

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

PRINTED: 10/21/2011  
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 10/07/2011
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NAME OF PROVIDER OR SUPPLIER  FOUNTAIN CIRCLE HEALTH AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 200 GLENWAY ROAD WINCHESTER, KY 40391
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
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F 000	INITIAL COMMENTS  A Standard Recertification Survey and an Abbreviated Survey investigating KY00017183, KY00017184, KY00017186, KY00017187, KY00017190, KY00017191, and KY00017201 was initiated on 10/04/11 and concluded on 10/07/11 with deficiencies cited. KY00017183 and KY00017187 were unsubstantiated without deficiencies. KY00017184 and KY00017201 were substantiated with deficiencies. KY00017186, KY00017190, and KY00017191 were substantiated without deficiencies. The highest Scope and Severity (S/S) cited was an "F".	F 000	<i>This Plan of Correction is the center's credible allegation of compliance.</i>  <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY  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 interview and record review, it was determined the facility failed to promote care in a manner and environment that maintains or enhances dignity and respect for two (2) of twenty-seven (27) sampled residents (Resident #8 and Resident #16). The facility failed to ensure Resident #8's care needs were provided in a timely manner on 09/17/11 resulting in the resident being incontinent. On 09/17/11, facility staff left Resident #16 unattended, uncovered and unclothed from the waist down.	F 241	<b>F241</b>  1. The facility initiated an investigation immediately upon the resident's report of the allegation for residents #8 and #16 (9/17/11). The S.R.N.A. was suspended pending completion of the investigation (9/17/11).  The S.R.N.A. received in-service education related to Residents Rights before returning to work.  The facility will conduct interviews of all current residents and or legal representatives by 11/15/11 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 facility policies, including the facility "Grievance" and "Abuse Neglect, Mistreatment/Misappropriation" policies.	11/16/11

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Robert Hollins</i>	TITLE Executive Director	(X9) DATE 11/9/11
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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 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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NAME OF PROVIDER OR SUPPLIER  <b>FOUNTAIN CIRCLE HEALTH AND REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>200 GLENWAY ROAD</b> <b>WINCHESTER, KY 40391</b>	
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F 241	<p>Continued From page 1 The findings include:</p> <p>1. Record review revealed the facility admitted Resident #8 on 12/31/10 with diagnoses which included Hypertension (HTN), History of Falls, Osteoporosis, Depression, Constipation and Reflux. Review of the quarterly Minimal Data Set (MDS) Assessment, dated 07/21/11 revealed the facility assessed Resident #8 as being oriented with no cognitive impairment.</p> <p>Interview with Resident #8, on 10/04/11 at 10:00 AM, revealed on 09/17/11 he/she rang the call light for toileting assistance. Further interview revealed the resident had to wait about forty-five (45) minutes and as a result was incontinent in his/her brief. The resident stated he/she was extremely wet and uncomfortable and it made him/her feel ashamed and embarrassed.</p> <p>Interview, on 10/07/11 at 2:45 PM, with State Registered Nursing Assistant (SRNA) #10, who worked on 09/17/11 but was not assigned to Resident #8, revealed she found Resident #8 lying in a heavily saturated urine filled brief. She indicated she reported the incident to Licensed Practical Nurse (LPN) #9.</p> <p>Interview with LPN #9, on 10/06/11 at 2:00 PM, revealed she was working on 09/17/11 when SRNA #10 reported the incident to her. She stated she went to Resident #8 and Resident #8 told her that he/she had been left wet for a long time.</p> <p>2. Record review revealed the facility admitted Resident #16 on 05/05/11 with diagnoses which included HTN, Esophageal Reflux, Diabetes,</p>	F 241	<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>3. The facility will continue to conduct the "Angel Care" and "Abaqis" interviews as outlined in #4 below.</p> <p>The facility will also provide in-service training to all staff conducted by the Social Services Staff between 10/31/11 and 11/15/11 to discuss the facility policy related to Resident Rights, Dignity and Respect.</p> <p>Any staff member who has not received the in-service education by 11/15/11 will not be allowed to work until they have received the in-service education.</p> <p>All new hires will receive the information regarding the facility policy related to Resident Rights, Dignity and Respect</p> <p>Each resident has been assigned an Angel Care Representative who has the responsibility to conduct "Angel Care" visits twice weekly to question</p>	11/16/11

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F 241	Continued From page 2 Osteoporosis and Anxiety. Review of the significant change MDS, dated 09/14/11, revealed the facility assessed the resident as being alert with no cognitive impairment. Further review revealed Resident #16 had a suprapubic catheter.  Interview on, 10/06/11 at 2:39 PM, revealed on 09/17/11 he/she was experiencing bladder spasms causing urine to leak around the catheter and onto the bed and his/her clothing. He/she further stated SRNA #31 removed the saturated pajama bottoms, put a brief under him/her and left him/her uncovered and unclothed from the waist down. Continued interview, on 10/07/11 at 6:50 PM, revealed this action resulted in the resident feeling very uncomfortable and cold.  Interview with SRNA #10, on 10/07/11 at 2:45 PM, revealed she worked on 09/17/11 and observed Resident #16 lying in the bed, uncovered, with an unfastened brief under the resident and reported that Resident #16 was very upset that he/she had been left in that manner. She indicated she reported the incident to LPN #9.  Interview with LPN #9, on 10/06/11 at 2:00 PM, revealed SRNA #10 reported the incident with Resident #16 to her. She further stated she went to talk with Resident #16 who reported SRNA #31 had left him/her exposed with an open brief. She further stated she reported SRNA #31 to her supervisor.	F 241	<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>  residents regarding any care concerns they may have. The Angel Care Representative also contacts the family/legal representative monthly to discuss any care concerns related to the resident.  The facility conducts Abaqis (Quality Indicator Survey) interviews at least quarterly for each resident which address several areas related to resident concerns involving resident rights, dignity and respect.  4. Any concerns identified via the Angel Care or Abaqis interviews are then addressed per the facility "Grievance" or "Abuse, Neglect, Mistreatment and Misappropriation" policy and procedures.  These concerns are also reviewed during the facility monthly	11/16/11	
F 257 SS=D	483.15(h)(6) COMFORTABLE & SAFE TEMPERATURE LEVELS  The facility must provide comfortable and safe temperature levels. Facilities initially certified	F 257	Performance Improvement meeting(Members include, but not limited to, ED, DNS, Assistant		

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F 257	<p>Continued From page 3 after October 1, 1990 must maintain a temperature range of 71 - 81° F</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview it was determined the facility failed to provide comfortable and safe temperature levels for residents on the 100 Unit. On 10/01/11, residents and families complained of cold temperatures on the 100 Unit.</p> <p>The findings include:</p> <p>A group interview conducted on 10/05/11 at 2:30 PM revealed two (2) unsampled residents on the 100 Unit described the temperature the evening of 10/01/11 as cold, revealing staff provided them with extra blankets as a result. One (1) unsampled resident revealed he/she did not attend some activities that day, as he/she wanted to stay in his/her room underneath blankets to stay warm.</p> <p>An interview conducted with Resident #1, on 10/05/11 at 2:20 PM, revealed he/she had little control over the temperature in his/her room. He/she revealed when the main air conditioning was on, he/she could turn it on or off in his/her room, and when the main heat was on he/she could turn it on or off in his/her room, but the residents were unable to switch between air conditioning and heat. He/she went on to reveal he/she covered up under five blankets on the night of 10/01/11 to keep warm.</p> <p>An interview with Daughter #14A, on 10/07/11 at 10:52 AM, revealed she entered the facility at</p>	F 257	<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>Director of Nursing Services (ADNS), UM, SW, NSM, RD, AD, TCU PD, RPD, Maintenance Director (MD) and the Medical Director), further interventions may be recommended based on the PIC review of the Angel Care/Abaqiis/Grievance data.</p> <p><b>F257</b></p> <ol style="list-style-type: none"> <li>1. The Maintenance Director adjusted the temperature of the boiler chiller heating air conditioner unit for the "A" wing, the unit where the affected resided, on 10/2/11.</li> <li>2. All residents on the "A" wing could have the potential to experience temperature control fluctuations therefore the facility will initiated the corrective actions and monitoring as outline in #3 and 4 below.</li> <li>3. The Maintenance Director has established an "on-call" schedule that has been made available for the "charge nurses" on the "A" wing.</li> </ol>	11/16/11
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F 257	<p>Continued From page 4</p> <p>approximately 9:30 PM on the night of 10/01/11, and that the outside temperature was an unseasonably cold, forty-eight (48) degrees Fahrenheit outside at that time. Although not certain what the inside temperature was, Daughter #14A described it as being cold, citing this as a reason she cut her visit short. Daughter #14A further stated the nurses and aides were warmly dressed with jackets or hoodies, and that residents had two (2) to three (3) extra blankets on to keep warm.</p> <p>An interview with LPN #12, on 10/06/11 at 1:48 PM, who worked on 10/01/11, revealed on the night of 10/01/11 several residents complained about being cold. Although not cold herself, LPN #12 stated some of the resident rooms were "cool". LPN #12 stated she notified the Maintenance Director, who turned the heat on the following morning.</p> <p>An interview with the Maintenance Director, on 10/05/11 at 4:00 PM, revealed he was informed on Saturday night, 10/01/11, that residents on the 100 Unit were complaining of being cold. The Maintenance Director stated that he turned the heat on in the morning on 10/02/11. The Maintenance Director further revealed residents on the other three units had control over their room temperatures with thermostats in their rooms, and that the 100 Unit had an older heating and cooling system that didn't offer the degree of control other units had. The Maintenance Director stated no one had previously informed him of being cold.</p> <p>An interview with the Executive Director conducted on 10/06/11 at 2:40 PM, revealed he</p>	F 257	<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>This will ensure that there will be an "on-call" maintenance staff person available to respond timely to make adjustments to the "boiler/chiller" heating cooler unit that controls the "A" wing temperature.</p> <p>The maintenance staff will receive in-service education conducted by the Executive Director or Assistant Executive Director on 10/31/11 related to the implementation of the on-call schedule and the expectation that a maintenance staff member will respond in a timely manner when notified of a temperature control issue related to the boiler chiller or any other resident location throughout the facility.</p> <p>Licensed Nursing Staff will receive in-service education conducted by the Director of Nursing (DNS), the Staff Development Coordinator (SDC) and/or the Weekend Supervisor (WS) between 10/31/11 and 11/15/11 related to the Maintenance on-call schedule.</p>	11/16/11

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<p>F 257</p> <p>F 281 SS=D</p>	<p>Continued From page 5</p> <p>was not aware of any temperature concerns prior to the weekend of 10/01/11, but was aware it was difficult to keep temperatures comfortable for everyone during the seasonal transition.</p> <p><b>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</b></p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to meet professional standards of care as evidenced by physician's orders not being followed for one (1) of twenty-seven (27) residents (Resident #3). The facility failed to ensure Resident #3 received antibiotics (Bactrim and Diflucan) for the ordered seven (7) days. The facility failed to ensure Resident #3 received the following ordered medications on 10/01/11 and 10/02/11: Amlodipine (for high blood pressure) 10 milligrams (mg) daily, Aspirin 81 mg daily, Lexapro (Antidepressant) 10 mg daily, Prevalite (lowers cholesterol) 4 grams daily, and Namenda (Anti Alzheimer) 10 mg twice a day. In addition, Imdur (heart medication) 30 mg daily was ordered but not given to the resident.</p> <p>The findings include:</p> <p>Record review revealed the facility admitted Resident #3 on 08/25/11 and re-admitted the resident on 09/14/11 with diagnoses which included Hypertension (HTN), Hyperlipidemia, Dementia, History of Percutaneous Endoscopic</p>	<p>F 257</p> <p>F 281</p>	<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>Any maintenance or licensed nurse staff member who has not received the in-service education by 11/15/11 will not be allowed to work until they have received the in-service education.</p> <p>All maintenance and licensed nurse new hires will receive the information regarding the facility policy related to Resident Rights, Dignity and Respect</p> <p>Each resident has been assigned an Angel Care Representative who has the responsibility to conduct "Angel Care" visits twice weekly to question residents regarding any care concerns they may have. The Angel Care Representative also contacts the family/legal representative monthly to discuss any care concerns, including their environment.</p> <p>The facility also conducts Abaqis (Quality Indicator Survey) interviews</p>	<p>11/16/11</p>
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F 281	<p>Continued From page 6</p> <p>Gastrostomy (PEG), and Depression. The admission orders on 08/25/11 included the following medication order: Imdur 30 mg enteral (given through the tube) per PEG tube daily for HTN.</p> <p>Further record review revealed Imdur was identified as a "Do Not Crush Medication" (which should not be administered enterally) on the September 2011 Medication Administration Record (MAR). The August 2011 and September 2011 MAR records revealed the medication was signed off as being given by staff to Resident #3 each day from 08/27/11 through 09/07/11.</p> <p>Interview, on 10/07/11 at 3:15 PM, with Registered Nurse (RN) #5 revealed Pharmacy should not have sent the Imdur 30 mg if it was to be given enterally via PEG tube since it was a "do not crush" medication. After RN #5 contacted the Pharmacy, further interview revealed Pharmacy denied sending the medication and she did not know why the Physician was not notified about the medication or why nurses documented it was given if not sent.</p> <p>Interview with the Pharmacy Technician, on 10/07/11 at 3:30 PM, revealed the Pharmacy had received the order for the Imdur 30 mg enteral per PEG on the admission orders dated 08/25/11, but did not send the medication. Imdur was an extended release medication and could not be crushed and given via the PEG tube. Further interview revealed the Pharmacy Technician had contacted a nurse at the facility (could only remember first name) and requested the Physician be notified that Imdur could not go</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>at least quarterly for each resident which address several areas including environmental temperature.</p> <p>4. Environmental concerns identified via the Angel Care and Abaqis interviews are also reviewed during the facility monthly Performance Improvement meeting (Members include, but not limited to, ED, DNS, Assistant Director of Nursing Services (ADNS).</p> <p>Further interventions may be recommended based on the PIC review of the Angel Care/Abaqiis/Grievance data related to environmental temperature control data.</p> <p><b>F281</b></p> <p>1. The resident's physician was notified by the registered nurse Unit Manager of the medication variance on 10/3/11. There were no adverse outcomes noted per assessment of</p>	11/16/11
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F 281	<p>Continued From page 7 through the PEG tube.</p> <p>Interview with the Nurse Consultant, on 10/07/11 at 4:15 PM, revealed Pharmacy did not dispense the Imdur medication to Resident #3. She provided documentation from the Pharmacy showing Imdur was not among the medications sent for Resident #3. The Nurse Consultant stated she did not know why the facility did not contact the Physician about the order or why the August 2011 and September 2011 MARs indicated the medication had been administered to the resident by staff.</p> <p>Interview with the Executive Director, on 10/07/11 at 6:05 PM, revealed they had investigated the Imdur 30 mg medication incident and determined the medication was not given. The facility did not have the medication to give to the resident. They reviewed the August 2011 and September 2011 MARs and got the name of every nurse who had documented giving Imdur and they all denied giving this medication to Resident #3. Further interview revealed the facility concluded it appeared to have been documentation errors by nursing staff regarding administering the medication. Resident #3 did not get the medication as ordered. In addition, their investigation revealed the nurses did not contact the Physician about the medication after being notified by Pharmacy that the medication would not be sent.</p> <p>Record review also revealed a verbal order on 09/29/11 for antibiotics Bactrim DS and Diflucan two-hundred (200) mg to be given enteral per PEG daily for seven (7) days. Review of the September 2011 and October 2011 MARs</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>resident completed by the registered nurse Unit Manager on 10/3/11.</p> <p>2. An audit of all other in-house residents will be conducted, by the Director of Nursing Services and the Unit Managers, of the October 2011 Medication Administration Records to validate that all residents receive their medications in accordance with physician orders. Any medication variance identified will be addressed.</p> <p>3. In-service education will be conducted by the Director of Nursing (DNS), the Staff Development Coordinator (SDC) and/or the Weekend Supervisor (WS) between 10/31/11 and 11/15/11 for all licensed staff and Certified Medication Technicians (CMTs) on medication administration, to include, but not limited to, administering medications in accordance with MD orders.</p> <p>Any licensed staff or CMT who did not receive the education by</p>	11/16/11

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PRINTED: 10/21/2011  
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 10/07/2011
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NAME OF PROVIDER OR SUPPLIER  FOUNTAIN CIRCLE HEALTH AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 200 GLENWAY ROAD WINCHESTER, KY 40391
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
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F 281	<p>Continued From page 8</p> <p>revealed the medication was started on 09/29/11 and given thru 10/04/11, a total of six (6) days and not for the ordered seven (7) days.</p> <p>Interview with RN #5, on 10/07/11 at 2:35 PM, revealed Resident #3 received six (6) days of antibiotics instead of the ordered seven (7) days. The resident should have received the ordered seven (7) days of antibiotics as prescribed. She should have finished the antibiotics on 10/05/11 because antibiotics need to be taken as prescribed.</p> <p>Further review of Resident #3's medical record revealed the October 2011 Physician's orders included medications Amlodipine (for blood pressure) 10 milligrams (mg) daily, Aspirin 81 mg daily, Lexapro (Antidepressant) 10 mg daily, Prevalite (lowers cholesterol) 4 grams daily, and Namenda (Anti Alzheimer) 10 mg twice a day. Review of the October 2011 MAR revealed the medications were not given 10/01/11 through 10/02/11.</p> <p>Interview with RN #5, on 10/07/11 at 3:15 PM, revealed the medications Amlodipine 10 mg daily, Aspirin 81 mg daily, Lexapro 10 mg daily, Prevalite 4 grams daily, and Namenda 10 mg twice a day were not given on 10/01/11 and 10/02/11 because the medications were not printed on the October 2011 MAR and the error was not identified until 10/03/11. Further interview revealed the facility's process when changing out the prior month's MAR (in this case September 2011) was to compare it to the new month's MAR (in this case October 2011) to make sure all applicable ordered medications were on the new MAR. RN #3 stated it was the</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>11/15/11 will not be allowed to work until they attend the in-service.</p> <p>All new hires will receive the information regarding the facility policy related to Resident Rights, Dignity and Respect</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> <p>4. The DNS will track and trend the audits through the PIC. The audits will be reviewed monthly for three months and as needed thereafter. Further inventions/corrective actions will be implemented as necessary.</p> <p><b>F371</b></p> <p>1. No individual resident was identified.</p> <p>2. All residents who receive an oral diet have the potential to be affected</p>	11/16/11
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F 281	Continued From page 9 night nurse's responsibility to reconcile the new MAR to the prior month's MAR. The medications were not added to the October 2011 MAR until 10/03/11 and Resident #5 did not start getting the medications until 10/03/11.	F 281	<i>This Plan of Correction is the center's credible allegation of compliance.</i>	
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions  This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility's policy it was determined the facility failed to distribute and serve food under sanitary conditions as evidenced by the improper storage of scoops and ladles, improper wearing of hair nets, improper storage of insulated plate covers, improper holding temperature of the ground sausage on tray line and improper hand washing.  The findings include:  Review of the facility's policy titled, "Principles of Safe Food Handling", dated 04/28/11, revealed hair restraints such as hats, hair covering or net are worn to effectively keep hair from contacting food and keep food handlers from touching their hair.	F 371	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.  by the alleged deficient practice; therefore the facility will implement the corrective interventions and monitoring as outlined in #'s 3 and 4 below.  3. All dietary staff will receive in-service education between 10/31/11 and 11/15/11, provided by the Assistant Executive Director, (AED), Registered Dietician (RD), with regard to the facility's policies and procedures related to serving food under sanitary conditions, including: cleaning and storage of utensils (scoops and ladles), pots, pans, insulated plate covers, hair (restraints) nets, food storage and serving temperatures and hand washing.  Any dietary staff member who has not received the in-service education by 11/15/11 will not be allowed to work until they have received the in-service education.	11/16/11

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F 371	<p>Continued From page 10</p> <p>Review of the facility's policy titled, "Hand Hygiene/Handwashing", dated 08/31/11, revealed hand hygiene is to be performed after handling soiled equipment.</p> <p>Review of the facility's policy titled, "Tray Line Set-Up and Service", dated 10/31/08, revealed china, glasses and flatware that are clean and in good condition should be used.</p> <p>Observation, on 10/04/11 at 5:35 AM, in the tray line kitchen area revealed scoops and ladles, in drawers under the coffee machine, were not stored with the handles all in the same direction in the drawer. The utensil handles were in multiple directions.</p> <p>Interview, on 10/04/11 at 5:35 AM, with Dietary Aide #4 revealed the scoop and ladle handles should be in the same direction for infection control reasons.</p> <p>Observation, on 10/04/11 at 6:10 AM, in the main kitchen area revealed scoop and ladle utensils, stored in a drawer under a prep table, with their handles in multiple directions.</p> <p>Interview, on 10/04/11 at 6:10 AM, with Dietary Aide #1 revealed the scoop and ladle handles should be stored with their handles in the same direction.</p> <p>Observation, on 10/04/11 at 7:02 AM, revealed Dietary Aide #1 touched around her eyes and adjusted her glasses with her left hand.</p> <p>Observation, on 10/04/11 at 7:08 AM, revealed Dietary Aide #1 used the telephone and then</p>	F 371	<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 dietary staff new hires will receive the information regarding the facility policy related to serving food under sanitary conditions, including: cleaning and storage of utensils (scoops and ladles), pots, pans, insulated plate covers, hair (restraints) nets, food storage and serving temperatures and hand washing.</p> <p>The Nutritional Services Manager or Assistant Executive Director or Registered Dietician will make daily "Quick Rounds" to ensure that the dietary staff is compliant with the facility's policies and procedures related to serving food under sanitary conditions, including: cleaning and storage of utensils (scoops and ladles), pots, pans, insulated plate covers, hair (restraints) nets, food storage and serving temperatures and hand washing.</p> <p>4. The compliance results, related to the "Quick Rounds" audits, will be</p>	11/16/11
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F 371	<p>Continued From page 11</p> <p>obtained serving utensils from the drawer without washing hands.</p> <p>Observation, on 10/04/11 at 7:10 AM, revealed a size sixteen (16) scoop had a brown spotted substance on the food contact surface area.</p> <p>Interview on 10/04/11 at 7:10 AM with Dietary Aide #1, revealed the substance appeared to be food and the utensil should not be stored in this manner.</p> <p>Observation, on 10/04/11 at 7:20 AM, revealed Dietary Aide #1, who was plating food items, handled the telephone and did not wash hands prior to returning to the plating of food items.</p> <p>Observation, on 10/04/11 at 7:22 AM, revealed Dietary Aide #1 used the telephone and did not wash hands before returning to tray line.</p> <p>Observation, on 10/04/11 at 7:35 AM, revealed Dietary Aide #3's hair net only covered the top portion of hair.</p> <p>Observation, on 10/04/11 at 7:52 AM and 7:54 AM, revealed Dietary Aide #4 opened the refrigerator door to retrieve food items and was not observed to wash hands prior to continuing to place seasoning packets and resident flat ware on trays.</p> <p>Observation, on 10/04/11 at 8:10 AM, revealed nineteen (19) insulated plate covers (bottoms) were stored wet while tray line was taking place.</p> <p>Interview with the Nutritional Services Manager (NSM), on 10/04/11 at 8:15 AM, revealed staff</p>	F 371	<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>reviewed in the monthly Performance Improvement (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) meeting for the next three months and as needed thereafter. Further interventions/corrective actions will be implemented as necessary.</p> <p><b>F431</b></p> <p>1. The medications at the nurses' station counter were locked in the medication cart by the Registered Nurse House Supervisor.</p> <p>All medication carts were reviewed between 10/10/11 and 11/2/11 by the Unit Managers, Director of Nursing, Assistant Director of Nursing and Consultant Pharmacist to ensure that all oral medications</p>	11/16/11
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F 371	<p>Continued From page 12 should ensure dishes are dry before using/storing.</p> <p>Observation, on 10/04/11 at 8:18 AM, 8:22 AM and 8:32 AM revealed Dietary Aide #4 opened the refrigerator to obtain drinks and did not wash hands prior to returning to tray line to place seasoning packets and flat ware on residents' trays.</p> <p>Observation, on 10/04/11 at 8:50 AM, revealed Dietary Aide #1, who was plating food items, used the microwave oven to heat cheese slices and did not wash hands prior to returning to the plating of food items.</p> <p>Observation, on 10/04/11 at 9:15 AM, of food temperatures on the resident tray line after the last food items were plated revealed the remaining small portion of ground sausage had a temperature of 124 degrees Fahrenheit.</p> <p>Interview, on 10/04/11 at 1:45 PM, with Registered Dietitian (RD) #2 revealed all hair should be covered by a hair net.</p> <p>Interview, on 10/05/11 at 10:20 AM, with Dietary Aide #1 revealed handwashing should be performed after using the phone or if she touched her face or glasses with her hands when working the tray line. She stated because she used the back of her hands to adjust her glasses she did not think she had to wash her hands.</p> <p>Interview, on 10/05/11 at 10:50 AM, with the NSM revealed hands should be washed when touching contaminated items by the person serving food or if they leave the tray line. If the server touched</p>	F 371	<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>were separated from liquid medications.</p> <p>The bleach wipes were immediately removed from the medication cart compartments where they were noted to be stored alongside medications and nutritional supplements.</p> <p>2. Any resident who receives medications has the potential to be affected by the alleged deficient practice; therefore the facility will implement the corrective actions and monitoring in steps detailed in #'s 3 and 4 below.</p> <p>3. Separate compartments on the medication carts were designated for pills and liquid medications.</p> <p>Separate compartments were designated in the bottom drawer of each medication cart so that bleach wipes would not be stored with medications.</p>	11/16/11
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F 371	<p>Continued From page 13</p> <p>their face with their hands they would need to wash their hands.</p> <p>Interview with RD #1, on 10/05/11 at 10:50 AM, revealed using the phone would be considered a change in tasks and staff would need to wash hands before returning to serve food. Further interview with RD #1 revealed the temperature of the ground sausage on the hot holding tray line should have been at least 140 degrees Farenheit.</p> <p><b>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS</b></p> <p>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.</p> <p>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.</p> <p>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.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the</p>	F 371	<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>In-service education will be conducted by the Director of Nursing (DNS), the Staff Development Coordinator (SDC) and/or the Evening or Weekend Supervisor (WS) between 10/31/11 and 11/15/11 for all licensed staff and Certified Medication Technicians (CMTs) related to the facility policies and procedure for the Medication Storage.</p> <p>Any licensed staff or CMT who did not receive the education by 11/15/11 will not be allowed to work until they attend the in-service.</p> <p>All new hire licensed staff and CMT's will receive the education related to the facility policy and procedures related to the storage of medications.</p> <p>The DNS, SDC, WS or UM will conduct 3 medication observations per month to validate that medications are stored in</p>	11/16/11
F 431 SS=E		F 431		

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F 431	<p>Continued From page 14</p> <p><b>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.</b></p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility's policy and procedure it was determined the facility failed to ensure medications were stored in accordance with facility policy and state and federal regulations. Observation on 10/06/11, revealed facility staff failed to ensure medications were properly stored as evidenced by five (5) cards of medication laying on the desk at the nurses' station accessible to residents, unlicensed staff, and visitors. Observation further revealed the facility stored harmful substances in the same area as stored medications. In addition, observations revealed the facility had pills stored along with liquid medications in the medication carts.</p> <p>The findings include:</p> <p>Review of the facility's policy "Storage of Medications", dated 02/23/11, revealed medications are stored in compliance with applicable federal and state laws/regulations and accreditation standards. Additionally, the policy detailed access to medications was limited to licensed nurses, the consultant pharmacist and those lawfully authorized to administer medication. Further review of the facility's policy</p>	F 431	<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>compliance with the facility policy and procedure to include the separate storage of pills and liquids and the separate compartment storage of bleach wipes in the bottom drawer of the medication cart.</p> <p>4. The DNS will track and trend the audits through the PIC. The audits will be reviewed monthly for three months and as needed thereafter. Further inventions/corrective actions will be implemented as necessary.</p> <p><b>F441</b></p> <p>1 No specific residents were identified in the CMS 2567.</p> <p>2. All residents have the potential to be affected by the alleged deficient practice; therefore the facility will implement the corrective actions and monitoring procedures outlined in #'s 3 and 4 below.</p>	11/16/11
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F 431	<p>Continued From page 15</p> <p>"Storage of Medications" revealed the following guideline: "Clearly identify and store potentially harmful substances (such as urine test reagents tablets, household poisons, cleaning supplies, disinfectants) in a locked area separately from medications". Further review revealed the policy failed to specify guidance related to the storage of pills along with liquid medications.</p> <p>1. Observation, on 10/06/11 from 5:08 PM until 5:18 PM, revealed two (2) cards of Seroquel (anti psychotic) 100 milligram (mg) tablets (sixty tablets total), one (1) card of Lexapro (anti depressant) 10 mg tablets (thirty tablets total), two (2) cards of Namenda (Alzheimer's medication) 10 mg tablets (sixty tablets total), and two (2) cards of Docusate (stool softener) 100 mg (sixty tablets total) were laying on the desk in the nurse's station. Observation further revealed the nurses station had an open, unlocked door and two open windows allowing the medications to be within reach of residents, visitors, and unauthorized staff.</p> <p>Review of the medication information provided by the facility for Seroquel, Lexapro, Namenda, and Docusate revealed some of the side effects of the medications included but not limited to drowsiness, dizziness, anxiety, blurred vision, confusion, and/or headache.</p> <p>Observation, on 10/06/11 at 5:12 PM, revealed a State Registered Nurse Aide (SRNA) entered the nursing station, obtained some forms, and left.</p> <p>Interview, on 10/06/11 at 5:18 PM, with Registered Nurse (RN) #1 revealed the medications should have been placed in a locked</p>	F 431	<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>3. In-service education will be conducted by the Director of Nursing (DNS), the Staff Development Coordinator (SDC) and/or the Weekend Supervisor (WS), Assistant Executive Director (AED), Registered Dietician (RD) between 10/31/11 and 11/15/11 for all nursing and dietary staff regarding the facility policies and procedures related to Infection Control, to include: hand hygiene, equipment cleaning and food storage (licensed nurses' and CMT's specific to storage of supplements and food administered/given during medication administration.</p> <p>Any licensed staff, CMT or dietary staff who did not receive the education by 11/15/11 will not be allowed to work until they attend the in-service.</p> <p>All new hire licensed staff; CMT's and dietary staff will receive the education with regard to the facility policy and procedures related to</p>	11/16/11
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F 431	<p>Continued From page 16 area. She stated she had just returned from break and found the medication laying on the desk.</p> <p>Interview, on 10/06/11 at 5:22 PM, with Licensed Practical Nurse (LPN) #4 revealed he placed the medications on the nurse's station desk because the nurse was not available to lock the medication in the medication cart.</p> <p>Interview, on 10/06/11 at 5:42 PM, with LPN #16 revealed medications were to placed in the medication cart when they were received from the pharmacy.</p> <p>Interview, on 10/06/11 at 5:48 PM, with LPN #17 revealed medications were to be put into the medication cart when they were delivered.</p> <p>2. Observation of the 300 Hall medication cart, on 10/07/11 at 11:00 AM, revealed bleach wipes were stored in the same drawer compartment with medications (Nexium), fluid thickener, and protein powder.</p> <p>During interview, on 10/07/11 at 11:00 AM, Registered Nurse (RN) #1 stated the bleach wipes should be in a separate drawer from any medications.</p> <p>Observation of the medication cart on the Reflections Unit, on 10/07/11 at 11:15 AM, revealed bleach disinfectant wipes were stored in a drawer with medications including protein powder, Miralax, nebulizer treatments, and Lidoderm patches.</p> <p>Interview, on 10/07/11 at 11:15 AM, with Licensed</p>	F 431	<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>Infection Control, to include: hand hygiene, equipment cleaning and food storage (licensed nurses' and CMT's specific to storage of supplements and food administered/given during medication administration.</p> <p>The DNS, SDC, WS or UM will conduct 3 infection control observations per month to validate compliance with the facility's infection control policies and procedures, to include: hand hygiene, equipment cleaning and food storage (licensed nurses' and CMT's specific to storage of supplements and food administered/given during medication administration.</p> <p>4. The DNS will track and trend the audits through the PIC. The audits will be reviewed monthly for three months and as needed thereafter. Further inventions/corrective actions will be implemented as necessary.</p>	11/16/11

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NAME OF PROVIDER OR SUPPLIER  <b>FOUNTAIN CIRCLE HEALTH AND REHABILITATION</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>200 GLENWAY ROAD WINCHESTER, KY 40391</b>
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F 431	<p>Continued From page 17</p> <p>Practical Nurse (LPN) #1 revealed there was no where else to store the wipes.</p> <p>Interview, on 10/07/11 at 4:20 PM, with the Director of Nursing (DON) revealed the facility utilized a policy on medication storage. She stated there was to be no non-medication items in the same compartment with medications. She further stated she was not aware bleach wipes were being stored with medications and they should be removed immediately.</p> <p>3. Observation, on 10/04/11 at 7:30 AM, during the morning medication pass revealed four (4) blister packs of pills were stored in the same drawer as liquid medications.</p> <p>Interview, conducted on 10/04/11 at 7:30 AM, with Certified Medication Aide (CMA) #1, revealed she was unsure if it was acceptable to store pills with liquid medications.</p> <p>Interview, on 10/04/11 at 7:35 AM, with LPN #11 revealed the blister packs of pills should be stored separately from liquid medications.</p>	F 431	<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><b>F514</b></p> <p>1. Resident #3's Medication Administration Record (MAR) was corrected. A Medication Variance was completed and the physician was notified. The resident had no adverse outcome.</p> <p>The October 2011 monthly Physician's Orders that was misfiled in un-sampled residents A and B medical records were placed in the correct charts.</p>	11/16/11
F 441 SS=E	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>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.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections</p>	F 441	<p>The current (October) monthly Physician's Orders for residents #1, #2 and #14 were placed in their medical record.</p> <p>2. The medical records staff will conduct an initial audit between 10/31/11 and 11/15/11 of all residents' medical record to ensure that any misfiled documents are placed in the correct chart.</p>	

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F 441	<p>Continued From page 18 in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of facility's policy and procedures it was determined the facility failed to provide a safe, sanitary and comfortable environment to prevent the development and transmission of disease and infection. Staff was observed to assess resident vital signs and not clean equipment between each resident. Staff was</p>	F 441	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>All residents have the potential to be affected by the alleged deficient practice; therefore the facility will implement the corrective and monitoring interventions as outlined in #'s 3 and 4 below.</p> <p>3. In-service education will be conducted by the Director of Nursing (DNS), the Staff Development Coordinator (SDC) and/or the Weekend Supervisor (WS) between 10/31/11 and 11/15/11 for all licensed staff with regard to the facility policies and procedure related to maintaining complete and accurate medical records, to include: having current monthly Physician's Orders. No licensed nursing staff will be allowed to work past 11/15/11 until they have received the in-service education.</p> <p>All new hire licensed staff will receive in-service education with regard to the facility policies and procedure related to maintaining complete and</p>	11/16/11
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F 441	<p>Continued From page 19</p> <p>observed to administer medication with outdated applesauce. Further, staff was observed to provide perineal care and proceed to other tasks without changing gloves and washing hands.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Review of the facility's policy "Blood Pressure Measurement", dated 10/31/10, revealed the blood pressure cuff was to be cleaned between patients per the manufacturer's recommendations.</li> </ol> <p>Review of the manufacturer's cleaning instruction of reusable blood pressure cuffs revealed the cuff, tubing, and port fitting could be cleaned using one or more of the following: mild detergent and water, Enzol solution, 0.5 percent bleach and water solution, 75 percent isopropyl alcohol or laundered with mild detergent in water (60 degrees maximum).</p> <p>Review of the facility's policy "Pulse Oximetry", dated 04/28/11, revealed the sensor was cleaned by gently rubbing with an alcohol wipe.</p> <p>Review of the facility's policy "Body Temperature", dated 10/31/10, revealed after each resident use the electronic thermometer's base and/or glass thermometers were to be cleaned with a 10 percent bleach moist wipe which allowed for two (2) minutes contact time.</p> <p>Observation, on 10/04/11 at 8:06 AM, revealed State Registered Nurse Aide (SRNA) #28 used a pulse oximeter (device to check blood oxygen levels) on three (3) residents. Observation of SRNA #28 revealed she did not clean the pulse</p>	F 441	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>accurate medical records, to include: having current monthly Physician's Orders.</p> <p>The Unit Managers and Assistant Directors of Nursing will be responsible to complete a verification audit each month after month end change over to verify the accuracy of Physicians Orders, Medication Administration Records and Treatment Records.</p> <p>A copy of the Physicians Orders, which includes all orders for each resident, will be used as the audit tool. This will enable the Unit Managers, Assistant Directors, Director of Nursing to verify that all Medication Administration Records, Treatment Records and Physicians Orders are accurate after change over has been completed.</p> <p>The Medical Records staff will be assigned to audit each resident's medical record by 7<sup>th</sup> of each month to validate that each resident has</p>	11/16/11
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F 441	<p>Continued From page 20</p> <p>oximeter between each resident.</p> <p>Observation, on 10/06/11 at 11:26 AM, SRNA #28 was observed to clean the stethoscope with alcohol prep pads. Then SRNA #28 was observed to take vital signs (temperature, blood pressure, and pulse oxymetry) on two (2) residents. SRNA #14 was observed to clean the stethoscope between each resident but failed to clean the thermometer, pulse oxymetry, or blood pressure cuff between each resident.</p> <p>Interview, on 10/07/11 at 10:40 AM, with the D-wing Unit Manager revealed staff should clean vital sign equipment between each resident. She explained the equipment was cleaned to prevent the spread of germs.</p> <p>Interview, on 10/07/11 at 11:41 AM, with the facility Nurse Consultant revealed the facility had no policy related to the cleaning of vital sign equipment. She explained the facility's only policy related to equipment cleaning for glucometers.</p> <p>Interview, on 10/07/11 at 1:17 PM, with SRNA #28 revealed she cleaned the blood pressure cuff when it became dirty. She stated she had never been told to clean the cuff.</p> <p>Interview, on 10/07/11 at 1:23 PM, with SRNA #32, revealed she would use alcohol prep pads to clean vital sign equipment. She stated if alcohol prep pads were not available she would use disinfectant wipes. She stated she did not clean the blood pressure cuff.</p> <p>2. Review of the facility's policy titled "Incontinence/Perineal Care", dated 11/02/11,</p>	F 441	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>current monthly Physician's Orders in their medical record.</p> <p>The Medical Records staff will conduct a monthly medical record review for each resident to ensure that any misfiled documents are placed in the correct chart.</p> <p>4. The DNS will track and trend the audits through the PIC. The audits will be reviewed monthly for three months and as needed thereafter. Further inventions/corrective actions will be implemented as necessary.</p>	11/16/11
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F 441	<p>Continued From page 21</p> <p>revealed staff were to remove gloves and perform hand hygiene after perineal care was completed, and prior to handling clean items and assisting the resident to a comfortable position.</p> <p>Observation, on 10/04/11 at 5:00 AM, revealed SRNA #17 and SRNA #19 performed perineal care on Unsampld Resident C. Continued observation revealed the SRNAs completed the peri-care, dressed the resident in street clothes, assisted the resident to the wheelchair, and brushed the resident's hair, all prior to removing their gloves and performing hand hygiene.</p> <p>During interview, on 10/04/11 at 6:00 AM, SRNA #17 stated she should have changed her gloves after performing peri care and before dressing the resident.</p> <p>Interview with SRNA #20, on 10/07/11 at 1:50 PM, revealed her duties included training newly hired SRNAs. She stated hands should be washed and gloves changed after performing perineal care and prior to any other tasks, including dressing and hair care.</p> <p>Interview with the Unit Manager, on 10/07/11 at 2:10 PM, revealed she expected the aides would change their gloves after performing peri-care and before any other tasks.</p> <p>During interview, on 10/07/11 at 2:50 PM, Registered Nurse (RN) #4 revealed she served as Staff Development Coordinator and was responsible for infection control activities in the facility. She stated gloves should be changed anytime they became contaminated. Continued interview revealed performing perineal care would</p>	F 441		
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F 441	Continued From page 22 result in contaminated gloves. She further stated the gloves should be changed and hands should be washed prior to assisting a resident with dressing and other personal care activities.  3. Observation of the medication pass, on 10/04/11 at 5:50 AM, revealed RN #3 administered crushed pills in applesauce. Continued observation revealed the lid of the applesauce was marked with two (2) dates, 10/01 and 10/03.  Interview with RN #3, on 10/04/11 at 6:15 AM, revealed the dates on the applesauce indicated when it was delivered and when it expired. She stated the applesauce should have been discarded and replaced on 10/03/11. 4. Observation, on 10/04/11 at 8:48 AM, revealed the Nutrition Services Manager (NSM) was touching a mask she was wearing which covered her mouth and nose with her hands, pulling it up and down, and was then observed to touch an unsampled resident's arm and set up his/her tray with out sanitizing or washing her hands.  Interview, on 10/04/11 at 9:15 AM, revealed the reason she was touching the mask was because the resident was unable to hear her and she should have performed hand hygiene.	F 441			
F 514 SS=E	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.	F 514			

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F 514	<p>Continued From page 23</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy it was determined the facility failed to maintain clinical records in accordance with accepted professional standards and practices that were complete, accurately documented, and systematically organized for four (4) of twenty-seven (27) sampled residents, (Residents #3, #14, #1, and #2) and two (2) unsampled residents, (Unsample Residents A and B). The facility failed to ensure the Medication Administration Record (MAR) was accurate for Resident #3, failed to ensure documents were in the correct chart for Unsampled Residents A and B, failed to ensure the current Physician's orders were in the records for Residents #1, #14, and #2.</p> <p>Review of the facility's policy titled "Documenting in a Resident's Medical Record" revealed the record is to be complete and accurate.</p> <p>1. Record review revealed the facility admitted Resident #3 on 08/25/11 and re-admitted the resident on 09/14/11 with diagnoses which included Hypertension (HTN), Hyperlipidemia, Dementia, History of Percutaneous Endoscopic Gastrostomy (PEG), B12 Deficiency Anemia, and</p>	F 514		
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F 514	<p>Continued From page 24</p> <p>Depression: Review of the admission orders dated 08/25/11 included the medication Imdur 30 mg enteral (through the tube) per PEG tube daily for HTN.</p> <p>Further record review revealed the Imdur medication was identified as a "Do Not Crush Medication" (contraindicated for enteral administration) on the September 2011 MAR. Review of the August 2011 and September 2011 MARs revealed the medication was signed off as being given each day from 08/27/11 thru 09/07/11.</p> <p>Interview, on 10/07/11 at 3:15 PM, with RN #5 revealed Pharmacy should not have sent the Imdur medication if it was a "do not crush" medication. After RN #5 contacted the Pharmacy, further interview revealed pharmacy denied sending the medication and she did not know why nurses documented it was given if it was not sent.</p> <p>Interview, on 10/07/11 at 3:30 PM, with the Pharmacy Technician revealed they had received the order for the Imdur 30 mg per PEG on the admission orders for Resident #3 dated 08/25/11, but did not send the medication.</p> <p>Interview, on 10/07/11 at 4:15 PM, with the Nurse Consultant revealed Pharmacy did not dispense the Imdur medication to Resident #3. She provided documentation from Pharmacy showing the resident was not sent Imdur medication. The Nurse Consultant revealed she did not know why the MAR indicated the medication had been administered to the resident.</p>	F 514		

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F 514	<p>Continued From page 25</p> <p>Interview with the Executive Director, on 10/07/11 at 6:05 PM, revealed they had investigated the Imdur 30 mg medication incident for Resident #3 and determined the medication was not given because it was not available to be given. They reviewed the MAR and got the name of every nurse who had documented they had given the Imdur and all denied giving the medication. Further interview revealed it appeared to have been documentation errors by the nurses regarding the administration of the medication.</p> <p>2. Review of the clinical record revealed the Physician's Orders dated October 2011, for Unsampled Resident B, were filed in the record for Unsampled Resident A.</p> <p>Interview with the Unit Manager, on 10/06/11 at 2:45 PM, revealed she was responsible for filing the monthly orders on the charts. She stated, since both residents had the same last name, she made an oversight and misfiled Unsampled Resident B's orders on Unsampled Resident A's chart.</p> <p>3. Review of Resident #1 and Resident #14's medical records on 10/05/11 revealed neither resident had current Physician's orders in the records.</p> <p>An interview with the Data Entry staff, on 10/05/11 at 10:25 AM, revealed October 2011 orders should have been in the medical records. She went on to reveal the 11:00 PM to 7:00 AM shift on 09/30/11 should have reviewed the orders and placed them in charts. Further, if the 11:00 PM to 7:00 AM shift were unable to review the orders, the 7:00 AM to 3:00 PM shift on 10/01/11 should have reviewed the orders and placed them on the charts. The Data Entry staff could think of no</p>	F 514			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185146</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/07/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>FOUNTAIN CIRCLE HEALTH AND REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>200 GLENWAY ROAD WINCHESTER, KY 40391</b>		
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F 514	<p>Continued From page 26</p> <p>reason why current orders should not be in the records.</p> <p>An interview with LPN #12, on 10/06/11 at 1:48 PM, revealed she worked the 11:00 PM to 7:00 AM shift on 09/30/11. LPN #12 stated there wasn't enough time to get to the filing, as she was the only nurse on the unit that night.</p> <p>4. Review of Resident #2's medical record revealed the facility admitted the resident on 07/18/11 with diagnoses which included Hypertension, Diabetes Mellitus, Hyperlipidemia, Schizophrenia, Bipolar Disorder, Hypothyroidism and Depression.</p> <p>Review of Resident #2's record revealed no documented evidence of Physician's orders for 10/01/11 through 10/31/11. Further review revealed the orders on the resident's record were dated 09/01/11 through 09/30/11.</p>	F 514			

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NAME OF PROVIDER OR SUPPLIER  <b>FOUNTAIN CIRCLE HEALTH AND REHABILITATION</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>200 GLENWAY ROAD WINCHESTER, KY 40391</b>
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{K 000}	<p><b>INITIAL COMMENTS</b></p> <p>CFR: 42 CFR 483.70(a) Building: 01 Plan Approval: 1968, 1972 Survey under: NFPA 101 (2000 edition) Chapter 19 Facility type: SNF/NF Type of structure: Type V protected Smoke Compartment: 15 Fire Alarm: Complete fire alarm. Panel upgraded in 2000 Sprinkler System: Installed in 1968 Generator: Type II, 1 natural gas and 1 diesel, facility unsure of installation date. A revisit survey for compliance with the Life Safety Code to the 10/06/11 survey was conducted on 11/21/2011. Fountain Circle Health and Rehabilitation was found not to be in compliance with their Plan of Correction. The census the day of the survey was one hundred sixty two (162). The facility is licensed for one hundred eighty one (181). The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)</p>	{K 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> <p><b>K062</b></p> <p>1. Between 11/23/11 and 11/28/11 the wiring was removed away from sprinkler pipe and re-anchored to the ceiling truss throughout the entire building.</p> <p>2. On 11/29/11 the Regional Director of Environmental Services verified that all areas with sprinkler pipe were clear of any cables or wiring.</p> <p>3. On 11/22//11 the Maintenance Director received in-service education conducted by the Executive Director (E.D.) and Regional Environmental Service Director (R.E.S.D.) related to the requirement that plan of correction interventions must be verified to ensure compliance with "Life Safety Code Standard" regulations.</p> <p>The Maintenance Director will conduct quarterly attic inspections in</p>	12/16/11
{K 062} SS=E	<p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and review of</p>	{K 062}	<p>RECEIVED DEC 20 2011</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Robert Hillman TITLE: Executive Director (X6) DATE: 12/16/11

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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{K 062}	<p>Continued From page 1</p> <p>the facility's Plan of Correction, it was determined the facility did not maintain the sprinkler system according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect three (3) of ten (15) smoke compartments, thirty six (38) residents, staff and visitors.</p> <p>The findings include:</p> <p>Review of the facility's Plan of Correction for the survey dated 10/06/2011 with a compliance date of 11/16/2011 revealed the facility inspected sprinkler piping with no concerns identified.</p> <p>Observation, on 11/21/2011 at 4:21 PM, revealed the sprinkler piping located above the drop ceiling in the C Wing (next to the Assistant Director of Nursing office) had numerous wires being supported by the sprinkler piping. Further observation revealed the same for the sprinkler piping located above the drop ceiling for the connector hall of the B and C wing, B wing lobby, and the B Hallway. The observations were confirmed with the Maintenance Director.</p> <p>Interview, on 11/21/2011 at 4:21 PM, with the Maintenance Director, revealed he believed all the sprinkler piping had been cleared of the wiring attached to the sprinkler piping.</p> <p>Reference: NFPA 25 (1998 edition)</p> <p>2-2.2* Pipe and Fittings. Sprinkler pipe and fittings shall be inspected annually from the floor level. Pipe and</p>	{K 062}	<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>order to ensure ongoing compliance with "Life Safety Code Standard" regulations.</p> <p>The Executive Director or Assistant Executive Director will verify that all contracted services are reviewed/observed by the Maintenance Director upon completion for compliance with "Life Safety Code Standard" regulations.</p> <p>4. The compliance results, related to the quarterly attic inspections, as well as the verification of Maintenance Director review of contracted services, will be reviewed in the monthly Performance Improvement (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] meeting for the next three quarters and as needed</p>	12/16/11

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{K 062}	Continued From page 2 fittings shall be in good condition and free of mechanical damage, leakage, corrosion, and misalignment. Sprinkler piping shall not be subjected to external loads by materials either resting on the pipe or hung from the pipe. Exception No. 1:* Pipe and fittings installed in concealed spaces such as above suspended ceilings shall not require inspection. Exception No. 2: Pipe installed in areas that are inaccessible for safety considerations due to process operations shall be inspected during each scheduled shutdown.	{K 062}	<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>  thereafter. Further interventions/ corrective actions will be implemented as necessary.	