". Additional interview revealed they finally gave Resident #34 a shower around 10:00 PM. The family continued that today (04/17/12) they walked in and he/she smelled "stinky" because he/she was only given a bed bath on Sunday (04/15/12) so they were going to have to give him/her a bed bath and demand another shower. Interview with CNA #12, on 04/20/12 at 11:40 AM, revealed she worked all three (3) shifts. CNA #12 indicated on Sunday (04/15/12) the first shift did not have time to give the resident a shower and it was probably because he/she was a mechanical lift and they put if off onto second shift. Additional interview revealed she worked second shift on 04/15/12 and didn't have time to give the shower either, so she gave the resident a bed bath because that wouldn't take as much time or require the assistance of two (2) CNAs. Additional interview, on 05/07/12 at 3:00 PM, revealed some CNAs would say or document that a resident had refused a shower because they didn't want to get in trouble for only giving a bed bath and not a shower.	F 241	Please see attachment 6.18.12	

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	185146		C 05/11/2012

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F 241	Continued From page 18 Interview with CNA #28 and CNA #34, on 04/20/12 at 12:00 PM, revealed Resident #34 had refused a shower during the 7 AM- 3 PM shift on 04/15/12 and stated a bed bath would be fine. Review of NNs and the Nurse Aide Flow Sheet Record, for 04/15/12, revealed no documented evidence Resident #34 had refused a shower. Interview with Registered Nurse (RN) #3, on 05/11/12 at 2:15 PM, revealed she was told by the CNAs Resident #34 refused a shower and he/she received a bed bath. Further interview revealed she was unaware Resident #34 had wanted a shower instead of a bed bath. RN #3 indicated if the CNAs needed help with getting the resident to the shower because the resident was a two (2) person assist then they could let her know and she could have assisted. Interview, on 05/08/12 at 2:55 PM, with the Registered Dietitian (RD), who was Resident #34's "Angel", revealed she visited Resident #34 twice a week since admission and no concerns had been brought to her attention related to the resident not getting a shower. Review of the RD's bi-weekly visitations with Resident #34, from 04/09/12 through 04/30/12 revealed there were no concerns voiced by Resident #34 related to not getting a shower. 5. Review of the medical record revealed Resident #45 was re-admitted to the A-Wing Rehab Unit of the facility, on 03/23/12, with diagnoses which included Pneumonia, Diabetes, Functional Decline After Hospitalization, and Obesity. Review of an Admission MDS, dated 03/30/12, revealed the facility assessed Resident	F 241	Please see attachment 6.18.12	

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	185146		C 05/11/2012

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F 241	Continued From page 19 #45 as having no behaviors, required extensive assistance of one person for personal hygiene, physical help in part of bathing, and had a BIMS score of 14/15, which indicated the resident was cognitively intact. Review of the Comprehensive Plan of Care for Resident #45, dated 04/09/12, revealed Resident #45 was to be taken to the shower room two (2) times per week and as needed. Review of the CNA Assignment/Flow Sheet for Resident #45, not dated, revealed Resident #45 was to be taken to the shower room on Mondays and Thursdays during the 7 AM-3 PM shift and the resident was to "get up by 10:00 AM daily". Review of Resident #45's Nurse Aide Flow sheet Record, from 04/01/12 through 04/20/12, revealed Resident #45 only received a shower on two (2) of the scheduled six (6) days. Resident #45 received a shower on Monday, 04/09/12 and 04/16/12, and did not receive a shower on Monday (04/02/12), or Thursdays (04/05/12, 04/12/12 and 04/19/12). Observation, on 04/20/12 at 2:00 PM, revealed Resident #45 was sitting up in his/her wheelchair in the dining/activity area of the C-Wing. Interview with Resident #45 at that time revealed he/she did not feel clean and felt "awful". Resident #45 indicated he/she was suppose to have a shower early that morning, but staff was busy giving a shower to another resident and he/she did not want to wait to have a shower after 10:00 AM because he/she liked going to the 10:00 AM activity or morning therapy group exercise. Further interview revealed Resident #45 had to miss getting a shower almost once a week	F 241	Please see attachment 6.18.12	

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F 241	Continued From page 20 due to the facility not having enough staff to give him/her a shower in the morning as he/she preferred. Resident #45 indicated he/she did not feel clean unless he/she had a shower and he/she felt "awful". Review of Nurse's Notes (NN), dated 04/27/12, revealed Resident #45 refused a late morning shower related to wanting to go out to eat with Activities. Review of NNs, dated 05/03/12, revealed Resident #45 refused a shower after being informed a shower would not be given until after lunch. Further review of the NNs revealed the resident stated he/she wanted showers in the morning. Review of NNs, dated 05/07/12, revealed Resident #45 requested to have a bed bath that morning related to not wanting to wait for a shower. During an interview with RN #3, on 05/11/12 at 2:15 PM, RN #3 revealed it was difficult for the CNAs starting work at 7:00 AM to give a resident a shower because they had to get residents up and ready for breakfast. Further interview revealed if a resident wanted an early morning shower it would have to be given around 6:00 AM. RN #3 indicated Resident #45 should get a shower early in the morning if that was his/her preference. Interview, on 05/08 at 2:55 PM, with the Registered Dietitian (RD), who was Resident #45's "Angel", revealed she visited Resident #45 two (2) times a week since admission and no	F 241	Please see attachment 6.18.12	

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	185146		C 05/11/2012

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WINCHESTER, KY 40391

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F 241	Continued From page 21 concerns had been brought to her attention related to the resident not getting a shower. Additional interview revealed the only concern Resident #45 had was related to wanting his/her food preferences changed. Review of the bi-weekly visitations with Resident #45 revealed there was only one (1) concern voiced by Resident #45 related to wanting his/her food preferences changed. Interview with CNAs #28 and #33, on 04/20/12 at 3:30 PM, revealed residents on the A-Wing Rehab Unit were more "needy" and it was difficult to meet all the residents' needs and sometimes showers couldn't be given during the scheduled first shift so they had to verbally inform the second shift a resident needed to be given a shower. Additional interview revealed Resident #34 and #45 were large people and required the use of a mechanical lift and two (2) CNAs to take the residents to the shower room. Further interview revealed if there were only three (3) CNAs on the unit then this could not always be done because that would leave only one (1) CNA to take care of the needs of the other twenty-nine (29) residents. Continued interview revealed Resident #45 wanted to take his/her shower earlier in the morning because the resident enjoyed going to the morning group activity and if they didn't have time to take the resident before 10:00 AM, the resident would refuse the shower and would accept a bed bath. Interview with CNA #6, on 04/16/12 at 9:15 PM, revealed it was difficult to answer the call bells, give showers, assist residents to the toilet, and feed residents with only having three (3) CNAs on the A-Wing Rehab Unit. Further interview	F 241	Please see attachment 6.18.12	

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F 241	Continued From page 22 revealed sometimes showers were missed, especially for residents who required a mechanical lift with assistance of two staff. She indicated if showers could not be given then the on-coming shift would be given a verbal report as to who still needed showers, or the residents would be given a bed bath. Interview with LPN #10, on 04/16/12 at 9:55 PM, revealed she felt like the A-Wing Rehab Unit needed four (4) CNAs because with only three (3) CNAs they had to rush through everything and didn't have time to interact with residents. An interview with CNA #26, on 04/18/12 at 3:40 PM, revealed she didn't feel like she had enough time to get everything done during her 3:00 PM to 11:00 PM shift on the A-Wing Rehab Unit. She indicated she usually had to stay over to complete her work, seldom getting out on time. CNA #26 revealed sometimes showers were missed, and if she was unable to get something completed she would tell the on coming staff. An interview with CNA #11, on 04/17/12 at 3:50 PM, revealed she took over and helped with staffing about three (3) weeks ago. She indicated she felt resident care suffered as a result of being understaffed, with no time available to talk to residents. Further interview revealed the facility only scheduled three (3) CNAs on the A-Wing and D-Wing Rehab Unit per budget, but there really needed to be at least four (4) CNAs on each unit to meet the residents' needs. Additional interview revealed some CNAs worked a lot of overtime and were exhausted and couldn't always meet residents' needs.	F 241	Please see Attachment 6.18.12	

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WINCHESTER, KY 40391

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F 241	Continued From page 23 Interview with the Administrator and Director of Nursing, on 04/19/12 at 3:00 PM, revealed they were not aware of any residents' complaints of call bells not being answered timely before residents had incontinent episodes, or complaints that residents did not receive their scheduled showers. Further interview revealed the facility had an "Angel Program" where management staff was assigned a certain number of residents and each staff was to check on the resident at least two (2) times per week for any concerns. Additional interview revealed if there were concerns, staff was to discuss it during the morning "stand-up" meetings, but nothing had been discussed related to call bells not being answered timely, or showers not being given.	F 241	Please see attachment 6.18.12	
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of facility's policy, it was determined the facility failed to ensure individual needs and preferences were accommodated related to what time a resident wanted a shower for one (1) of forty-five (45) sampled residents. The facility failed to ensure Resident #45 received a shower prior to 10:00 AM as requested by the resident.	F 246		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185146	A. BUILDING B. WING	C 05/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE & REHAB-FOUNTAIN CIRCLE	200 GLENWAY ROAD WINCHESTER, KY 40391

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F 246	Continued From page 24 The findings include: Review of facility policy entitled "Activities of Daily Living", revised date of 01/04/12, revealed Activities of Daily Living include the resident's ability to bathe. Additional review of the policy revealed a resident's preferences should be respected and reasonable accommodations should be made to maximize the resident's functional abilities. Medical record review revealed the facility re-admitted Resident #45 on 03/23/12, with diagnoses which included Pneumonia, Diabetes, Functional Decline After Hospitalization, and Obesity. Review of the Admission MDS, dated 03/30/12, revealed the facility assessed Resident #45 to required extensive assistance of one person for personal hygiene, physical help in part of bathing, and had a Brief Interview of Mental Status (BIMS) score of 14/15, indicating the resident was cognitively intact. Observation, on 04/20/12 at 2:00 PM, revealed Resident #45 was sitting up in his/her wheelchair in the dining/activity area of the C-Wing. Interview with Resident #45, at that time, revealed he/she was suppose to have a shower early that morning, but staff was busy giving a shower to another resident and he/she did not want to wait to have a shower after 10:00 AM because he/she liked going to the 10:00 AM activity or morning therapy group exercise. Further interview revealed Resident #45 had to miss getting a shower almost once a week due to staff not being able to take him/her to the shower prior to 10:00 AM. Resident #45 indicated he/she did not feel	F 246	Please see attachment 6.18.12	

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F 246	Continued From page 25 clean unless he/she had a shower. Review of the Comprehensive Plan of Care for Resident #45, dated 04/09/12, and the CNA Assignment/Flow Sheet, not dated, revealed the resident was to be taken to the shower room two (2) times per week on Mondays and Thursdays during the 7 AM-3 PM shift and as needed. Per the assignment sheet, the resident was to "get up by 10:00 AM daily". Review of the Nurse Aide Flow Sheet Record, from 04/01/12 through 04/20/12, revealed Resident #45 only received a shower on two (2) of the scheduled six (6) days. Resident #45 received a shower on Monday, 04/09/12 and Monday, 04/16/12, and did not receive a shower on Monday, 04/02/12 or Thursdays 04/05/12, 04/12/12, and 04/19/12. Review of Nurse's Notes (NN) revealed, on 04/27/12, Resident #45 refused a late morning shower related to wanting to go out to eat with Activities. On 05/03/12, revealed Resident #45 refused a shower after being informed a shower would not be given until after lunch. On 05/07/12, revealed Resident #45 requested to have a bed bath that morning related to not wanting to wait for a shower. Further review of the NNs revealed the resident stated he/she wanted showers in the morning. Interview with CNAs #28 and #33, on 04/20/12 at 3:30 PM, revealed Resident #45 wanted to take his/her shower earlier in the morning because the resident enjoyed going to the morning group activity and if they didn't have time to take the resident before 10:00 AM, the resident would	F 246	Please see attachment 6.18.12	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	185146		C 05/11/2012

NAME OF PROVIDER OR SUPPLIER
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WINCHESTER, KY 40391

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F 246	Continued From page 26 refuse the shower and would accept a bed bath. During an interview with RN #3, on 05/11/12 at 2:15 PM, RN #3 indicated it was difficult for the CNAs starting work at 7:00 AM to give residents a shower because they had to get residents up and ready for breakfast. Further interview revealed if a resident wanted an early morning shower it would have to be given around 6:00 AM. RN #3 indicated Resident #45 should get a shower early in the morning if that was his/her preference.	F 246	Please see attachment 6.18.12	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced	F 279		

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F 279	Continued From page 27 by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to develop a Comprehensive Care Plan with measurable objectives and timetables for four (4) of the forty-five (45) sampled residents (Residents #8, #11, #2 and #27). The facility failed to develop a Comprehensive Care Plan to direct the care for Resident #8 related to the development of a Vancomycin-Resistant Enterococci (VRE) urinary tract infection and the Contact Precautions that were implemented. The facility failed to develop a care plan for Resident #11 related to Resident #11's need for a two (2) person assist with toileting and the need to use a bed pan. Resident #2's care plan was not developed related to the resident's need for the assistance of two (2) with toileting after a Significant Change Assessment, dated 03/16/12. The facility failed to develop a plan of care for Resident # 27 related to the resident's specific toileting needs after the resident was re-admitted to the facility on 02/09/12 with diagnoses of Status Post Open Reduction Internal Fixation for a Left Bimalleolar Fracture. The findings include: Review of the facility's policy titled, "Care Plans (POL 605)", dated 01/04/12, revealed the Comprehensive Care Plan would be developed	F 279	Please see attachment 6.18.12	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185146		C 05/11/2012

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F 279	Continued From page 28 within seven (7) days after the completion of the comprehensive assessment. The policy confirmed that the comprehensive care plan was developed to address the resident's specific conditions, risks, needs, behaviors, preferences and with standards of practice that included measurable objectives, interventions/services, and timetables to meet the resident's needs as identified in relation to the resident's response to the interventions or changes in the resident's condition. 1. Review of the medical record for Resident #8 revealed the facility admitted the resident on 03/17/12, with diagnoses which included Chronic Obstructive Pulmonary Disease, Atrial Fibrillation/Flutter, Depression, Anxiety, Arthritis and Depression. Review of the Admission Minimum Data Set (MDS) Assessment for Resident #8, dated 03/24/12, revealed the facility assessed Resident #8 as being alert and oriented and requiring extensive assistance from staff for Activities of Daily Living. Review of the Physician's orders, dated 03/26/12, revealed Resident #8 had Vancomycin-Resistant Enterococci (VRE) infection confirmed by a urine culture report. Zyvox (an antibiotic) 600 milligrams (mgs) was ordered to be administered orally to Resident #8 twice each day. Further review revealed Contact Precautions were required, based on nursing judgement, to prevent person to person transmission of the urine infection VRE. Review of the Comprehensive Care Plan, dated	F 279	Please see attachment 6.18.12	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185146	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED C 05/11/2012
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB-FOUNTAIN CIRCLE		STREET ADDRESS, CITY, STATE, ZIP CODE 200 GLENWAY ROAD WINCHESTER, KY 40391	

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F 279	Continued From page 29 04/04/12, revealed no documented evidence the facility had developed a care plan to address Resident #8's urinary tract infection of VRE, or the resident being on Contact Precautions. Interview, on 04/19/12 at 11:45 AM, with the MDS Coordinator revealed the Comprehensive Care Plan was developed from information obtained from the comprehensive assessment, care area assessments, change in condition forms, Physician's orders and the initial care plan. The MDS Coordinator revealed acute infections were addressed on a separate care plan and were completed by the Infection Control Nurse. Interview, on 04/19/12 at 2:40 PM, with the Director of Nursing (DON) revealed the Infection Control Nurse was on maternity leave and the DON had resumed the responsibilities of Infection Control. The DON stated the Comprehensive Care Plan was completed by the MDS staff after the comprehensive assessment and should address infections and any precautions required. The DON stated she was not aware the Infection Control Nurse was required to develop care plans related to infections. 2. Record review revealed the facility admitted Resident #11, on 01/31/12, with diagnoses which included Diabetes Mellitus, Anemia, Anxiety, Atrial Fibrillation, Constipation, Motor Vehicle Accident with severe Blunt Trauma with multiple Fractures involving both Tibias, Right Arm, Spine and Pelvis, and Left Pneumothorax. Review of an Admission Nursing Evaluation, dated 01/31/12, revealed the facility assessed Resident #11 to be alert and oriented and as being non ambulatory due to instability of the fractures.	F 279	Please see attachment 6.18.12	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185146	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED C 05/11/2012
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB-FOUNTAIN CIRCLE		STREET ADDRESS, CITY, STATE, ZIP CODE 200 GLENWAY ROAD WINCHESTER, KY 40391	

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F 279	Continued From page 30 Review of Resident #11's Admission MDS Assessment, dated 02/07/12, revealed the facility assessed the resident as being continent of bowel, utilizing a catheter for bladder, and required the total assistance of two (2) persons for toileting. Interview with Resident #11, on 04/20/12 at 10:45 AM, revealed he/she could not get up out of bed and relied on staff to bring him/her a bed pan to have bowel movements. Interview with CNA #12, on 04/20/12 at 11:40 AM, revealed Resident #11 was currently not able to get out of the bed due to his/her car accident and utilized a bed pan to have a bowel movement. During an interview with Registered Nurse (RN) #3, on 05/11/12 at 2:15 PM, RN #3 indicated Resident #11 was alert and oriented and continent of bowel. Further interview revealed Resident #11 needed assistance of two (2) staff for transfer and the resident could use a bed pan or be taken to the toilet by two (2) staff members. Review of Resident #11's Comprehensive Plan of Care, dated 01/31/12, revealed Resident #11 had problems providing self care and was dependent upon others for daily care needs related to being in a car accident in December of 2011. Further record review revealed no documented evidence the facility developed a care plan to address Resident #11's need to utilize a bed pan with the assistance ot two (2) for bowel movements. Interview, on 05/08/12 at 1:30 PM, with MDS Coordinator #3, who developed the plan of care	F 279	Please see attachment 6.18.12	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185146	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED C 05/11/2012
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB-FOUNTAIN CIRCLE		STREET ADDRESS, CITY, STATE, ZIP CODE 200 GLENWAY ROAD WINCHESTER, KY 40391	

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F 279	Continued From page 31 for Resident #11, revealed Resident #11 did not have a plan of care developed related to bowel toileting needs because the resident was continent of bowel. Interview with MDS Coordinator #2, on 05/09/12 at 1:45 PM, revealed even though Resident #11 was continent of bowel a Comprehensive Plan of Care should have been developed to address the resident's need for assistance with toileting to include the use of a bed pan. 3. Review of Resident #2's medical record revealed diagnoses which included Dementia, Anxiety, Parkinson's Disease and a History of Falls. Review of the Bowel Assessment, dated 02/17/12, which was the most recent Bowel Assessment prior to the Significant Change Minimum Data Set (MDS) Assessment dated 03/16/12, revealed Resident #2 had incontinence of bowel due to a recent admission to the hospital, wore briefs, was able to perceive the need to defecate and was toileted every two hours and as needed. Further review revealed the resident needed two (2) to assist with transfer. Review of the Significant Change Minimum Data Set (MDS) Assessment, dated 03/16/12, completed by Registered Nurse (RN)/ MDS Coordinator #2 revealed the facility assessed the resident as having moderate impairment in cognitive skills for decision making, and as requiring extensive assist of one (1) for toileting, and transfers. Further review revealed the resident was assessed as frequently incontinent	F 279	Please see Attachment 6.18.12	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185146		C 05/11/2012

NAME OF PROVIDER OR SUPPLIER
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STREET ADDRESS, CITY, STATE, ZIP CODE
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F 279	Continued From page 32 of bowel and bladder. Review of the Care Area Assessment Summary (CAAS), dated 03/20/12, completed by RN/MDS Coordinator #2 revealed the Urinary Incontinence CAAS stated the resident had Functional Incontinence (unable to toilet in time due to physical disability, external obstacles, or problems thinking or communicating) and was unable to toilet independently. Further review of the Falls CAAS, dated 03/20/1,2 revealed the resident required the extensive assistance of two (2) for transfers. Review of the Comprehensive Plan of Care, with a problem date of 01/30/09, revealed the resident had an alteration in elimination and required assistance with toileting. The interventions included toileting every hour and as needed with the assist of one (1). Interview, on 05/09/12 at 10:45 AM and on 05/11/12 at 1:30 PM, with Registered Nurse/MDS Coordinator #2, revealed she completed the Care Plan for the Significant Change MDS, dated 03/16/12, due to the resident receiving a feeding tube and becoming weak after hospitalization. She further stated she did not complete a whole new Care Plan; however, updated the Care Plan in the areas needed. She verified the Care Plan she reviewed and revised for the 03/16/12 MDS stated the resident was to be toileted with one assist every hour and as needed. Further interview revealed she gathered information for updating the Care Plan from resident interviews, staff interviews, Resident Progress Notes and nurse aide flow sheets to include the Flow Sheet Records, and the Late Loss ADL (Activities of	F 279	Please see attachment 6.18.12	

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F 279	Continued From page 33 Daily Living) Flow Sheet. She stated she did not ensure a new bowel and bladder assessment was done and was unsure if the policy stated there was to be a new bowel and bladder assessment with a Significant Change MDS. Further interview revealed she relied heavily on Certified Nursing Assistant interviews and Flow Sheets when completing the MDS and Care Plan and after review felt the resident was a one (1) person assist for toileting at the time the MDS dated 03/16/12 was completed. She did not revise the Care Plan related to transfers/toileting because she did not feel it was needed. Interview, on 05/11/12 at 5:00 PM, with the Director of Nursing revealed there should have been a new bowel and bladder assessment completed with the Significant Change MDS, dated 03/16/12, in order to have current information related to the resident's functional status related to toileting. She further stated per the information in the CAAS, dated 03/20/12, and the Bowel Assessment, dated 02/17/12, a Comprehensive Plan of Care should have been developed with the MDS dated 03/16/12 to include two (2) person assist with transfer and toileting. (Refer to F-315) 4. Review of Resident #27's medical record revealed the facility re-admitted this resident to the D-Wing Rehab Unit, on 02/09/12, with diagnoses which included Aftercare Trauma Fractured Bone/ Status Post Open Reduction Internal Fixation for a Left Bimalleolar Fracture, Muscle Weakness General, and Depressive Disorder. The facility assessed Resident #27, in a Significant Change MDS Assessment, dated 02/16/12, as being cognitively intact, as requiring	F 279	Please see attachment 6.18.12	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER: KINDRED TRANSITIONAL CARE & REHAB-FOUNTAIN CIRCLE

STREET ADDRESS, CITY, STATE, ZIP CODE: 200 GLENWAY ROAD, WINCHESTER, KY 40391

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F 279	Continued From page 34 extensive assistance of two (2) people for toilet use, and as frequently incontinent of bowel and bladder. Review of the Urinary Incontinence Care Area Assessment Summary (CAAS), dated 02/22/12, revealed Resident #27 had Transient Incontinence (temporary/occasional related to a potentially improvable/reversible cause) and Functional Incontinence (temporarily can't get to the toilet in time due to physical disability, external obstacles or problems thinking or communicating). Further review of the CAAS revealed Resident #27 was noted to have some urinary incontinence since fracturing his/her foot and was expected to regain full control of his/her bladder when he/she was more mobile and self sufficient. Review of the Comprehensive Plan of Care, dated 02/24/12, revealed Resident #27 was having frequent incontinence of bladder, and occasional incontinence of bowel since he/she sustained a fractured foot. The interventions included, "I do not want or need you to check me for incontinence every two (2) hours, especially at night. I am very aware when I have lost control and will let your know when it happens. Assist me as needed with peri care". Another intervention stated, "You can offer me toileting assist every two (2) hours to help me maintain continence". The interventions had conflicting information about how often the resident was to be checked and toileted. Review of Nurse's Notes, dated 03/31/12 at 2:45 PM, revealed when the nurse asked Resident #27 if he/she had a CNA assist him/her to the	F 279	Please see attachment 6.18.12	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
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F 279	Continued From page 35 toilet that morning the resident stated "No, I had my call light on for a long time and no one came to help me so I put myself on the toilet". Further review of the Nurse's Notes revealed the CNA had come once during the night to help, but no one had come that morning. Additional review of the Nurse's Notes revealed the nurse discussed with Resident #27 the importance of waiting for staff to come and assist him/her when needed. (Refer to F-241) An interview conducted with Resident #27, on 03/29/12 at 1:15 PM, revealed he/she "sometimes" had to wait thirty (30) minutes for staff to respond to his/her call light, and that he/she had incontinent episodes "about every couple of weeks" while waiting on staff to respond. He/she revealed his/her longest waits had been on the three (3) to eleven (11) shift, usually around 10:00 PM, and that he/she felt embarrassed with him/her self and upset with staff when he/she was incontinent. Further interview with Resident #27, on 05/11/12 at 4:00 PM, revealed when he/she fractured his/her foot he/she was unable to toilet self and depended on staff. The resident stated at that time, she/he was not given the option of being checked on every two (2) hours, but was told to ring the call bell if needing assistance. Continued interview revealed it was not true that he/she did not want to be disturbed. "I would really appreciate someone coming in every two (2) hours, that would be wonderful". Observation of the resident at the time of the interview, revealed he/she was transfering self and ambulating independently with a walker.	F 279	Please see attachment 6.18.12	

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	185146		C 05/11/2012

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KINDRED TRANSITIONAL CARE & REHAB-FOUNTAIN CIRCLE	200 GLENWAY ROAD WINCHESTER, KY 40391

(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 279	Continued From page 36 Interview, on 05/08/12 at 12:30 PM and 1:00 PM, with Licensed Practical Nurse (LPN) #3/ Unit Manager where Resident #27 resided, verified the incontinence Care Plan was contradictory and the MDS Coordinators completed the Care Plans. She stated the Certified Nursing Assistants (CNA's) were to check the CNA Assignment Sheets for reference to provide care which was not a part of the permanent record and was updated frequently. She stated she was unsure of what interventions were on the Assignment Sheet for Resident #27 related to incontinence care during the period when he/she could not independently toilet self related to the fractured foot. Interview, on 05/09/12 at 10:00 AM, with Registered Nurse/RN/MDS Coordinator #2, revealed she had completed the Care Plan for Resident #27 dated 02/24/12. She stated she reviewed the chart and interviewed staff at the time she was developing the Care Plan. However, she relied on the interview with the resident who was alert and oriented and informed her he/she did not want staff to check on her/him every two (2) hours due to the resident being aware of the need to toilet. Continued interview revealed she could see how the interventions on the Care Plan were contradictory; however, what she was trying to convey on the Care Plan was the resident did not feel the need to be checked for incontinence. She stated the resident was to be toileted as needed and was to ring the bell when needing assistance.	F 279	Please see attachment 6.18.12	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185146		C 05/11/2012

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F 280	Continued From page 37 incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review it was determined the facility failed to review and revise the comprehensive plan of care for two (2) of forty-five (45) sampled residents (Residents #19 and #36) related to the residents being on contact isolation precautions. The findings include: Review of the facility's policy titled, "Care Plans", dated 01/04/12, revealed a comprehensive care plan would be developed that was consistent with the resident's specific conditions. The policy also revealed the facility would monitor the resident's condition and the effectiveness of the care plan	F 280	Please see attachment 6.18.12	

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	185146	A. BUILDING B. WING	C 05/11/2012

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F 280	Continued From page 38 interventions and would revise the care plan quarterly, annually, with any significant change assessment, or as needed and it would reflect current professional practice standards and have treatment objectives with measurable outcomes. 1. Observation of Resident #19, on 03/27/12, at 12:15 PM, revealed an isolation supply sleeve hanging on the bedroom door. The supply sleeve contained masks, gowns and gloves. Further observation revealed a sign in the sleeve stating to check at the nurses' station prior to entering the resident's room. Review of Resident #19's medical record revealed the facility admitted the resident on 12/11/09, with diagnoses which included Chronic Obstructive Pulmonary Disease (COPD), Fibromyalgia and Depression. Review of the laboratory reports for Resident #19, revealed a urine culture report dated 03/01/12, which was positive for Methicillin Resistant Staphylococcus Aureus (MRSA). A review of the Physician's orders revealed a telephone Physician's order, dated 03/01/12, for the resident to take Bactrim DS (antibiotic) twice daily orally for seven (7) days. Resident #19 was placed on contact isolation precautions on 03/01/12. The resident had a repeat urine culture, dated 03/19/12, which was not positive for MRSA. However the resident remained on isolation precautions. Review of the most recent quarterly Minimum Data Set (MDS) Assessment, dated 01/26/12, revealed the facility had assessed the resident to be continent of both bowel and bladder and	F 280	Please see Attachment 6.18.12	

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F 280	Continued From page 39 required the extensive assistance of two (2) persons to toilet. A review of the comprehensive plan of care for Resident #19, dated 09/01/11, revealed no documented evidence the care plan was revised to address the isolation precaution interventions when the resident was placed on isolation precautions on 03/01/12. Review of the Certified Nursing Assistant (CNA) assignment sheet also did not identify what isolation precautions were suppose to be in place for Resident #19. An interview conducted with CNA #10, who was assigned to provide care for Resident #19 on 03/27/12, revealed she was unaware of what isolation precautions were required for the resident. CNA #10 stated she utilized the CNA assignment sheet for the information regarding the required care for each resident. CNA #10 stated she did not routinely work on the C Wing and was not sure what precautions were suppose to be used for Resident #19. The CNA stated the information was not on her CNA assignment sheet. However, observation of the door to the resident's room revealed a sign stating that staff/visitors should check with the nurse before entering the resident's room and the isolation cart was observed in the hallway outside the resident's room. An interview conducted with the Unit Manager for the 300 Unit, (the unit where Resident #19 resided), on 03/29/12 at 1:20 PM, revealed Resident #19 was suppose to be on contact precautions and the staff was expected to wear gloves and should also wear a gown if coming into contact with urine. During further interview,	F 280	Please see attachment 6.18.12	

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F 280	Continued From page 40 the Unit Manager stated interventions should have been placed on the resident's care plan as well as on the CNA assignment sheet related to the resident being on contact isolation precautions. The Unit Manager stated either she or the Supervisor was responsible for updating the CNA assignment sheet as well as the care plan. She stated she was responsible to make rounds several times daily to ensure residents were being provided the care they required. An interview conducted with the ADON, who was covering for the Director of Nursing (DON), on 03/29/12, at 1:25 PM, revealed she made rounds daily to ensure the residents in the facility were being provided the care they required. The ADON stated the comprehensive care plan should have had interventions regarding Resident #19 being in isolation and the precautions should have been on the CNA assignment sheet. Per interview with the Unit Manager, on 03/29/12 at 1:20 PM and the ADON, on 03/29/12 at 1:25 PM, Resident #19 should have been taken out of isolation on 03/19/12 when the repeat urine culture was negative for MRSA; however, Resident #19's isolation precautions were discontinued on 03/27/12 after surveyor intervention. 2. Review of Resident #36's medical record revealed the facility admitted Resident #36 on 01/10/12, with diagnoses which included Mental Retardation, Schizophrenia, and Acute Respiratory Failure. The facility assessed Resident #36, in a Significant Change Minimum Data Set (MDS) Assessment, dated 03/14/12, as an eight of fifteen (8/15) on the Brief Interview of Mental Status (BIMS), which indicated the	F 280	Please see attachment 6.18.12	

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F 280	Continued From page 41 resident was moderately cognitively impaired. Further review of Resident #36's medical record revealed he/she was admitted to a hospital on 03/25/12, and was discharged back to the facility on 04/02/12 with a diagnosis of Sepsis secondary to MRSA/aspiration pneumonia. Observations of Resident #36 during the course of the survey revealed the facility was following contact precautions for Resident #36. Review of Resident #36's Comprehensive Care Plan, dated 01/20/12, revealed no documented evidence the facility updated the care plan to include contact precautions. Further, review of the CNA Assignment Sheet revealed it was not updated to include contact precautions. An interview with MDS Nurse #2, on 04/19/12 at 10:55 AM, revealed Resident #36 should have had contact precautions revised on his/her care plan. MDS Nurse #2 went on to reveal Resident #36's care plan wasn't revised upon his/her return from the hospital to include contact precautions, and that it should have been. An interview with the Administrator, on 04/19/12 at 3:00 PM, revealed information on contact precautions should have been on the care plan, as well as on the CNA assignment sheets.	F 280	Please see attachment 6.18.12	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced	F 281		

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F 281	Continued From page 42 by: Based on observation, interview, record review, and review of facility's policy it was determined the facility failed to develop an Initial Care Plan to meet the needs of newly admitted residents for two (2) of the forty-five (45) sampled residents (Resident #8 and #34). The facility failed to develop an Initial Care Plan on admission to direct the care for Resident #8 related to a sputum/respiratory infection of Extended Spectrum Beta Lactamase (ESBL)/E. Coli, Contact Precautions and care required for a peripherally inserted central catheter (PICC). The facility failed to develop an initial plan of care for Resident #34's infection of Methicillin Resistant Staphylococcus Aureus (MRSA) in the sputum and a diagnosis of Bacteremia, and Contact Precautions. In addition, the facility failed to develop a specific plan of care related to the use of a Hoyer (mechanical Lift) when providing a shower to Resident #34. The findings include: Review of the facility's policy titled "Care Plans" (POL 605), dated 01/04/12, revealed the Initial Care Plan would be developed within twenty-four (24) hours of admission to address the immediate needs of the resident until the Comprehensive Care Plan was developed. 1. A review of the medical record for Resident #8 revealed the facility admitted the resident on 03/17/12, with diagnoses which included Chronic Obstructive Pulmonary Disease, Atrial Fibrillation/Flutter, Depression, Anxiety, Arthritis	F 281	Please see attachment 6.18.12	

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F 281	Continued From page 43 and Depression. During the acute hospitalization it was determined Resident #8 had positive sputum for Extended Spectrum Beta Lactamase ESBL/E. Coli infection and Contact Precautions were indicated to reduce the transmission of the infection among resident, staff, volunteers, students and visitors. Review of the admission orders revealed Resident #8 was ordered an intravenous antibiotic, Invanz 1 Gram to be administered via the PICC line every morning. Review of the Initial Care Plan, dated 03/17/12, revealed no documented evidence to direct staff of the care required for the peripherally inserted central catheter (PICC) and failed to indicate Resident #8's sputum/respiratory infection of ESBL/E. Coli and the need for Contact Precautions. Interview, on 04/19/12 at 9:10 AM, with Registered Nurse (RN) #2/Unit Coordinator revealed the Initial Care Plans were developed upon admission by the nurse who admitted the resident. RN #2/Unit Coordinator stated the Initial Care Plan should have addressed the PICC line, ESBL/E. Coli infection and the need for contact precautions. Interview, on 04/19/12 at 2:40 PM, with the Director of Nursing (DON) revealed the nurse who admitted a resident to the facility was responsible for the development of the initial care plan. The DON confirmed the initial care plan failed to direct the care for Resident #8 related to contact precautions, ESBL infection, and the care required for a PICC line. Several telephone attempts, on 04/19/12, to	F 281	Please see attachment 6-18-12	

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F 281	Continued From page 44 contact the weekend nurse responsible for admitting Resident #8 were unsuccessful. 2. Review of the medical record revealed the facility admitted Resident #34 from the hospital, on 04/09/12, with diagnoses which included Recent Pneumonia, Morbid Obesity, Diabetes Mellitus, Methicillin Resistant Staphylococcus Aureus (MRSA) in the sputum, and Bacteremia. Review of the Admission Nursing Evaluation, dated 04/09/12, revealed Resident #34 was alert and oriented and had a Brief Interview of Mental Status (BIMS) score of 15/15, required assistance of two (2) for transfer and bed mobility and needed physical help in part of bathing activity. Further record review revealed the facility placed Resident #34 on Contact Precautions to reduce the transmission of infections. Review of Physician's Orders and the Medication Administration Record (MAR), from 04/09/12 through 04/16/12 revealed Resident #34 was ordered and administered an antibiotic, Doxycyline 100 milligrams (04/09/12-04/11/12) and Bactrim (initiated 04/12/12) to be administered twice a day. Observation, on 04/16/12 at 9:00 PM, revealed there was a sign on Resident #34's door directing visitors to report to the nurse's station before entering the room. Additional observation revealed a plastic sleeve with inserts was overhanging the door and contained gloves, masks, and gowns. Interview with CNAs #28 and #33, on 04/20/12 at 3:30 PM, revealed Resident #34 was a large	F 281	Please see attachment 6.18.12	

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F 281	Continued From page 45 person and required the use of a mechanical lift and two CNAs to take the residents to the shower room. Review of an Initial Plan of Care, dated 04/09/12, revealed Resident #34 was to have a shower for personal hygiene. The area on the Initial Plan of Care to describe what was to be done by staff related the resident receiving showers was blank. Review of the CNA Assignment/Flow sheet revealed Resident #34 was to have a shower on Wednesdays and Sundays during the 7 AM-3 PM shift. Additional review of the Initial Care Plan revealed no documented evidence the facility developed a plan of care to direct staff of the care required for Resident #34's sputum/respiratory infection of MRSA and Bacteremia, the resident being on Contact Precautions, or the need to utilize a Hoyer (mechanical lift) to to take Resident #34 to the shower. Interview with the admitting nurse, LPN #10, on 04/16/12 at 9:50 PM, revealed on nights when there were two to three (2-3) admissions it was difficult to get all the paperwork finished, including Initial Plans of Care. Interview, on 04/19/12 at 9:10 AM, with RN #2/Unit Coordinator revealed the Initial Care Plans were developed upon admission by the nurse who admitted the resident. RN #2/Unit Coordinator stated the Initial Care Plan should have addressed the infections, the need for contact precautions and the need for staff to utilize a Hoyer (mechanical lift) to take the resident to the shower. Interview with the Minimum Data Set	F 281	Please See Attachment 6-18-12	

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F 281	Continued From page 46 Coordinators #1, #2 and #3, on 04/19/12 from 10:25 AM through 11:15 AM, revealed it was the responsibility of the nurse who admitted a resident to initiate the initial plan of care. Further interview revealed there were pre-made plans of care for infections and the admitting nurse just needed to fill in what the infection was and if the resident was on any kind of isolation. Additional interview revealed admitting nurse should have described staffs need to utilize a Hoyer (mechanical lift) when giving the resident a shower.	F 281	Please see attachment	6-18-12
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to ensure care was provided in accordance with the written plan of care for three (3) of forty-five (45) sampled residents (Resident #15, #2 and #45). The facility failed to ensure Resident #15's comprehensive plan of care was followed related to turning and repositioning every two (2) hours, and as needed for comfort. Observations of the resident on 03/27/12 revealed the resident was positioned on his/her right side from 12:30 PM to 6:30 PM.	F 282		

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F 282	Continued From page 47 Observation, on 05/07/12 at 5:00 PM, revealed Resident #2 was not transferred from the broda chair to the toilet by the assistance of two (2) as per the plan of care. Resident #45 was not taken to the shower room twice a week per the plan of care. The findings include: Review of the facility's policy titled "Comprehensive Plan of Care", dated 05/28/08, revealed the facility would communicate new or changed care plans to caregivers and ensure any care cues were placed appropriately to remind caregivers of the resident's special needs. 1. Review of the medical record revealed the facility admitted Resident #15, on 04/21/10, with diagnoses which included Late Effects of Spinal Cord Injury, Quadriplegia, Dementia, Hypotension and Deep Vein Thrombosis. A review of the quarterly Minimum Data Set (MDS) Assessment, dated 02/09/12, revealed Resident #15 was severely impaired in his/her cognitive skills. The facility assessed the resident as having a Stage IV pressure ulcer. The resident was assessed as rarely or never making decisions regarding tasks of daily living. Further, review of the MDS revealed Resident #15 was totally dependent on the physical assistance of two (2) staff for bed mobility. Review of the Comprehensive Care Plan, dated 02/15/12, revealed the facility identified the following problem "skin integrity impairment: actual as well as potential for further breakdown, Stage IV coccyx and scar tissue both heels". The	F 282	Please see Attachment	6-18-12

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F 282	Continued From page 48 facility developed and implemented the following intervention for staff to turn and reposition the resident every two (2) hours and as needed for comfort related to presence of skin breakdown upon admission. Further review of the State Registered Nursing Assistant (SRNA) assignment sheet, dated 03/27/12, revealed the resident required the assistance of two (2) staff for bed mobility and transfers; however, it did not indicate how often the staff was to turn and reposition the resident. A review of the Weekly Pressure Ulcer Condition Report for Resident #15, dated 03/21/12, revealed the facility assessed the resident to have a Stage III pressure ulcer to the coccyx and a Stage II pressure ulcer to the right buttock. A review of the Nurse Aide Flow Record, dated 03/27/12, revealed there was no evidence Resident #15 had been turned and repositioned every two (2) hours as required on the resident's comprehensive plan of care. An interview with Resident #15's daughter, 03/27/12 at 6:35 PM and on 03/28/12 at 12:40 PM, revealed she came daily to check on Resident #15. On 03/28/12 at 12:40 PM, the previous night before she left, she asked the staff to come in and turn Resident #15. She stated it was after 8:00 PM when she talked to the staff. She questioned the aides when they came to reposition Resident #15 when he/she had been turned. She stated the aides informed her they did not know when he/she was last turned. Additionally, she voiced she was concerned Resident #15 was not being turned every two (2) hours and did not want the resident to develop	F 282	Please See Attachments	6-12-12

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F 282	Continued From page 49 anymore "bed sores". Observations of Resident #15, on 03/27/12 at 12:30 PM and 1:00 PM, revealed the resident was in his/her bed lying on his/her right side awake and alert. At 3:30 PM and 5:15 PM, Resident #15 was lying on his/her right side sleeping. At 6:35 PM, Resident #15's daughter was in the room feeding him/her and the resident was lying on his/her right side. Observation during a skin assessment with a facility LPN, on 03/28/12 at 11:20 AM, revealed the resident was identified as having an intact blister to the right buttock covered with a dressing. The observation revealed the resident had an intact blister above the left heel. The left heel was noted as discolored and there was an old blister to the left shin. An interview with Certified Nursing Assistant (CNA) #12, on 03/29/12 at 3:30 PM, revealed she was assigned to provide care for Resident #15 on 03/27/12. She stated she was moved to the B-wing to help provide care to the residents. The residents were turned every two (2) hours and she had tried to reposition them every two (2) hours but she was not able to related to completing residents' care needs. She stated she did not turn Resident #15 every two (2) hours and admitted she only turned him/her once when she changed his/her incontinent brief. She revealed she had only turned Resident #15 once during the shift and did not inform her nurse. Additionally, she informed the next shift all of the residents in the section needed to be checked again.	F 282	Please See Attachments	6-18-12

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	185146		C 05/11/2012

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KINDRED TRANSITIONAL CARE & REHAB-FOUNTAIN CIRCLE	200 GLENWAY ROAD WINCHESTER, KY 40391

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F 282	Continued From page 50 An interview with Licensed Practical Nurse (LPN) #2, on 03/29/12 at 3:40 PM, revealed she was the Unit Manager for the B-wing of the facility. The LPN revealed she did three (3) compliance rounds daily during the shift to ensure the residents were being provided the care they required. The LPN stated she monitored to ensure residents were being turned and repositioned during the compliance rounds. She had not identified any problems recently. She had not received any reports from the aides related to not being able to complete their work by the end of their shift. She stated the aides may struggle with completing care timely but it was being completed. She was unaware Resident #15 was turned only once during the day on 03/27/12, but the aides were expected to complete the residents' care according to their plan of care. An interview with the Interim Director of Nursing Service, on 03/29/12 at 6:00 PM, revealed the staff was to provide care according to the residents' written plans of care and what was on the CNA assignment sheet. The aides should be turning Resident #15 every two (2) hours, as per the Plan of Care. 2. Review of Resident #2's medical record revealed diagnoses which included Dementia, Anxiety, Parkinson's Disease and a History of Falls. Review of the Significant Change Minimum Data Set (MDS) Assessment dated 04/03/12 revealed the facility assessed the resident as having moderate impairment in cognitive skills for decision making, as requiring extensive assist by two (2) staff for toileting, and total dependence on two (2) staff for transfers.	F 282	Please see Attachment	6-18-12

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F 282	Continued From page 51 Review of the Care Area Assessment Summary (CAAS), dated 04/09/12, revealed the resident was non-ambulatory, required assistance, was recently admitted to Hospice and was at risk for further decline. Review of the Comprehensive Plan of Care revealed a problem, dated 01/30/09, which stated the resident had an alteration in mobility; positioning, ambulation related to poor balance, nonambulatory status, and weakness. The goal with a target date of 07/14/12 revealed the resident would continued to transfer with the assistance of two (2). The interventions revealed the resident was to be transferred with the assistance of two (2) staff. Observation, on 05/07/12 at 5:00 PM, revealed Certified Nursing Assistant (CNA) #15 assisted Resident #2 from the broda chair to the toilet by having the resident hold on to the grab bar. After the resident had toileted, CNA #15 provided incontinence care and applied briefs while the resident was standing in front of the toilet holding on to the grab bar. The CNA applied the briefs by taping the attends together while the resident was standing and then pulling up the attends. The CNA then pulled the broda chair near the resident and transferred the resident into the broda chair while holding on to the resident. Interview, on 05/07/12 with CNA #15, immediately after the transfer, revealed Resident #2 was a one (1) person transfer and had always been a one (1) person transfer. She stated she referred to her Nurse Aide Assignment Sheet which she carried in her pocket if there was a question	F 282	Please see Attachment	6-18-12

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F 282	Continued From page 52 related to a resident's care. Review of the Nurse Aide Assignment Sheet revealed Resident #2 was incontinent of bowel and bladder and was to be transferred with the assistance of two (2) staff. Interview, on 05/07/12 at 5:30 PM, with Licensed Practical Nurse (LPN) #3/Nurse Manager for the "D" Wing where Resident #2 resided, revealed the CNAs carried the Assignment Sheets in their pockets in order to have a reference to provide care. After review of the Assignment Sheet, she stated Resident #2 required two (2) to assist with transfers. 3. Review of the medical record revealed the facility re-admitted Resident #45 on 03/23/12, with diagnoses which included Pneumonia, Diabetes, Functional Decline After Hospitalization, and Obesity. Review of the Admission MDS, dated 03/30/12, revealed the facility assessed Resident #45 to require extensive assistance of one person for personal hygiene, physical help in part of bathing, and had a BIMS score of 14/15 indicating the resident was cognitively intact. Review of the Care Area Assessment Summary (CAAS), dated 03/30/12, revealed Resident #45 was morbidly obese, had cardiac disorders, was hospitalized due to Pneumonia, had a functional decline and was extensively to totally dependent upon others for his/her daily care needs. Review of Resident #45's Comprehensive Plan of Care, dated 04/09/12, revealed the resident was to be taken to the shower two (2) times per week and as needed. Review of the CNA	F 282	Please see Attachment	6-18-12

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F 282	Continued From page 53 Assignment/Flow Sheet, not dated, revealed Resident #45 was to be taken to the shower room on Mondays and Thursdays during the 7 AM-3 PM shift and to get him/her up by 10:00 AM daily. Observation, on 04/20/12 at 2:00 PM, revealed Resident #45 was sitting up in his/her wheelchair in the dining/activity area of the C-Wing. Interview with Resident #45 at that time revealed he/she should have had a shower early in the morning, but only got a bed bath because he/she did not want to wait to have a shower after 10:00 AM due to wanting to go to activities at 10:00 AM. Resident #45 indicated he/she had to miss getting a shower almost once a week due to staff not being able to take him/her to the shower prior to 10:00 AM. Resident #45 indicated he/she did not feel clean unless he/she had a shower and he/she felt "awful". Review of the Nurse Aide Flow Sheet Record, from 04/01/12 through 04/20/12, revealed Resident #45 only received a shower on two (2) of the scheduled six (6) days. Resident #45 received a shower on Monday, 04/09/12 and 04/16/12, and did not receive a shower on Monday (04/02/12), or Thursdays (04/05/12, 04/12/12, and 04/19/12). Interview with CNAs #28 and #33, on 04/20/12 at 3:30 PM, revealed Resident #45 wanted to take his/her shower earlier in the morning because the resident enjoyed going to the morning group activity and if they didn't have time to take the resident before 10:00 AM, the resident would refuse the shower and would accept a bed bath. Interview with RN #3, on 05/11/12 at 2:15 PM,	F 282	Please See Attachment	6-12-12

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F 282	Continued From page 54 revealed it was difficult for the CNAs starting work at 7:00 AM to give residents a shower because they had to get residents up and ready for breakfast. Further interview revealed if a resident wanted an early morning shower it would have to be given around 6:00 AM. RN #3 indicated Resident #45 should be given a shower twice a week per the plan of care by adjusting the time his/her shower was given.	F 282	Please See Attachment	6-18-12
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy, it was determined the facility failed to ensure residents who were unable to carry out activities of daily living (ADL) received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for two (2) of forty-five (45) sampled residents (Residents #34 and #45). Residents #34 and #45 were assessed by the facility to need physical help with bathing. Residents #34 received a bed bath instead of a scheduled shower on 04/15/12. Resident #45 received bed baths instead of showers for four (4) of the six (6) scheduled shower days in April. The findings include:	F 312		

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F 312	Continued From page 55 Review of facility policy entitled "Activities of Daily Living", revised 01/04/12, revealed Activities of Daily Living include the resident's ability to bathe. Further review of the policy revealed a resident's abilities in activities of daily living should not diminish unless the deterioration was unavoidable. Continued review of the policy revealed a resident's preferences should be respected and reasonable accommodations should be made to maximize the resident's functional abilities. 1. Medical record review revealed Resident #34 was admitted to the facility, on 04/09/12, with diagnoses which included Recent Pneumonia, Morbid Obesity, Diabetes Mellitus, and Gout. Review of the Admission Nursing Evaluation, dated 04/09/12, revealed Resident #34 was alert and oriented and had a Brief Interview of Mental Status (BIMS) score of 15/15, indicating the resident's cognition was intact, required assistance of two (2) for transfer and bed mobility and needed physical help in part of bathing activity. Review of an initial plan of care, dated 04/09/12, revealed Resident #34 was to have a shower for personal hygiene. Review of the Certified Nursing Assistant (CNA) Assignment/Flow sheet revealed Resident #34 was to have a shower on Wednesdays and Sundays during the 7 AM-3 PM shift. During an interview with Resident #34, on 04/17/12 at 3:45 PM, Resident #34 stated he/she did not receive a shower on Sunday (04/15/12) and had only received a bed bath. Resident #34 stated he woke up and smelled something "rank".	F 312	Please See Attachment	6-18-12

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F 312	Continued From page 56 Review of Resident #34's Nurse Aide Flow Sheet Record revealed Resident #34 was scheduled for a shower on 04/15/12, however a bed bath was documented. Interview with CNA #12, on 04/20/12 at 11:40 AM, revealed on Sunday (04/15/12) the first shift did not have time to give the resident a shower and it was probably because he/she was a mechanical lift and they put if off onto second shift. She indicated she did not have time to give the resident a shower on second shift, so she gave the resident a bed bath because that wouldn't take as much time or require the assistance of two (2) CNAs. Interview with CNA #28 and CNA #34, on 04/20/12 at 12:00 PM, revealed Resident #34 had refused a shower during the 7 AM- 3 PM shift on 04/15/12 and stated a bed bath would be fine. Review of NNs and the Nurse Aide Flow Sheet Record, for 04/15/12, revealed no documented evidence Resident #34 had refused a shower. 2. Review of the medical record revealed Resident #45 was re-admitted to the facility, on 03/23/12, with diagnoses which included Pneumonia, Diabetes, Functional Decline After Hospitalization, and Obesity. Review of the Admission MDS, dated 03/30/12, revealed the facility assessed Resident #45 as requiring extensive assistance of one (1) person for personal hygiene, physical help in part of bathing, and had a BIMS score of 14/15, indicating the resident was cognitively intact. Review of the Comprehensive Plan of Care for	F 312	Please see attachment 6-18-12	

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	185146	A. BUILDING ____ B. WING ____	C 05/11/2012

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F 312	Continued From page 57 Resident #45, dated 04/09/12, revealed Resident #45 was to be taken to the shower room two (2) times per week and as needed. Review of the CNA Assignment/Flow Sheet for Resident #45, not dated, revealed Resident #45 was to be taken to the shower room on Mondays and Thursdays during the 7 AM-3 PM shift. Review of Resident #45's Nurse Aide Flow sheet Record, from 04/01/12 through 04/20/12, revealed Resident #45 only received a shower on two (2) of the scheduled six (6) days. Resident #45 received a shower on Monday, 04/09/12 and 04/16/12, and did not receive showers on Monday (04/02/12), or Thursdays (04/05/12, 04/12/12 and 04/19/12). Interview with Resident #45, on 04/20/12 at 2:00 PM, revealed he/she was suppose to have a shower early that morning, but staff was busy giving a shower to another resident and he/she did not want to wait to have a shower after 10:00 AM because he/she wanted to go to the 10:00 AM activity. Resident #45 indicated he/she had missed receiving a shower weekly due to not enough staff in the facility to give him/her a shower in the morning as he/she preferred. Resident #45 indicated he/she did not feel as clean unless he/she had a shower instead of a bed bath. Interview with Registered Nurse (RN) #3, on 05/11/12 at 2:15 PM, revealed Resident #45 needed physical help with getting to the shower and if the resident wanted a shower early in the morning the resident should get the shower per his/her preference.	F 312	Please See Attachment 6-18-12	

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F 312	Continued From page 58 Interview with CNAs #28 and #33, on 04/20/12 at 3:30 PM, revealed Resident #45 wanted to take his/her shower earlier in the morning because the resident enjoyed going to the morning group activity and if they didn't have time to take the resident before 10:00 AM, the resident would refuse the shower and would accept a bed bath. Interview with RN #3, on 05/11/12 at 2:15 PM, revealed Resident #34 and Resident #45 were both a two (2) person assist with bathing and if the CNAs needed help getting the residents to the shower they should let her know and she could have assisted. She indicated Resident #34 should be assisted with getting a shower as scheduled and Resident #45 should be given a shower early in the morning per the resident's preference.	F 312	Please See Attachment 6-18-12	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to ensure the necessary treatment and services were provided for one (1) of forty-five (45)	F 314		

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F 314	Continued From page 59 sampled residents (Resident #15) with pressure sores, to promote healing and prevent new sores from developing. Resident #15 was assessed as having a Stage IV pressure sore and being totally dependent on the physical assistance of two (2) staff for bed mobility. Observations revealed the facility failed to ensure care was provided according to the written plan of care related to turning and repositioning (Refer to F282). The findings include: Review of the medical record revealed the facility admitted Resident #15, on 04/21/10, with diagnoses which included Late Effects of Spinal Cord Injury, Quadriplegia, Dementia, Hypotension and Deep Vein Thrombosis. Review of the quarterly Minimum Data Set (MDS) Assessment, dated 02/09/12, revealed Resident #15 was severely impaired in his/her cognitive skills. The facility assessed the resident as having a Stage IV pressure ulcer to the coccyx measuring four (4) centimeter (cm) by two point two (2.2) cm. The resident was assessed as rarely or never making decisions regarding tasks of daily living. Further, review of the MDS revealed Resident #15 was totally dependent on the physical assistance of two (2) staff for bed mobility. Review of the Comprehensive Care Plan, dated 02/15/12, revealed the facility identified the following problem "skin integrity impairment: actual as well as potential for further breakdown, Stage IV coccyx and scar tissue both heels". The facility developed and implemented the following intervention for staff to turn and reposition the resident every two (2) hours and as needed for comfort related to presence of skin breakdown	F 314	Please See Attachment	6-18-12

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F 314	Continued From page 60 upon admission. A review of the Weekly Pressure Ulcer Condition Report for Resident #15, dated 03/21/12, revealed the facility assessed the resident to have a Stage III pressure ulcer to the coccyx and a Stage II pressure ulcer to the right buttock. Review of the State Registered Nursing Assistant (SRNA) assignment sheet, dated 03/27/12, revealed the resident required the assistance of two (2) staff for bed mobility and transfers; however, it did not indicate how often the staff was to turn and reposition the resident. A review of the Nurse Aide Flow Record, dated 03/27/12, revealed no documented evidence Resident #15 was turned and repositioned every two (2) hours as required on the resident's comprehensive plan of care. An interview with Resident #15's daughter, 03/27/12 at 6:35 PM and on 03/28/12 at 12:40 PM, revealed she came daily to check on Resident #15. On 03/28/12 at 12:40 PM, the previous night before she left, she asked the staff to come in and turn Resident #15. She stated it was after 8:00 PM when she talked to the staff. She questioned the aides when they came to reposition Resident #15 when he/she had been turned. She stated the aides informed her they did not know when he/she was last turned. Additionally, she voiced she was concerned Resident #15 was not being turned every two (2) hours and did not want the resident to develop anymore "bed sores". Observations of Resident #15, on 03/27/12 at	F 314	Please See Attachment	6-18-12

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F 314	Continued From page 61 12:30 PM and 1:00 PM, revealed the resident was in his/her bed lying on his/her right side awake and alert. Observation at 3:30 PM and 5:15 PM, revealed Resident #15 was lying on his/her right side sleeping. Continued observation at 6:35 PM, revealed Resident #15's daughter was in the room feeding him/her and the resident was lying on his/her right side. Observation during a skin assessment with Licensed Practical Nurse (LPN) #12, on 03/28/12 at 11:20 AM, revealed the resident had an intact blister to the right buttock covered with a dressing. The observation revealed the resident had an intact blister above the left heel. The left heel was noted as discolored and there was an old blister to the left shin. An interview with State Registered Nursing Assistant (SRNA) #12, on 03/29/12 at 3:30 PM, revealed she was assigned to provide care for Resident #15 on 03/27/12. She stated she was moved to the B-wing to help provide care to the residents. She stated she tried to reposition Resident #15 every two (2) hours but she was not able to related to completing residents' care needs for her other assigned residents. She stated she did not turn Resident #15 every two (2) hours and admitted she only turned him/her once when she changed his/her incontinent brief. She revealed she had only turned Resident #15 once during the shift and did not inform her nurse. Additionally, she informed the next shift all of the residents in the section needed to be checked again. An interview with LPN #2, on 03/29/12 at 3:40 PM, revealed she was the Unit Manager for the	F 314	Please See Attachment 6-18-12	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185146		C 05/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 314	Continued From page 62 B-wing. LPN #2 revealed she did three (3) compliance rounds daily during the shift to ensure the residents were being provided the care they required and residents were being turned and repositioned. She was unaware Resident #15 was turned only once during the day on 03/27/12, but the aides were expected to complete the residents' care according to their plan of care. Interview with the Interim Director of Nursing Service, on 03/29/12 at 6:00 PM, revealed staff was to provide care according to the residents' written plans of care and the SRNA assignment sheets. The aides should be turning Resident #15 every two (2) hours, as per the Plan of Care because of Resident #15's skin breakdown.	F 314	Please See Attachment	6-18-12
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that 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. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy, it was determined the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and services to restore as much normal bladder	F 315		

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F 315	Continued From page 63 function as possible for one (1) of forty-five (45) sampled residents (Resident #2). Resident #2 had a decline in incontinence according to the Significant Change Minimum Data Set (MDS), dated 03/16/12; however, there was no documented evidence a Bladder Status Evaluation was completed as per policy. The findings include: Review of the facility "Bladder Status Evaluation" Policy, revealed a bladder status evaluation was performed on residents identified as incontinent upon admission/readmission, annually if change in patient condition that affects continent status, significant change of condition that affects continent status, or change in continence status. Review of Resident #2's medical record revealed diagnoses which included History of Fall, Dementia, Anxiety, and Parkinson's Disease. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 01/31/12, revealed the facility assessed the resident as moderately impaired in cognitive skills for decision making, as requiring extensive assistance with one staff for transfers and toileting, and as always continent of bowel and bladder. Review of the Bladder Evaluation, completed 02/17/12, revealed the resident had Functional Incontinence and was placed on a program of prompted voiding and incontinence care. Review of the Bowel Evaluation dated 02/17/12 revealed the resident required two (2) to assist with toileting. Further review revealed the resident was usually continent with occasional episodes of	F 315	Please See Attachment	6-18-12

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F 315	Continued From page 64 incontinence and the voiding pattern record completed 02/19/12 through 02/21/12 revealed the resident was mostly dry, and able to tell the urge to urinate. Review of the Significant Change MDS dated 03/16/12, revealed the facility assessed Resident #2 as moderately impaired in cognitive skills for decision making, requiring extensive assistance of one (1) for toileting and transfers, and frequently incontinent of bowel and bladder. Review of the Nurse Aide Flow Sheets, dated March 2012, revealed the resident was continent of bladder from 03/01/12 through 03/10/12. Further review revealed the resident was incontinent of bladder from 03/11/12 through 03/31/12. Further review revealed there was no documented evidence a Bladder Evaluation was completed with the Significant Change MDS Assessment dated 03/16/12 as per policy even though the Nurse Aide Flow Sheets revealed there was a decline in continence status for March 2012. Review of the Urinary Incontinence Care Area Assessment Summary (CAAS), dated 03/20/12, revealed during the observation period the resident was noted to be totally continent during week #1, incontinent every day with some control during week #2 and wore incontinence products. The CAAS stated staff were to check the resident for incontinence every two (2) hours and as needed as the resident was unable to toilet independently and did not always recognize the urge. Review of the Falls CAAS, dated 03/20/12,	F 315	Please See Attachment	6-18-12

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	185146		C 05/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 315	Continued From page 65 revealed the resident required the extensive assistance of two (2) for transfers. Review of the Comprehensive Plan of Care with a problem date of 01/30/09, revealed the resident had alteration in elimination and required assist with toileting. The interventions included toileting every hour and as needed with the assist of one (1). Interview, on 05/07/12 at 5:30 PM, with Licensed Practical Nurse/LPN #3/Unit Manager where Resident #2 resided, revealed she received calendars with a schedule of when Quarterly, Annual, Initial, and Significant Change MDSs were to be completed. She stated she assigned staff to complete bowel and bladder assessments according to the calendar; however, was unsure if they were to be completed with Significant Change MDS. Interview, on 05/09/12 at 10:45 AM and 05/11/12 at 1:30 PM, with Registered Nurse/ MDS Coordinator #2, revealed she completed the Care Plan for the Significant Change MDS dated 03/16/12 because the resident received a feeding tube on 03/06/12 and became weak after hospitalization. She further stated, she gathered information for developing the Care Plan from resident interviews, staff interviews, Resident Progress Notes and nurse aide flow sheets. Continued interview revealed after review, she felt Resident #2 was a one person assist for toileting at the time the MDS dated 03/16/12 was completed. She confirmed the Care Plan she reviewed and revised for the 03/16/12 MDS stated the resident was to be toileted with one assist every hour and as needed, although the	F 315	Please See Attachment	6-18-12

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	185146		C 05/11/2012

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WINCHESTER, KY 40391

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F 353	Continued From page 67 The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility staffing schedule, it was determined the facility failed to provide sufficient staff to meet the residents' needs in order to maintain or enhance each resident's dignity and respect for five (5) of forty-five (45) sampled residents (Residents #2, #11, #27, #34 and #45). Residents #2, #11 and #27 did not receive prompt assistance with toileting, resulting in incontinent episodes. Residents #34 and #45 did not receive scheduled showers per the plan of care. (Refer to F241)	F 353	Please See Attachment	6-18-12

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	185146		C 05/11/2012

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F 353	Continued From page 68 The findings include: Review of the facility's Skilled Nursing Facility/Nursing Facility Bed Listing, dated 03/27/12, revealed the facility had one hundred and seventy-nine (179) beds. Review of the facility's Census and Condition, dated 03/27/12, revealed the facility's census was one hundred sixty-seven (167). Further review of the Census and Condition revealed the facility had determined there were one hundred and one (101) residents who were occasionally or frequently incontinent of bladder and one hundred and six (106) residents who were occasionally or frequently incontinent of bowel. In addition, twenty (20) residents were bedfast all or most of the time, eighty-three (83) residents were in a chair all or most of the time, forty-two (42) residents ambulated with assistance or assistive devices and only twenty-two (22) residents were independent with ambulation. Interview with the Ombudsman, on 04/20/12 at 4:00 PM, revealed he would get complaints from residents approximately three (3) to four (4) times a week that call bells weren't answered timely. Additional interview revealed it could involve wanting staff to retrieve something off of a shelf to needing assistance with toileting. He stated he had brought the issues to the Administrator's attention and he was told when there were call-ins from Certified Nursing Assistants (CNAs) the facility was able to get coverage as well as have the nurses assist the CNAs. Interview during a Resident Group Meeting, on 03/27/12 at 3:30 PM, revealed Resident #27 and #28 indicated sometimes aides were slow	F 353	Please See Attachment	6-18-12

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F 353	Continued From page 69 answering call bells, especially on the 3:00 PM to 11:00 PM shift. 1. Review of Nurse's Notes, dated 03/31/12 at 2:45 PM, revealed Resident #27 was asked if he/she had a CNA assist him/her to the toilet that morning and the resident stated "No, I had my call light on for a long time and no one came to help me so I put myself on the toilet". Further review of the Nurse's Notes revealed the resident reported the CNA had come once during the night to help, but no one had come that morning. An interview conducted with Resident #27, on 03/29/12 at 1:15 PM, revealed he/she "sometimes" had to wait thirty (30) minutes for staff to respond to his/her call light, and that he/she had incontinent episodes "about every couple of weeks" while waiting on staff to respond. Interview, on 05/09/12 at 2:45 PM, with Certified Nursing Assistant (CNA) #9, who was assigned to Resident #27 on 03/30/12, revealed he was the only CNA when he worked the "D" Wing. Additional interview revealed he had to help with rounds on the Reflections Unit nightly because there was only one CNA on the night shift on the Reflections Unit. Continued interview revealed Licensed Practical Nurse (LPN) #13 usually worked with him and LPN #13 would not answer call bells when the CNA was off the unit. He stated he could hear bells ringing when he was off the unit and did not think it was safe because the bed alarms and call bells were not answered promptly by this nurse. Record review of the data supplied by the	F 353	Please See Attachment	6-18-12

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	185146		C 05/11/2012

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F 353	Continued From page 70 Director of Nursing, on 05/11/12, revealed there were seventeen (17) residents, six (6) residents who required the assistance of two (2) staff to turn and reposition and eleven (11) residents who required the assistance of two (2) staff to transfer on the "D" Wing outside of the Reflections Unit where Resident #27 resided. However, review of the Daily Staffing Sheet for 03/30/12 on the 11PM-7AM shift revealed there was one (1) nurse and one (1) CNA for the "D" Wing outside of the Reflections Unit and the same nurse and one (1) CNA for the Reflections Unit. 2. Interview with Kentucky Medication Assistant (KMA) #1, on 05/10/12 at 4:00 PM, revealed Resident #2 told her, while she was administering medications, to "come here" and informed her that she/he either needed incontinence care or needed to go to the bathroom. Further interview revealed Resident #2 needed assistance of two (2) staff with transfers and he/she was unable to find anyone to assist her with transferring Resident #2 on 02/23/12. Interview with CNA #10, on 03/29/12 at 12:50 PM, revealed she and CNA #9 were assisting an unsampled resident and couldn't get to Resident #2 quick enough. She further stated it took approximately five (5) minutes before they were able to check on Resident #2 and the resident was incontinent of a diarrhea stool. Continued interview revealed Resident #2 needed two (2) to assist with transfer at that time due to her/his legs were wobbly. Interview, on 05/11/12 at 5:15 PM, with the Director of Nursing (DON) revealed if a resident indicated he/she needed to go to the bathroom or	F 353	Please See Attachment	6-18-12

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	185146		C 05/11/2012

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F 353	Continued From page 71 needed incontinence care they would need assistance in a timely manner. She stated could have gone to the "C" wing which was attached to the "D" wing for assistance. 3. Interview with Resident #11, on 03/29/12 at 2:00 PM and on 04/20/12 at 10:45 AM, revealed he/she rang the call light one evening about a month ago (sometime in February) and it took an hour and a half before anyone came to the room and his/her bowels had moved while waiting. Interview with CNA #12, on 04/20/12 at 11:40 AM, revealed Resident #11, as well as other residents on the A-Wing knew what they needed so when they used the call bell staff needed it answered right away. Further interview revealed one evening in February, Resident #11's call bell was going off but it was about thirty (30) minutes before she could get to the resident. Per interview, by the time she got to Resident #11, the resident had a large loose bowel movement. Further interview revealed when one staff person was on break that left only two people to answer call bells. Additional interview revealed she would have to wait until there was another aide available to assist her with a resident who required a two person assistance to the toilet. 4. Interview with Resident #34, on 04/17/12 at 3:45 PM, revealed there wasn't enough staff to get him/her up and take him/her to the shower. During an interview with Resident #34's family, on 04/17/12 at 4:00 PM, the family indicated staff had told them the first shift did not have time to give the resident a shower and the second shift didn't have time to have two (2) CNAs get him/her	F 353	Please See attachment	6-18-12

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	185146		C 05/11/2012

NAME OF PROVIDER OR SUPPLIER
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F 353	Continued From page 72 up with the mechanical lift and take him/her to the shower. Interview with CNA #12, on 04/20/12 at 11:40 AM, revealed the first shift did not have time to give Resident #34 a shower on 04/15/12 and she didn't have time to give the shower on the second shift. Additional interview, on 05/07/12 at 3:00 PM, revealed some CNAs would say or document that a resident had refused a shower because they didn't want to get in trouble. 5. Interview with Resident #45, on 04/20/12 at 2:00 PM, revealed there was not enough staff to give him/her a shower in the morning as he/she preferred. Interview with CNAs #28 and #33, on 04/20/12 at 3:30 PM, revealed sometimes showers couldn't be given during the scheduled first shift. Additional interview revealed if a resident required the use of a mechanical lift with two (2) CNAs to take the residents to the shower room and there were only three (3) CNAs on the unit then this could not always be done. Interview with CNA #6, on 04/16/12 at 9:15 PM, revealed it was difficult to answer the call bells, give showers, assist residents to the toilet, and feed residents with only having three (3) CNAs. Further interview revealed sometimes showers were missed for residents who required a mechanical lift with assistance of two staff. Interview with CNA #26, on 04/18/12 at 3:40 PM, revealed she didn't feel like she had enough time to get everything done and sometimes showers were missed.	F 353	Please See attachment	6-8-12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185146		C 05/11/2012

NAME OF PROVIDER OR SUPPLIER
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F 353	Continued From page 73 An interview with CNA #11, on 04/17/12 at 3:50 PM, revealed she felt resident care suffered as a result of being understaffed. Further interview revealed there really needed to be at least four (4) CNAs on each unit to meet the residents' needs. Additional interview revealed some CNAs worked a lot of overtime and were exhausted and couldn't always meet residents' needs. Interview with CNA #35, on 05/07/12 at 6:00 PM, revealed sometimes she could not promptly answer a resident's call light because of being in a room with another resident and being the only CNA outside the Reflections Unit. She indicated when the state was in the building, the facility would call people in and the staffing would be almost doubled. Interview with the Administrator and Director of Nursing, on 05/08/12 at 4:00 PM, revealed they were like any other skilled nursing facility in the state and would have staff call in sometimes. Further interview revealed they had call ins, but were able to cover each position based on their staffing pattern because they scheduled one to two "extra" staff per shift in anticipation of "call ins". Additional interview revealed they were not aware of resident care needs not being met due to staffing.	F 353	Please See Attachment	6-18-12
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185146		C 05/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE & REHAB-FOUNTAIN CIRCLE	200 GLENWAY ROAD WINCHESTER, KY 40391

(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)	(X6) COMPLETION DATE
F 431	Continued From page 74 records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, it was determined the facility failed to label, date, and store all drugs and biologicals in accordance with currently accepted professional principles. Three (3) vials of Influenza Virus Vaccine, one (1) vial of Tuberculin Purified Protein, and one (1) vial of Novolog Insulin, all	F 431	Please see attachment	6-18-12

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	185146		C 05/11/2012

NAME OF PROVIDER OR SUPPLIER
KINDRED TRANSITIONAL CARE & REHAB-FOUNTAIN CIRCLE

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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 431	Continued From page 75 intended for multi-dose had been opened and were available for use; however, the medications were not labelled and dated to indicate the dates the vials had been opened. One (1) medication cart on "B" Wing was observed to have two pills in a plastic medicine cup in the top drawer containing no identification as to what the medications were nor for which resident they were intended. Two (2) bags of intravenous antibiotics which had been premixed by the pharmacy were observed to be expired. One (1) medication cart on the "A" Wing was observed to have five and one-half (5 1/2) unpackaged pills in the cart and one multi-dose vial of Heparin Sodium with no label to indicate when the vial was opened. The findings include: A review of the facility's policy entitled "Vials and Ampules of Injectable Medications", dated 10/31/10, revealed the fist nurse to use the multi-dose visal was expected to date and initial on the label or an accessory label affixed for that purpose. A review of the facility's policy entitled "Medication Administration", dated 08/31/11, revealed staff was required to dispose of any medication that was prepared but not administered. A review of the facility's policy entitled "Medication Labels and Packaging", dated 10/31/09, revealed medications were to be discarded by the expiration date. 1. Observation on, 03/29/12 at 3:50 PM, of the medication carts and medication room on the "B"	F 431	Please See Attachment	6-18-12

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	185146		C 05/11/2012

NAME OF PROVIDER OR SUPPLIER
KINDRED TRANSITIONAL CARE & REHAB-FOUNTAIN CIRCLE

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F 431	Continued From page 76 Wing/200 Unit, revealed one (1) vial of Influenza Virus Vaccine intended for multi-use had been opened in the refrigerator and was available for use' however the vial was not labeled and dated to indicate the date the vial was opened. Two (2) intravenous bags containing Aztreonam (antibiotic) and normal saline which had been premixed by the pharmacy with an expiration date of 03/23/12 were in the medication room . The "B Wing" cart was observed to have an orange and a pink pill in a plastic medicine cup in the top drawer. An interview conducted with the Licensed Practical Nurse (LPN) #8, on 03/29/12 at 4:00 PM, revealed the LPN stated she was responsible for the "B Wing" cart; however, she had not placed the orange and pink pills in the plastic medicine cup and was unaware of which resident they were intended for. The LPN also stated nurses were not supposed to set medications up and leave them in the medicine cart. LPN #8 stated the medications should have been discarded. The LPN stated she was aware it was the facility's policy to date and initial all multi-use vials of medication when the vial was opened. The LPN stated she only checked medications for outdates when she was ready to administer the medications. An interview with the Unit Manager (UM) for the "B" Wing/200 Unit, on 03/29/12 at 4:10 PM, revealed nurses should not be setting up medications and placing them in the medication cart. The UM also stated she was responsible for checking the refrigerator for all outdated medications and had missed the Aztreonam. The UM revealed it was the policy of the facility to date	F 431	Please See Attachment	6-18-12

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F 431	Continued From page 77 and initial all multi-use vials of medication when the vials were opened. 2. Observation, on 03/29/12 at 4:20 PM, of the "D" Wing/400 Unit medication carts and the medication room revealed two (2) vials of Influenza Virus Vaccine, one (1) vial of Tuberculin Purified Protein, and one (1) vial of Novolog Insulin, intended for multi-use, were opened in the refrigerator, and were available for use; however, the vials were not labeled and dated to indicate the date the vials were opened. An interview conducted, on 03/29/12 at 4:25 PM, with the UM of the "D" Wing/400 Unit, revealed the nurses were required to date and initial all multi-use vials of medication when the medication was opened. The UM revealed it was her responsibility to monitor to ensure the nurses were dating and initialing all opened vials of medications. The UM also revealed she was responsible for monitoring the medication room for outdated medications. 3. Observations on the "A" Wing/100 Unit, on 03/29/12 at 5:00 PM, revealed a multi-dose vial of Heparin Sodium with no label to indicate when the vial was opened and put into service. Further observation of the medication cart revealed five and one-half (5 1/2) unpackaged pills were loose in the drawer. An interview with LPN #8, on 03/29/12 at 5:15 PM, revealed nurses were to label all multi-dose vials when opened and discard any unpackaged pills that were found in the cart. An interview conducted, on 03/29/12 at 5:00 PM,	F 431	Please See Attachment	6-18-12

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F 431	Continued From page 78 with the Assistant Director of Nursing (ADON) revealed nurses were expected to discard any medications that were taken out of the package and not administered to the resident. The ADON also stated the nurse was expected to date and initial any multi-use vial of medication after opening the vial. The ADON further revealed the UM's were responsible for checking the medication rooms for any outdated medications and sending them back to the pharmacy.	F 431	Please See Attachment	6-18-12
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.	F 441		

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F 441	Continued From page 79 (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to maintain an infection control program to ensure a safe, sanitary environment and to help prevent the development and transmission of disease and infection for three (3) out of forty-five (45) sampled residents (Residents #8, #2 and #35). The facility failed to ensure appropriate technique was used for Resident #8 who was on contact precautions. The facility failed to ensure contract staff washed hands prior to changing gloves during resident care when Staff did not follow proper handwashing techniques after providing care to Resident #2. The facility failed to ensure proper handwashing techniques were followed by a Speech Therapist during treatment and care of Resident #35. The facility failed to ensure a housekeeping sanitized resident's bathroom sinks utilizing the appropriate sanitizer to prevent spread of infection. The facility failed to ensure sanitary conditions of medications as several medication carts were observed to be soiled and	F 441	Please See Attachment	6-18-12

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F 441	Continued From page 80 contain pill residue/debris. The findings include: A review of the facility's "Infection Control Policy", dated 10/31/09, revealed the facility had procedures to explain how to use Standard and Transmission Based Precautions and to communicate information about residents with potentially transmissible infectious agents. According to the Contact Precautions policy/procedure the use of a gowns and gloves were required when entering the resident's room. Review of the Disease Specific Information policy for Extended Spectrum Beta Lactamase (ESBL), dated 04/28/10, revealed Contact Precautions were required during any provision of care for a resident that tested positive for ESBL. Review of the facility's policy entitled "Procedures for Infection Control", dated 01/01/2000, revealed housekeeping staff were to use an effective quaternary germicidal solution to clean all resident areas. Additional review of the policy revealed staff were to wash hands between changing gloves. Review of the facility's "Hand Hygiene/Handwashing" Policy, revised 08/31/11, revealed handwashing was the single most important procedure for preventing the spread of infection. Hand hygiene was to be performed after assisting with toileting, intermittently after gloves were removed, between patient contacts, and when otherwise indicated to avoid transfer of microorganisms to other patient or environments. 1. A review of the medical record for Resident #8	F 441	Please See Attachment	6-18-12

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F 441	Continued From page 81 revealed the facility admitted the resident on 03/17/12 with diagnoses that included Chronic Obstructive Pulmonary Disease, Atrial Fibrillation/Flutter, Depression, Anxiety, Arthritis and Depression. Upon admission the facility determined Resident #8 required Contact Precautions related to a positive sputum for ESBL/E. Coli infection. Observations of Resident #8, on 03/27/12 at 10:40 AM, revealed an isolation supply pack hanging on the resident's room door that contained gowns, gloves, and masks and a sign informing "Visitors and Personnel speak to the Nurse". On the other side of the sign staff were directed to wear gowns and gloves during care if coming into direct contact with the resident. Observations of Registered Nurse (RN) #1, on 03/28/12 at 12:40 PM, revealed RN #1 performed a complete body skin assessment. RN #1 was observed to utilize only gloves and did not don a protective gown. An interview with RN #1, at 1:00 PM on 03/28/12, revealed the RN was aware of the contact precautions for Resident #8, but according to RN #1 since the resident didn't have a catheter or anything, she didn't wear a gown. An interview with the "A" Wing Unit Manager (UM), on 03/29/12 at 1:20 PM, revealed contact precautions meant the staff were to wear gloves for all contact and a gown if in close contact, within three (3) feet of the resident. The UM stated RN #1 should have worn a gown when completing the skin assessment. An interview with the Assistant Director of Nursing (ADON), on 03/29/12 at 2:10 PM, revealed the	F 441	Please See Attachment	6-18-12

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

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FORM APPROVED
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F 441	Continued From page 82 nursing supervisors were responsible to monitor the staff to ensure appropriate techniques for contact precautions were utilized. According to the ADON, "We all make rounds to see if everything is okay and we tell the nurse in charge of the unit if something is wrong". The ADON further stated there was no documentation of these supervisory rounds to ensure care delivery. 2. Observation, on 05/07/12 at 5:00 PM, revealed Certified Nursing Assistant (CNA) #15 removed Resident #2's soiled attends and placed them in a plastic bag, then provided incontinence care for Resident #2 by cleansing the perineal area and buttocks with a wet wash cloth. She then placed the soiled wash cloth in a plastic bag. After applying a new attends and pulling up the resident's pants, she assisted the resident to the broda chair. The CNA then picked up the two (2) plastic bags and tied them, and removed her gloves and discarded them. Further observation, revealed the CNA pushed the resident in the broda chair out of the bathroom and into the hall while holding the bags. The CNA then opened the soiled utility room and placed the two (2) plastic bags in a hamper. She then walked out of the soiled utility room and into Room 403 to wash her hands at the sink. Interview, on 05/07/12 immediately after the observation, with CNA #15 revealed she usually washed her hands after she placed the soiled wash cloths and soiled attends in the soiled utility room. Interview, on 05/07/12 at 5:30 PM, with Licensed Practical Nurse (LPN) #3/ Nurse Manager of the "D" Wing where Resident #2 resided, revealed	F 441	Please See Attachment	6-18-12

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F 441	Continued From page 83 CNA #15 should have washed her hands immediately after removing the soiled gloves. 3. Observation, on 04/17/12 at 11:30 AM, revealed Speech Therapist (ST) #1 entered Resident #35's room after HSK #1 had "cleaned" the bathroom between Resident #35's and Resident #34's rooms. Further observation revealed ST #1 put on a pair of gloves after entering the room and attempted to wake Resident #35 up by calling the resident's name and gently stroking the side of his face with her gloved hand. ST #1 removed her gloves and put on a new pair of gloves without washing or sanitizing her hands. She went to a cart in the hall, which contained clean towels and wash clothes, obtained a towel and re-entered Resident #35's room, went to the bathroom sink turned the faucet on with her gloved hand and proceeded to wet a portion of the towel as another portion of the towel touched the sink. ST #1 utilized the warm wet towel to wipe around Resident #35's face, placed the towel on the bedside table and changed her gloves without washing or sanitizing her hands. ST #1 assisted a CNA to place Resident #35 in his/her wheelchair, opened a closet door, opened drawers and then gently stroked Resident #35's face with the same gloved hand. She pushed the resident to the dining room, fed Resident #35 his/her thickened liquid by placing her gloved hand around the rim of the glass, touched the resident's cloth napkin and then wiped the resident's face all with the same gloved hand. Interview with ST #1, on 04/17/12 at 12:10 PM, revealed she utilized gloves frequently to prevent the spread of infection. She indicated she was	F 441	Please See Attachment	6-18-12

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F 441	Continued From page 84 aware hands were supposed to be washed between changes gloves and thought she inadvertently did not wash her hands between changing gloves. Review of ST's training/inservice log revealed ST #1 was inserviced related to infection control at the facility on 09/14/11. Interview with the Director of Nursing/Infection Control Nurse, on 04/19/12 at 3:00 PM, revealed she made rounds to monitor nursing staff was following proper infection control practices, but did not monitor ancillary staff, such as housekeeping or contract therapy services to ensure they were following proper infection control practices. 4. Observation of one (1) medication cart on "A" wing, two (2) medication carts on "B" wing and one (1) medication cart on "C" wing revealed several drawers with pill residue, soil and debris inside. An interview with LPN #9, on 03/29/12 at 5:15 PM, revealed nurses were to clean the medication carts at the end of each shift, but there was no specific schedule for "deep" cleaning. An interview with the ADON, on 03/29/12 at 5:30 PM, revealed there was no policy or schedule related to cleaning/sanitizing the medication carts. 5. Observation, on 04/17/12 from 10:00 AM until 11:15 AM, revealed Housekeeper (HSK) #1 cleaned the toilets and rails around the toilets of	F 441	Please See Attachment	6-18-12

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F 441	Continued From page 85 the four South Hall resident bathrooms of the A-Wing Rehab Unit a 'Quat Disinfectant Cleaner'. Additional observation revealed HSK #1 cleaned the bathroom sinks and faucets with a bottle of 'Country Day Scent'. Interview with HSK #1, on 04/17/12 at 11:15 AM, revealed she had been employed at the facility for five months and had always utilized the 'Quat Disinfectant Clean' to clean the toilets and rails around the toilets, and utilized a "deodorizer/sanitizer" (Country Day Scent) to clean the sink and faucets. Review of the "Country Day Scent" Material Safety Data Sheets (MSDS) as well as the manufactures instructions revealed it was a long lasting deodorizer and did not contain any products to clean or sanitize. Interview with the Housekeeping Director, on 04/18/12 at 1:30 PM, revealed HSK staff was to utilize the Quat Disinfectant Cleaner on all areas of the bathroom to ensure the area was disinfected thoroughly to prevent the spread of infection. Further interview revealed he made periodic rounds on the units to ensure staff were cleaning and disinfecting properly, but did not document any of these rounds. Additional interview revealed he had not identified any concerns with staff utilizing the wrong product. Interview with the Director of Nursing/Infection Control Nurse, on 04/19/12 at 3:00 PM, revealed the HSK Director was responsible for ensuring HSK staff utilized the proper sanitizer to disinfect and clean the bathrooms and the Country Day Scent was only to be used as an air freshener,	F 441	Please See Attachment	6-18-12

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F 441	Continued From page 86 not as a disinfectant.	F 441		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure the clinical records for two (2) of forty-five (45) sampled residents (Residents #8 and #32) were accurately documented. Resident #8's record revealed a change of condition and treatment related to a Stage II pressure ulcer, however, Resident #8, did not have a pressure ulcer. Resident #32 had a monthly Physician's order for Norvasc (blood pressure medication) on the orders dated 03/01/12, however, the resident had a telephone Physician's order dated 12/06/11 to discontinue the Norvasc. The findings include: 1. Review of the medical record for Resident #8	F 514	Please See Attachment	6-18-12

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F 514	Continued From page 87 revealed the facility admitted the resident to the facility, on 03/17/12, with no pressure areas identified. A review of the Braden Scale evaluation completed on 03/17/12 and 03/26/12 identified Resident #8 as having "no risk" factors for pressure sore development. Further review of the medical record revealed a Physician's order and change of condition form dated 03/26/12, "Stage II Coccyx - cleanse with normal saline, pat dry and apply mepilex border, change every three (3) days and as needed." Review of the Treatment Administration Record (TAR) for Resident #8 revealed the treatment order was transcribed on 03/27/12 and had been initialed as done on 03/27/12. Further review of the medical record revealed the change of condition and Physician's order forms were actually for another resident and not Resident #8. A complete skin assessment was performed for Resident #8, on 03/28/12 at 12:45 PM, which revealed there was no Stage II pressure ulcer on the resident's coccyx. An interview with Licensed Practical Nurse (LPN) #7, on 03/29/12 at 3:35 PM, revealed the LPN did not administer treatment to Resident #8's coccyx on 03/27/12. LPN #7 stated he was on duty on 03/27/12 on day shift until lunch time when he left due to illness. An interview with the "A" Wing Unit Manager, (UM), on 03/29/12 at 3:20 PM, revealed the UM was unaware the order written on Resident #8's medical record was actually for a different resident. The UM stated, "I don't know how that happened and I don't recognize the handwriting". The UM further stated the nurse's initials on the	F 514	Please see Attachment	6-18-12

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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)	(X6) COMPLETION DATE
F 514	Continued From page 88 treatment record look like LPN #7's but he was off work with illness. 2. Observation of LPN #4 administering medications, on 03/28/12 at 9:55 AM, revealed LPN #4 administered the morning medications to Resident #32. Review of the Medication Administration Record (MAR) for Resident #32 revealed Norvasc five (5) milligrams orally to be administered daily had been discontinued on 12/06/11. A review of the medical record for Resident #32 revealed a monthly Physician's order for Norvasc five (5) milligrams orally to be administered every day; however, review of a Physician's telephone order, dated 12/06/11, revealed an order to discontinue the Norvasc. Interview conducted, on 03/28/12 at 1:00 PM, with LPN #4, revealed the LPN was also responsible for putting all telephone Physician's orders into the computer. LPN #4 stated after she put the orders into the computer the information then generated the monthly Physician's orders . The LPN stated it was then the responsibility of the Unit Manager (UM) to check the monthly Physician's orders for accuracy. Interview with the UM for the "B" Wing/200 Unit, on 03/29/12 at 10:25 AM, revealed she was responsible for checking the monthly Physician's orders for accuracy. The UM revealed the order for Norvasc for Resident #32 had been discontinued on 12/06/11; however, had been on the monthly Physician's orders for January and March 2012, but was not on the February 2012 orders. The UM stated it was an oversight. Interview with the Assistant Director of Nursing	F 514	Please see attachment	6.18.12

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

PRINTED: 05/25/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185146		C 05/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE & REHAB-FOUNTAIN CIRCLE	200 GLENWAY ROAD WINCHESTER, KY 40391

(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 514	Continued From page 89 (ADON) #2, on 03/29/12 at 1:00 PM, revealed it was the responsibility of the UM to check the accuracy of the monthly Physician's orders. The ADON stated the UMs were responsible for comparing the current MAR with the monthly Physician's orders and the telephone Physician's orders. The ADON stated the facility had not identified any problems with the monthly Physician's orders prior to this.	F 514	Please See Attachment	6-18-12

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Fountain Circle Health and Rehabilitation
Plan of Correction for Survey Exit 5/11/12
Attachment

K072

Cart storage/equipment areas have been identified on each unit to store all carts and lifts when not in use for resident care to ensure there are no obstructions or impediments in egress.

A facility wide in-service was conducted, by the Staff development Coordinator (SDC) on 6/7/12 through 6/16/12, for all employees to educate them on the cart/equipment storage.

Three (3) audits per week, times one month, then weekly for two months will be done by the Maintenance Director or Assistant Executive Director to observe that means of egress are clear through out the facility. Any concerns identified will be corrected immediately.

The audits will be brought to the Performance Improvement Committee (PIC) which includes the Executive Director (ED), Assistant Executive Director (AED), Director of Nursing (DON), Assistant Director of Nursing (ADON), Unit Managers, Social Service Director (SS), Registered Dietitian (RD), Activities Director (AD) Maintenance Director, Staff Development Coordinator (SDC), Dietary Manager, Certified Dementia Practitioner (CDP), Medical Director (MD) Case Manager (CM) every month for the next three months. Action plans will be developed and implemented as indicated. The PIC will determine if further action is needed.

F166

Resident #27 was visited by the social worker 6/1/12 to assess for any unresolved grievances. Resident #27 voiced no concerns and has no unresolved grievances.

Unit managers, Dietary manager, Medical Records, Supply Clerk, Activities Director, Activities assistants, Certified Dementia Practitioner, Social Services and Admissions Coordinator will ask all residents by 6/16 /12 during Angel Care rounds, if they have any grievances that they need to report. Residents will also be encouraged to voice any concerns they may have to any facility staff. Any grievances will be forwarded to the Executive Director for follow-up in the morning stand up meeting.

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JUN - 6 2012
BY:

The Staff Development Coordinator will in-service all staff on the grievance process on 6/7/2012.

Grievances will be tracked and trended by the Social Service Director on a monthly basis through the Performance Improvement Committee (PIC). The Performance Improvement Committee (PIC) which includes the Executive Director (ED), Assistant Executive Director (AED), Director of Nursing (DON), Assistant Director of Nursing (ADON), Unit Managers, Social Service Director (SS), Registered Dietitian (RD), Activities Director (AD) Maintenance Director, Staff Development Coordinator (SDC), Dietary Manager, Certified Dementia Practitioner (CDP), Medical Director (MD) Case Manager (CM). Action plans will be developed and implemented as indicated. The audits will be reviewed in the monthly PIC for three months and as needed there after.

F241

The facility initiated an investigation immediately upon resident's report of the allegation of not receiving incontinence care for resident #2. This resident has no skin breakdown and is receiving continence care for bowel and bladder.

Resident #11 was discharged on 5/10/12.

The facility has encouraged resident #27 to ask for assistance before the urge to void is strong, secondary to history of incontinence. She continues to receive detrol LA 4 mg.
This resident has no skin breakdown and staff is responding timely to her call bell to prevent incontinence.

Resident #34 was discharged on 5/10/12.

The shower time for resident #45 has been changed to ensure she is up and ready by 10:00 am for morning activities per her request and she is receiving her shower as scheduled.

The Unit managers, Dietary manager, Medical Records, Supply Clerk, Activities Director, Activities assistants, Certified Dementia Practitioner, Social Services, and Admissions Coordinator will conduct interviews of all current interviewable residents as indicated by a BIMS score of 12-15 and or legal representatives of non-interviewable residents, by 6/16/12 related to whether they have unresolved concerns involving "dignity and respect in provision of care" in terms of staff treatment of residents and the provision of care. Any concerns identified as a result of the interviews will be addressed on a grievance form and followed up on by the

Social Worker.

The Staff Development Coordinator conducted an in-service on 6/7/12 through 6/16/12 with all staff on resident dignity and respect with an emphasis on addressing residents receiving timely incontinence care, toileting, showers, and response to call lights. All new hires will receive the information regarding the facility policy related to Resident Rights, Dignity and Respect.

Grievances will be tracked and trended by the Social Service Director 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 there after.

F246

The shower time for resident #45 has been changed to ensure she is up and ready by 10:00 am for morning activities per her request and she is receiving her showers as scheduled.

The Unit managers, Dietary manager, Medical Records, Supply Clerk, Activities Director, Activities assistants, Certified Dementia Practitioner, Social Services, and Admissions Coordinator will conduct interviews of all current interviewable residents as indicated by a BIMS score of 12-15 and or legal representatives of non interviewable residents, by 6/16/12 related to whether they have unresolved concerns involving "accommodation of individual needs and preference" in terms of staff treatment of residents. Any concerns identified as a result of the interviews will be addressed on a grievance form and followed up on by the Social Worker.

The Staff Development Coordinator conducted an in-service with all staff on 6/7/12 through 6/16/12 on accommodations of needs and preference with an emphasis on addressing accommodating the resident's needs and preferences.

All new hires will receive the information regarding the facility policy related to accommodation of needs and preferences.

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Any identified accommodation, needs, or preference concerns identified will be followed up on by the Social Worker . Concerns will be tracked and trended by the Social Service Director 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 there after.

F279

A comprehensive care plan was developed for resident #8 related to her VRE and the contact precautions on 4/4/12.

Resident #11 was discharged on 5/10/12.

A comprehensive care plan was developed for resident #2 related to a need of assistance of two with toileting on 4/16/12.

A comprehensive care plan was developed for resident # 27's toileting needs on 5/24/12.

All residents with multi drug resistant organisms and those requiring two person assists with toileting will have chart reviews done by the MDS nurses and develop a comprehensive care plan to include their specific care need. The Minimum Data Set nurses will complete audits and will develop a comprehensive care plan if indicated by 6/16/12.

All MD orders will be bought to the daily clinical meeting Monday through Friday for review of the MD order by DNS, ADON, or UMs as well as to check for care plan updates.

The Staff Development Coordinator conducted an in-service all Licensed Nurses on the developing comprehensive care plans on 6/7/12 through 6/16/12.

Each month the unit managers will audit 5 residents on each unit to validate for a comprehensive care plan for three months then as needed.

The audits will be brought to the Performance Improvement Committee (PIC) which includes the Executive Director (ED), Assistant Executive Director (AED), Director of Nursing (DON), Assistant Director of Nursing (ADON), Unit Managers, Social Service Director (SS), Registered Dietitian (RD), Activities Director (AD) Maintenance Director, Staff Development Coordinator (SDC), Dietary Manager, Certified Dementia Practitioner (CDP), Medical Director (MD) Case Manager (CM) every month for the next three months, and thereafter as needed. The PIC will determine if further action is needed.

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F280

Resident # 19 is no longer on precautions related to MRSA as of 3/27/12.

Resident #36's care plan was revised to include contact precautions on 4/19/12 Certified Nursing Assistants (CNA) assignment sheet was revised to include contact precautions. 4/19/12.

All residents with multi drug resistant organisms will have chart reviews done by the MDS nurses and revisions will be made to the care plans to include their specific precautions indicated. The Minimum Data Set nurses will update any identified care plans by 6/16/12.

All residents with multi drug resistant organisms will have their CNA assignment sheets reviewed and revised to include their specific precautions needed. The Unit Managers will update any identified revisions needed on the CNA assignment sheets by 6/16/12.

The Staff Development Coordinator conducted an in-service with all Licensed Nurses on the review and revisions of the care plans and Nurse Aide Assignment sheets on 6/7/12 through 6/16/12.

New physician orders and corresponding care plan updates will be brought to the daily clinical meeting for review by DNS and ADON and validate revision. New admits and readmitted resident charts will be brought to the daily clinical meeting for review by DNS, ADON, and UM to validate revisions and any new precautions.

Each month the unit managers will audit 5 residents on each unit to validate care plan revision for three months then as needed.

The audits will be brought to the Performance Improvement Committee (PIC) which includes the Executive Director (ED), Assistant Executive Director (AED), Director of Nursing (DON), Assistant Director of Nursing (ADON), Unit Managers, Social Service Director (SS), Registered Dietitian (RD), Activities Director (AD) Maintenance Director, Staff Development Coordinator (SDC), Dietary Manager, Certified Dementia Practitioner (CDP), Medical Director (MD) Case Manager (CM) every month for the next three months, and thereafter as needed. The PIC will determine if further action is needed.

F281

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A care plan was developed for Resident #8 related to her ESBL and the contact precautions on 4/4/12. The PICC was discontinued on 5/21/12.

Resident #34 was discharged on 5/10/12.

The UMs will conduct an audit of initial care plans for accuracy and completeness weekly times three months.

The SDC has conducted an in-service between 6/7/12 through 6/16/12 with the licensed nurses on developing initial care plans and on resident dignity and respect with an emphasis on addressing residents receiving timely incontinence care, toileting, showers, and response to call lights. All new hires will receive the information regarding the facility policy related to care plans and assignment sheets.

The audits will be brought to the Performance Improvement Committee (PIC) which includes the Executive Director (ED), Assistant Executive Director (AED), Director of Nursing (DON), Assistant Director of Nursing (ADON), Unit Managers, Social Service Director (SS), Registered Dietitian (RD), Activities Director (AD) Maintenance Director, Staff Development Coordinator (SDC), Dietary Manager, Certified Dementia Practitioner (CDP), Medical Director (MD) Case Manager (CM) every month for the next three months, and as needed thereafter. The PIC will determine if further action is needed.

F282

Resident #15 is turned and repositioned every two hours and as need for comfort per her plan of care.

Resident #2 is now being transferred with the assistance of two aides as per her plan of care 4/16/12.

Resident #45's shower time has been adjusted per her preference and updated on her assignment sheet. She is receiving showers per her plan of care.
The shower time for resident #45 has been changed to ensure she is up and ready by 10:00 am for morning activities per her request.

The Unit managers, Dietary manager, Medical Records, Supply Clerk, Activities Director, Activities assistants, Certified Dementia Practitioner, Social Services and Admissions Coordinator will conduct interviews of all current interviewable residents as indicated by a BIM's score of 12 to 15 and or legal representatives non interviewable by 6/16/12 related to services rendered to ensure care is provided in accordance with the care plan.

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The Staff Development Coordinator conducted an in-service between 6/7/12 through 6/16/12 for all State Registered Nursing Assistants and Licensed staff on providing resident care per the Nursing Assistant assignment sheets and following the care plan.

The MDS nurses will audit three (3) residents total each week to validate accuracy of care plans for three months.

The Unit managers, Dietary manager, Medical Records, Supply Clerk, Activities Director, Activities assistants, Certified Dementia Practitioner, Social Services and Admissions Coordinator will conduct interviews of all current residents and or legal representatives between on 6/7/12 through 6/16/12 related to whether they have unresolved concerns involving "dignity and respect" in terms of staff treatment of residents.
Any concerns identified as a result of the interviews will be addressed per the facility policies, including.

.The audits will be brought to the Performance Improvement Committee (PIC) which includes the Executive Director (ED), Assistant Executive Director (AED), Director of Nursing (DON), Assistant Director of Nursing (ADON), Unit Managers, Social Service Director (SS), Registered Dietitian (RD), Activities Director (AD) Maintenance Director, Staff Development Coordinator (SDC), Dietary Manager, Certified Dementia Practitioner (CDP), Medical Director (MD) Case Manager (CM) every month for the next three months, and as needed thereafter. The PIC will determine if further action is needed.

F312

Resident # 34 was discharged on 5/10/12.

The shower time for resident #45 has been changed to ensure she is up and ready by 10:00 am for morning activities per her request. Showers are being given per her request.

The Unit managers, Dietary manager, Medical Records, Supply Clerk, Activities Director, Activities assistants, Certified Dementia Practitioner, Social Services and Admissions Coordinator will conduct interviews/audits of all current interviewable residents as indicated by a BIM's score of 12 to 15 and or legal representatives of non interviewable 6/16/12 related to if residents are receiving necessary services to maintain good nutrition, grooming and personal and oral hygiene.

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The Staff Development Coordinator conducted an in-service with the nursing staff between 6/7/12 through 6/16/12 on if residents are receiving necessary services to maintain good nutrition, grooming, personal and oral hygiene.

A daily shower audit of each unit will be done by the Unit Managers, Monday through Friday and by the Weekend Supervisor on the weekends for four weeks, then twice weekly for four weeks then weekly for four weeks.

The audits will be brought to the Performance Improvement Committee (PIC) which includes the Executive Director (ED), Assistant Executive Director (AED), Director of Nursing (DON), Assistant Director of Nursing (ADON), Unit Managers, Social Service Director (SS), Registered Dietitian (RD), Activities Director (AD) Maintenance Director, Staff Development Coordinator (SDC), Dietary Manager, Certified Dementia Practitioner (CDP), Medical Director (MD) Case Manager (CM) every month for the next three months, and as needed thereafter. The PIC will determine if further action is needed.

F314

Resident #15 is turned and repositioned every two hours and as needed per her plan of care. Resident # 15 received a Stat 2 air mattress on 11/23/11.

Weekly skin assessments are completed by the licensed nurses to observe the skin integrity of all residents and to validate treatment and services to prevent and heal pressure sores. Notification is made to the physician and resident/family and interventions implemented as appropriate.

The Staff Development Coordinator conducted an in-service between 6/7/12 through 6/16/12 with the State Registered Nursing Assistants and Licensed Staff on treatment and services to prevent and heal pressure sores.

A daily turn audit will be done by the Unit Managers Monday through Friday and by the Weekend Supervisor on the weekends for four weeks, then twice weekly for four weeks then weekly for four weeks.

The tracked and trended audits will be brought to the Performance Improvement Committee (PIC) which includes the Executive Director (ED), Assistant Executive Director (AED), Director of Nursing (DON), Assistant Director of Nursing (ADON), Unit Managers, Social Service Director (SS), Registered Dietitian (RD), Activities Director (AD) Maintenance Director, Staff Development Coordinator (SDC), Dietary Manager, Certified Dementia Practitioner (CDP), Medical Director (MD) Case Manager (CM) every month for the next three months and as needed thereafter. The PIC will determine if further action is needed.

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F315

Resident #2's Bladder assessment was updated on 4/5/12 and will be updated annually or with a significant change.

All residents that are currently in a comprehensive assessment period will have their bowel and bladder status completed as indicated. Charts have been audited by the Medical Records Clerk to validate that a current bowel and bladder assessment is in place 6/1/12. Any assessments identified as needing updating will be addressed. 6/16/12

Significant change assessment dates will be reviewed in morning stand up by DNS and ADON and will be communicated to the Unit Managers via the facility follow-up form. 6/16/12.

Between 6/7/12 through 6/16/12 the SDC conducted in-servicing on the facility's policy and system change related to the significant change assessments.

Unit Managers will conduct audits of Bowel and Bladder assessments per the MDS schedule weekly, for three months, to validate completion of the assessments.

The UMs and DNS will report, track and trend audit findings to the PIC which includes the Executive Director (ED), Assistant Executive Director (AED), Director of Nursing (DON), Assistant Director of Nursing (ADON), Unit Managers, Social Service Director (SS), Registered Dietitian (RD), Activities Director (AD) Maintenance Director, Staff Development Coordinator (SDC), Dietary Manager, Certified Dementia Practitioner (CDP), Medical Director (MD) Case Manager (CM) three months and thereafter as needed. Appropriate corrective action will be taken as indicated.

F353

As of 5/21/12 a concern regarding residents not receiving showers and incontinence care secondary to staffing issues was brought forth.

The facility initiated an investigation immediately upon resident's report of the allegation of not

receiving incontinence care for resident #2. This resident has no skin breakdown and is receiving continence care for bowel and bladder.

Resident #11 was discharged on 5/10/12.

The facility has encouraged resident #27 to ask for assistance before the urge to void is strong, secondary to history of incontinence. She continues to receive detrol LA 4 mg.
This resident has no skin breakdown and staff is responding timely to her call bell to prevent incontinence.

Resident #34 was discharged on 5/10/12.

The shower time for resident #45 has been changed to ensure she is up and ready by 10:00 am for morning activities per her request and she is receiving her shower per scheduled.

A resident council meeting was held on 5/3/12 various items were discussed, lack of showers or incontinence care were never voiced as not timely. The meeting was attended by the residents, Activity Director, Director of Nursing, and the Assistant Executive Director. This meeting was to discuss any care issues that may be present.

The facility staffing pattern will be reviewed weekly by the ED/DNS and discuss monthly times three months in the PIC which includes the Executive Director (ED), Assistant Executive Director (AED), Director of Nursing (DON), Assistant Director of Nursing (ADON), Unit Managers, Social Service Director (SS), Registered Dietitian (RD), Activities Director (AD) Maintenance Director, Staff Development Coordinator (SDC), Dietary Manager, Certified Dementia Practitioner (CDP), Medical Director (MD) Case Manager (CM) committee, concerns are also reviewed, further interventions may be recommended based on the PIC review of the Staffing pattern or grievance data.

F431

Between 5/7/12 through 5/16/12 audits were done on all medication carts and medication rooms by the Pharmacy to validate no expired, loose, or undated medications were in the facility. No residents were found to have been affected.

The SDC and Pharmacy have in-serviced licensed nurses and Certified Medication Technicians (CMTs) on proper procedures for dating medications, removing expired medications, and medication administration.

The UMs will conduct audits of the medication carts and medication rooms weekly, for three

months, to validate multi dose vials are labeled, no expired medications are present and that there

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are no medications are set up.

The UMs and the DNS will report, track and trend audit findings to the PIC which includes the Executive Director (ED), Assistant Executive Director (AED), Director of Nursing (DON), Assistant Director of Nursing (ADON), Unit Managers, Social Service Director (SS), Registered Dietitian (RD), Activities Director (AD) Maintenance Director, Staff Development Coordinator (SDC), Dietary Manager, Certified Dementia Practitioner (CDP), Medical Director (MD) Case Manager (CM) for three months and thereafter as needed. Appropriate corrective action will be taken as indicated.

F441

Resident #8 continues to be on contact precautions and staff will follow precautions per policy.

Resident #2 was not adversely affected by improper hand-washing technique.

Resident #35 was not adversely affected by improper hand-washing technique
The SDC has in-serviced all nursing, housekeeping, and therapy staff on hand-washing procedures between 6/7/12 through 6/16/12. Additional in-servicing was provided to housekeeping staff on the proper chemicals to use while cleaning resident's rooms.

All medication carts were cleaned and a cleaning schedule developed to verify carts are cleaned routinely.

The Housekeeping Supervisor audited by observation all housekeeping staff are using appropriate chemicals to sanitize resident rooms. This audit will continue to be done weekly for three months, to validate housekeeping are using correct chemicals. The Housekeeping Supervisor will audit the exterior of 3 med carts per week times three months to validate cleanliness. The Manager will report, track and trend audit findings to the PIC which includes the Executive Director (ED), Assistant Executive Director (AED), Director of Nursing (DON), Assistant Director of Nursing (ADON), Unit Managers, Social Service Director (SS), Registered Dietitian (RD), Activities Director (AD) Maintenance Director, Staff Development Coordinator (SDC), Dietary Manager, Certified Dementia Practitioner (CDP), Medical Director (MD) Case Manager (CM) for three months and thereafter as needed. Appropriate corrective action will be as indicated.

The UMs and Rehab Director conducted audits of proper hand-washing techniques being demonstrated by staff and monitor medication carts weekly, for three months, to validate staff

are following hand-washing procedures. The UMs and Rehab Director will report, track and

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trend audit findings to the PIC which includes the Executive Director (ED), Assistant Executive Director (AED), Director of Nursing (DON), Assistant Director of Nursing (ADON), Unit Managers, Social Service Director (SS), Registered Dietitian (RD), Activities Director (AD) Maintenance Director, Staff Development Coordinator (SDC), Dietary Manager, Certified Dementia Practitioner (CDP), Medical Director (MD) Case Manager (CM) for three months and thereafter as needed. Appropriate corrective action will be taken as indicated.

F514

The Physician's order for Resident # 8 clarified and discontinued. Her skin was intact.

Resident #32 did not receive any incorrect medication and his orders were clarified.

All active medical records have been reviewed by the Medical Records clerk, and the Medical Records Assistant to validate that only the correct medical record is in the chart. Review was complete 6/16/12.

The SDC in-serviced all licensed staff on proper filing in the medical record and procedures to discontinue medications in the medical record between 6/7/12 through 6/16/12.

The Medical Records clerk will audit three (3) resident medical records per month to validate accuracy for three months. The Medical Records clerk will report, track and trend audit findings to the PIC which includes the Executive Director (ED), Assistant Executive Director (AED), Director of Nursing (DON), Assistant Director of Nursing (ADON), Unit Managers, Social Service Director (SS), Registered Dietitian (RD), Activities Director (AD) Maintenance Director, Staff Development Coordinator (SDC), Dietary Manager, Certified Dementia Practitioner (CDP), Medical Director (MD) Case Manager (CM) for three months and thereafter as needed. Appropriate corrective action will be taken as indicated.

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

PRINTED: 05/25/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185146	A. BUILDING 01 - BUILDING 0101 B. WING	03/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE & REHAB-FOUNTAIN CIRCLE	200 GLENWAY ROAD WINCHESTER, KY 40391

(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)	(X6) COMPLETION DATE
K 000	INITIAL COMMENTS	K 000		
	SURVEY UNDER: 2000 Existing		Please See Attachment	6-18-12
	FACILITY TYPE: SNF/NF			
	TYPE OF STRUCTURE: One Story, Type II (222) Protected			
	SMOKE COMPARTMENTS: Sixteen (16)			
	COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM			
	FULLY SPRINKLERED, SUPERVISED (Dry SYSTEM)		RECEIVED JUN - 6 2012 BY:	
	EMERGENCY POWER: Three (3) Type II Diesel			
	A life safety code survey was initiated and concluded on 03/27/12. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility was found not in substantial compliance with the Requirements for Participation for Medicare and Medicaid. The facility is licensed for one hundred seventy-nine (179) beds and the census was one hundred sixty-seven (167) on the day of the survey.			
	A deficiency was cited with the highest Scope and Severity identified at an "E" level.			
K 072 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD	K 072		
	Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Beth Smith | TITLE: Ex Director | (X6) DATE: 6-4-12

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185146	A. BUILDING 01 - BUILDING 0101 B. WING _____	03/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE & REHAB-FOUNTAIN CIRCLE	200 GLENWAY ROAD WINCHESTER, KY 40391

(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
K 072	Continued From page 1 7.1.10 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain exit access in accordance with National Fire Prevention Association (NFPA) standards. The deficiency had the potential to affect five (5) of sixteen (16) smoke compartments, fifty (50) residents, staff, and visitors. The facility is licensed for one hundred seventy-nine (179) beds with a census of one hundred sixty-seven (167) on the day of the survey. The findings include: Observation, on 03/27/12 between 10:30 AM and 2:30 PM, with the Maintenance Director revealed trash and soiled linen carts were stored and not in use in corridors near rooms #106, #118, #224 and #319. Mechanical lifts were observed stored and not in use near room #317. Also during the tour two (2) medication carts were observed stored and not in use at the A Wing nurses station. Interview, on 03/27/12 at 11:45 AM, with the Maintenance Director revealed he was aware the facility routinely stored the carts and lifts in the corridors and he repeatedly told staff this was not an acceptable practice. Reference: NFPA 101 (2000 Edition) Means of Egress Reliability 7.1.10.1 Means of egress shall be continuously	K 072	Please see Attachment 6.18.12	

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

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K 072	Continued From page 2 maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.	K 072	Please see Attachment 6.18.12	

This Plan of Correction is the center's credible allegation of compliance.

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. This plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.

Fountain Circle Health and Rehabilitation
Plan of Correction for Survey Exit 5/11/12
Attachment

K072

Cart storage/equipment areas have been identified on each unit to store all carts and lifts when not in use for resident care to ensure there are no obstructions or impediments in egress.

A facility wide in-service was conducted, by the Staff development Coordinator (SDC) on 6/7/12 through 6/16/12, for all employees to educate them on the cart/equipment storage.

Three (3) audits per week, times one month, then weekly for two months will be done by the Maintenance Director or Assistant Executive Director to observe that means of egress are clear through out the facility. Any concerns identified will be corrected immediately.

The audits will be brought to the Performance Improvement Committee (PIC) which includes the Executive Director (ED), Assistant Executive Director (AED), Director of Nursing (DON), Assistant Director of Nursing (ADON), Unit Managers, Social Service Director (SS), Registered Dietitian (RD), Activities Director (AD) Maintenance Director, Staff Development Coordinator (SDC), Dietary Manager, Certified Dementia Practitioner (CDP), Medical Director (MD) Case Manager (CM) every month for the next three months. Action plans will be developed and implemented as indicated. The PIC will determine if further action is needed.

F166

Resident #27 was visited by the social worker 6/1/12 to assess for any unresolved grievances. Resident #27 voiced no concerns and has no unresolved grievances.

Unit managers, Dietary manager, Medical Records, Supply Clerk, Activities Director, Activities assistants, Certified Dementia Practitioner, Social Services and Admissions Coordinator will ask all residents by 6/16 /12 during Angel Care rounds, if they have any grievances that they need to report. Residents will also be encouraged to voice any concerns they may have to any facility staff. Any grievances will be forwarded to the Executive Director for follow-up in the morning stand up meeting.