

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

PRINTED: 09/21/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185146	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 09/12/2011
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NAME OF PROVIDER OR SUPPLIER  FOUNTAIN CIRCLE HEALTH AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 200 GLENWAY ROAD WINCHESTER, KY 40391
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F 000	<p>INITIAL COMMENTS</p> <p>Amended</p> <p>An abbreviated survey was conducted 09/07/11 through 09/12/11 investigating KY00016998, KY00017000, KY00017039 and KY00017040. KY00016998 was unsubstantiated with no deficiencies. KY00017000, KY00017039 and KY00017040 were substantiated with no deficiencies cited. Unrelated deficiencies were cited at the highest S/S of a "D".</p>	F 000	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p>	
F 279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>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.</p> <p>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).</p> <p>This REQUIREMENT is not met as evidenced</p>	F 279	<p><b>F279</b></p> <p>A plan of care was developed for Resident #31 on 9/8/11 to address the resident's known behavior of non-compliance with physician ordered medications.</p> <p>On 9/14-22/11, all inhouse residents Resident Progress Notes (RPN) were audited for the 7 day period of the Assessment Reference Date (ARD) of the most recent Minimum Data Set (MDS) Assessment to identify information that should be included in the plan of care. Any area identified not included in the plan of care was corrected during the audit. The audit was conducted by the MDS Coordinators (MDSC), Unit Managers (UM), Registered Dietician (RD), Transitional Care Unit Program Director (TCU PD), Social Worker (SW), Shift Supervisor (SS), Reflections Program Director (RPD).</p>	9/23/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Robert J. Hillins Executive Director</i>	TITLE Executive Director	(X6) DATE 9/23/11
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 30 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 279	<p>Continued From page 1</p> <p>by:</p> <p>Based on interview, record review and review of the facility's care plan policy it was determined the facility failed to develop a comprehensive care plan to obtain or maintain the resident's highest practical physical, mental, and psychosocial well-being for one (1) of thirty-three (33) sampled residents, Resident #31. The facility failed to ensure a plan of care was developed for Resident #31 to address the resident's known behavior of non-compliance with physician ordered medications.</p> <p>The findings include:</p> <p>Review of the facility's "Comprehensive Care Plan Policy", dated 05/28/08 revealed the Minimum Data Set (MDS) Coordinator was to review the medical record in preparation for the care plan meeting.</p> <p>Review of Resident #31's "Resident Progress Notes", dated 08/10/11 at 9:15 AM, revealed therapy had reported to the nurse that a Percocet (pain medication) pill was found in Resident #31's bed. Additional review of the progress notes revealed a second entry by the social worker, dated 06/10/11 at 9:30 AM, related to the finding the medication in the resident's bed. Further review of the "Resident Progress Notes" revealed an second entry by the social worker, dated 06/13/11, which detailed the resident, was hiding pills, to take at a later time.</p> <p>Review of Resident #31's Admission Minimum Data Set Assessment (MDS), dated 06/13/11, and Care Area Assessments (CAA's), dated 06/17/11, revealed no written evidence the facility</p>	F 279	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>On 9/15/11, the District Director of Case Management (DDCM) conducted education with the Interdisciplinary Team (IDT) members, to include SW, Recreational Services Manager (RSM), Nutrition Services Manager (NSM), MDSC and RD on developing a comprehensive plan of care based on record review and interview during the ARD of the MDS.</p> <p>On 9/20/11, the Executive Director (ED) conducted education with the RPD, Activities Assistant (AA) and the SW on developing a comprehensive plan of care based on record review and interview during the ARD of the MDS.</p> <p>All members of the IDT, who are involved in the completion of MDS Assessments, received education.</p>	9/23/11
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F 279	Continued From page 2 had assessed and care planned the resident's behavior of non-compliance with medications or hiding Percocet pills.  Interviews, on 09/12/11 at 11:12 AM, with the facility's three (3) MDS (Registered Nurses (RN) # 4, #5 and #6) nurses revealed they obtained information from various sources including "Resident Progress Note" when completing assessments and developing care plans. In additional interview RN #6 revealed he completed the 08/13/11 assessment but had no knowledge of Resident #31's medication non-compliance behavior and did not develop a care plan related to resident pocketing the Percocet.	F 279	<i>This Plan of Correction is the center's credible allegation of compliance.</i>  <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>	
F 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 interview, record review and review of the facility's policies it was determined the facility failed to follow physician's orders for one (1) of thirty-three (33) sampled resident, (Resident #31).  The facility failed follow physician's orders to crush Resident #31's Percocet (pain medication) prior to administration.  The findings include:  Review of the facility's policy "Physician Orders", dated 04/28/11, revealed physician's orders are	F 281	The Director of Nursing Services (DNS) will audit 3 medical records per month to validate that information in the RPN, in the 7 day ARD period, is developed into a comprehensive plan of care, if indicated.  The DNS will track and trend the audits during the monthly Performance Improvement Committee (PIC) (Members include, but not limited to, ED, DNS, Assistant Director of Nursing Services (ADNS), UM, SW, NSM, RD, AD, TCU PD, RPD, Maintenance Director (MD) and the Medical Director. The audits will be reviewed monthly for three months and as needed thereafter.  <b>F281</b>  The medication for Resident #31 was crushed prior to administration on 9/13/11.	9/23/11

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F 281	<p>Continued From page 3</p> <p>only administered upon the clean, complete, and signed order of persons lawfully authorized to prescribe. The policy did not address the issue of altering the form of the medication, such as from whole to crushed.</p> <p>Review of the facility's policy "Medication Administration" dated 08/31/11 revealed medications were to be prepared and administered using the five (5) rights of medication administration. These five (5) rights included: Right patient, Right route, Right medication and strength, Right time of administration and Right frequency. The policy did not address the use of the right form of medication i.e. crushed versus whole.</p> <p>Review of the Resident #31's clinical record, on 09/12/11, revealed a telephone order was written, on 09/06/11, to crush the resident's Percocet. Review of the September 2011 Medication Administration Record (MAR) revealed the resident's pain medication was to be crushed.</p> <p>Interview, on 09/12/11 at 11:20 AM, with Licensed Practical Nurse (LPN) #6 revealed she had given Resident #31's Percocet whole during the morning of 09/12/11. She explained she thought she could choose to give the pain medication whole if she wanted. LPN #6 stated she was aware of the order to crush the Percocet.</p> <p>Interviews, on 09/12/11 and with LPN #7 at 11:05 AM; Registered Nurse (RN) #1 at 1:21 PM; LPN #2 at 1:32 PM; and LPN #8 at 1:44 PM, revealed once an order was received to crush medications the nurses cannot give the medication whole. LPN #8 stated if a nurse gave the medication</p>	F 281	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>All other inhouse residents receive their medications in accordance with physician orders.</p> <p>On 9/15-17/11, the DNS, the Staff Development Coordinator (SDC) and/or the Weekend Supervisor (WS) conducted education with all licensed staff and Certified Medication Technicians (CMTs) on medication administration, to include, but not limited to, appropriately crushing medications in accordance with MD orders.</p> <p>Any licensed staff or CMT who did not receive the education by 9/22/11 will not be allowed to work until they attend the inservice.</p> <p>The DNS, SDC, WS or UM will conduct 3 medication observations per month to validate that medications are administered in accordance with MD orders.</p>	9/23/11	

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F 281  F 514 SS=D	Continued From page 4 whole she/he was not following the physician's orders.  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 interview, record review and review of the facility's policies it was determined the facility failed to ensure residents' records were complete and accurate for one (1) of thirty-three (33) sampled residents (Resident #31).  The facility failed to write physician's orders and revise the care plan to crush Resident #31's Percocet (a pain medication) on 08/29/11, when the order was received.  The findings include:  Review of the facility's policy "Physician Orders", dated 04/26/11 revealed physician's orders were administered only upon complete orders of a	F 281  F 514	<i>This Plan of Correction is the center's credible allegation of compliance.</i>  <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>  The DNS will track and trend the audits through the PIC. The audits will be reviewed monthly for three months and as needed thereafter.  F514  The physician's order for Resident #31 was clarified and written on 9/6/11. The care plan for Resident #31 was revised on 9/8/11.  On 9/14-22/11, all inhouse residents Resident Progress Notes (RPN) were audited for the previous 30 days to identify information that should be included in the plan of care and have a physician's order. Any area identified not included in the plan of care or not having a physician's order was corrected during the audit. The audit was conducted by the MDS Coordinators (MDSC), Unit Managers (UM), Registered Dietician (RD),	9/23/11

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F 514	<p>Continued From page 5</p> <p>person lawfully authorized to prescribe. Additionally the physician orders policy stated staff was to document each medication in the resident's medical record with the date, time, and signature of the person receiving the order. Per the policy the order was to be recorded on the physician order sheet/telephone order sheet if it was a verbal order, and on the Medication Administration Record (MAR).</p> <p>Review of the clinical record for Resident #31 revealed a "Resident Progress Note", dated 08/29/11 at 11:50 PM, written by Licensed Practical Nurse (LPN) #6 indicating a physician's order was received to crush Resident #31's pain medication.</p> <p>Review of the physician's telephone orders revealed no documented evidence LPN #6 had written the order per the facility's policy.</p> <p>Review of Resident #31's care plan revealed no written evidence the care plan had been revised to address the order to crush the Percocet.</p> <p>Interview, on 09/12/11 at 10:25 AM, with LPN #6 revealed she had not written a telephone order to crush the resident's Percocet. She explained she did not think she had to write an order and could just pass it on in report.</p> <p>Interviews, on 09/12/11 with LPN #1 at 11:01 AM; LPN #7 at 11:05 AM; LPN #9 at 11:46 AM and LPN #2 at 1:32 PM, revealed if a nurse receives an order to crush a medication, he/she must write the order on the telephone order sheet. They explained the order sheet is how changes to medications were communicated to the</p>	F 514	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>Transitional Care Unit Program Director (TCU PD), Social Worker (SW), Shift Supervisor (SS), Reflections Program Director (RPD).</p> <p>On 9/15-17/11, the DNS, the Staff Development Coordinator (SDC) and/or the Weekend Supervisor (WS) conducted education with all licensed staff on writing physician's orders and appropriate care plans.</p> <p>Any licensed staff or CMT who did not receive the education by 9/22/11 will not be allowed to work until they attend the inservice.</p> <p>The DNS will audit 3 resident medical records per month and review the previous 30 days of RPN to identify any area that would require a physician's order and/or a care plan.</p>	9/23/11
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F 514	Continued From page 6 pharmacy, physicians, and other care givers within the facility.  Interviews, on 09/12/11 at 11:12 AM, with the facility's three (3) Minimum Data Set (MDS) nurses (Registered Nureee #4, #5 and #6) revealed the telephone order was a three (3) part form. They explained the third part of the order served as the care plan revision until the next quarterly review.	F 514	<i>This Plan of Correction is the center's credible allegation of compliance.</i>  <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>  The DNS will track and trend the audits through the PIC. The audits will be-reviewed monthly for three months and as needed thereafter.	9/23/11	