

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

PRINTED: 09/18/2015  
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 09/03/2015
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NAME OF PROVIDER OR SUPPLIER  FOUNTAIN CIRCLE CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 200 GLENWAY ROAD WINCHESTER, KY 40391
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F 000	INITIAL COMMENTS  An Abbreviated/Partial Extended Survey investigating Complaint KY00023708 and Complaint KY00023773 was initiated on 08/20/15 and concluded on 09/03/15. Complaint KY00023773 was unsubstantiated. Complaint KY00023708 was substantiated with deficiencies cited. Immediate Jeopardy (IJ) was identified on 08/25/15 at 42 CFR 483.10 Resident Rights, F-155; 42 CFR 483.20 Resident Assessment, F-281; 42 CFR 483.25 Quality of Care, F-309; 42 CFR 483.40 Physician Services, F-385; and, 42 CFR 483.75 Administration, F-490 and F-514 all at a Scope and Severity of a "J". Substandard Quality of Care was identified at 42 CFR 483.25 Quality of Care, F-309. The Immediate Jeopardy was determined to exist on 08/15/15 and the facility was notified of the Immediate Jeopardy on 08/25/15.  On 08/15/15 at approximately 7:15 AM, Resident #1, who's Responsible Party implemented Advance Directives on 08/13/15 requesting the resident to be a Full Code, was found non-responsive and was assessed by Licensed Practical Nurse (LPN) #1 and #2 with no pulse. However, there was no documented evidence Cardiopulmonary Resuscitation (CPR) was immediately initiated per the resident's Advance Directives and Physician's orders. Registered Nurse (RN) #1 was called to the resident's room by LPN #2. RN #1 documented the resident had no heart rate and no respirations; however, there was no documented evidence she immediately initiated a Full Code including CPR as per the resident's Advance Directives and Physician's orders. RN #1 pronounced Resident #1 deceased at 7:23 AM.	F 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Silena M. Hudson* TITLE *Administrator* (X6) DATE *10-9-15*

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000 Continued From page 1

An acceptable credible Allegation of Compliance was received on 08/31/15, alleging removal of the Immediate Jeopardy on 08/29/15. The State Survey Agency verified the Immediate Jeopardy was removed as alleged on 8/29/15, prior to exit on 09/03/15, with remaining non-compliance at 42 CFR 483.10, Resident Rights, F-155; 42 CFR 483.20, Resident Assessment, F-281; 42 CFR 483.25, Quality of Care, F-309; 42 CFR 483.40, Physician Services, F-385 and 42 CFR 483.75 Administration, F-490 and F-514 all at a Scope and Severity of a "D".

F 155 483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES

The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section.

The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.

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1. The Director of Nursing reviewed Resident #1's medical record on 8/15/15. During the review of the medical record, Resident #1's code status was a full code and the advanced directive was not honored on 8/15/15.

2. All residents advance directive/code status/physician order for code status along with resident care plan and SRNA care plan were audited by 8/17/15 by the Director of Nursing, Unit Managers, Nursing supervisor or medical records to ensure accuracy. The review of audit revealed that on 4 different residents, it was noted of missing dates and times of physician notification upon admission to the facility.

8-29-15

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F 155	Continued From page 2  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 have an effective system to ensure the Advance Directives for one (1) of twelve (12) sampled residents (Resident #1) were honored.  On 08/13/15, Resident #1's Responsible Party (RP) signed Advance Directives requesting the resident have a Full Code status (Full Code indicated life-saving measures were to be implemented in the event of cardiac or respiratory failure), to include Cardiopulmonary Resuscitation (CPR). However, on 08/15/15 at approximately 7:15 AM, when State Registered Nursing Assistant (SRNA) #1 entered Resident #1's room, found him/her unresponsive and notified Licensed Practical Nurse (LPN) #1 and #2, the LPN's failed to honor the resident's Advance Directives regarding his/her Full Code status. LPN #1 entered Resident #1's room, checked Resident #1 for a pulse, could not obtain a pulse and failed to initiate CPR as per the resident's Advance Directives. LPN #2 entered Resident #1's room, observed LPN #1 checking the resident for a pulse, went to the nurse's station, checked the resident's chart for his/her code status and called Registered Nurse (RN) #1. LPN #2 also failed to initiate CPR as per the resident's Advance Directives. RN #1, who was on another unit, arrived to Resident #1's room, assessed the resident to have "no heart rate" and "no respirations" and pronounced the resident deceased at 7:23 AM. Per interview, RN #1 determined Resident #1 was a Full Code, but she did not initiate CPR according to the resident's	F 155	3. All nursing staff were educated by the SDC, SCC, Nursing Supervisors, or Unit Managers on the advance directive policy and procedure, admission/physician order policy and procedure, care plan policy and procedure, resident rights policy and procedure, quality of care delivery, and professional standards. Education was initiated on 8/15/15 with 100% of full time licensed nurses completed by 8/28/15, except for those on LOA, vacation, or suspension, which consisted of 4 nurses. Prior to returning back to work, these 4 nurses will have to complete the education listed above.  4. All new employees will receive education on the advance directive policy and procedure, admission/physician order policy and procedure, care plan policy procedure, resident rights policy and procedure, quality of care delivery, and professional standards during the orientation process.  DON, ADONs, Unit Managers Nursing supervisor or Medical Records will review all new admissions daily starting on 8/25/15 during the morning clinical meeting to ensure compliance with physician notification, physician orders, interim care plan, advance directive, and resident rights. Audits will be completed on all new admission records daily for four weeks then three times per week for two weeks, then 10% of all new admission records monthly for 2 months. The ongoing process will be discussed in the Quality Assurance committee meeting monthly for three months, for recommendations and for		

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F 155 Continued From page 3  
Advance Directives.

The facility's failure to ensure resident's Advance Directives regarding their requested Full Code status was honored has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy (IJ) was identified on 08/25/15, and was determined to exist on 08/15/15. The facility was notified of the Immediate Jeopardy on 08/25/15.

An acceptable credible Allegation of Compliance (AOC) was received on 08/31/15 which alleged removal of the Immediate Jeopardy on 08/29/15. The Immediate Jeopardy was verified to be removed on 08/29/15 as alleged, prior to exit on 09/03/15, with remaining non-compliance in the area of 42 CFR 483.10, Resident Rights, F-155 at a Scope and Severity of a "D" while the facility develops and implements a Plan of Correction (POC) and the facility's Quality Assurance (QA) monitors to ensure compliance with systemic changes.

The findings include:

Review of the facility's policy titled "Advance Directives - Kentucky", effective 12/2010, revealed it was the policy of the facility to recognize and support the use of Advance Directives through family, staff and community education, and to encourage the resident's rights to self-determination through recognition and assistance with executing such directives. Continued review revealed, as long as the resident was competent to make decisions, his/her wishes would be followed to the maximum extent possible as dictated by state law and sound medical judgment. If a resident became

F 155 further follow up as indicated. The members of the Quality Assurance committee include, but not limited to the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, SDC, Social Services Director, Dietician, Quality of Life Director, and Unit Managers.

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F 155	<p>Continued From page 4</p> <p>incompetent, but had provided evidence of a properly executed Advance Directive, the facility would implement the resident's choices as outlined in the document or expressed to the appointed agent to the same extent that the competent resident's wishes would be followed. Further review revealed, all residents would receive full resuscitative measures unless a "Do Not Resuscitate" (DNR) directive was written in the resident's medical record and was identified in the resident's Advance Directive.</p> <p>Review of the facility's policy titled, "Cardiopulmonary Resuscitation", undated, revealed CPR would be attempted for any resident who was found to have no pulse and or no discernible respirations, unless there was a written physician order to the contrary and or written Advance Directives.</p> <p>Review of the facility's policy titled "Resident Rights", reviewed 06/01/15, revealed residents had the right to choose a physician, treatment, participation in decisions, and care planning. Further review revealed, residents were entitled to exercise their rights and privileges to the fullest extent possible. Per the policy, employees had a duty to read and learn the residents' rights.</p> <p>Review of Resident #1's medical record, revealed the facility admitted him/her on 08/13/15, with diagnoses which included Syncope, Dementia, Alzheimer's and Combativeness.</p> <p>Review of Resident #1's "Nursing Admission Information", dated 08/13/15, revealed the resident was alert and oriented to person with independent mobility. Review of the "Advance Directives/Informed Consent", dated 08/13/15,</p>	F 155		

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F 155	<p>Continued From page 5</p> <p>revealed it was signed by the resident's Responsible Party on 08/13/15. Continued review of the form revealed the resident wished to be a "Full Code". Review of the Physician's Orders, dated 08/13/15, revealed Resident #1 had an order for a Full Code status.</p> <p>However, review of the Nurse's Note, dated 08/15/15, not timed, signed by LPN #1, revealed the nurse found Resident #1 sitting on the floor next to the bed with blood noted to be on the pillow and ear with no pulse found. Continued review revealed no documented evidence LPN #1 immediately initiated CPR according to Resident #1's Advance Directive.</p> <p>Interview with LPN #1, on 08/20/15 at 6:12 PM, revealed when he found Resident #1 on 08/15/15 around 7:15 AM, he did not initiate CPR. Continued interview revealed he did not know if Resident #1 was a "Full Code" status and felt the resident required further assessment, and stated the RN was more qualified. Per interview, LPN #1 was unfamiliar with the facility's policy; however, he stated he did not know why he didn't initiate CPR.</p> <p>Review of the Nurse's Note, dated 08/15/15 at 7:23 AM, signed by LPN #2, revealed LPN #2 found Resident #1 sitting beside the bed with his/her back to the bed and leaning to his/her left side with fresh "wet" blood from the left ear on the pillow. Continued review revealed no documented evidence LPN #2 initiated CPR according to Resident #1's Advance Directive. Further review of the Nurse's Note revealed LPN #2 immediately called the RN and the on-call Physician. Continued review of the Note revealed, LPN #2 received an order from the on</p>	F 155	

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F 155	<p>Continued From page 6</p> <p>call Physician to "with hold CPR" related to no signs of life, no pulse, no respiration and no blood pressure.</p> <p>Interview with the on-call Physician, on 08/24/15 at 8:13 AM, revealed the facility did notify him of the resident's death. However, per interview, he was not aware Resident #1 was a "Full Code" status and he would not give an order to withhold CPR.</p> <p>Interview with LPN #2, on 08/20/15 at 4:31 PM, revealed she had entered Resident #1's room behind LPN #1 and found the resident with no pulse; however, she did not initiate CPR. LPN #2 stated she went to the nurse's station to check the resident's code status and call the RN. Further interview revealed, she identified the resident to be a "Full Code" status and informed LPN #1 and RN #1 of the resident's Advance Directive; even though she did not initiate CPR. LPN #2 reported the resident was "just too far gone". Per interview, LPN #2 stated she reported to the on-call Physician the resident had expired and the RN had decided the resident was "too far gone" to perform CPR.</p> <p>Review of the Nurse's Note, dated 08/15/15 at 7:30 AM, signed by RN #1, revealed she found the resident sitting on the floor with his/her back to the bed and leaning to the left side with blood from the left ear with no heart rate and no respirations. Further review of the Note, revealed Resident #1 was pronounced deceased by RN #1 at 7:23 AM.</p> <p>Interview with RN #1, on 08/20/15 at 5:50 PM, revealed she responded to a call on 08/15/15 around 7:10 AM or 7:15 AM, from LPN #2</p>	F 155	

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requesting a nurse to pronounce a resident deceased. Per interview, RN #1 was not aware Resident #1 was a "Full Code" status until she went to the nurse's station to document her assessment; however, she did not initiate CPR because "in my nursing opinion, she had been passed for a while". Further interview revealed, it was the facility's policy to initiate CPR when a resident was found in cardiac arrest or unresponsive and was a "Full Code" status. RN #1 stated she did not follow the facility's policy.

Interview with the Director of Nursing (DON), on 08/24/15 at 3:09 PM, revealed if a resident was found unresponsive, staff should confirm the resident's Advance Directive, and CPR should be immediately initiated for any resident with a "Full Code" status Advance Directive. Continued interview revealed staff did not follow the facility's policy for Resident #1.

Interview with the Administrator, on 08/24/15 at 4:50 PM, revealed Resident #1 had the right to an Advance Directive and the resident's wishes should have been honored by the facility and the staff. Continued interview revealed, staff did not follow the facility's policy related to the initiation of CPR.

The facility provided an acceptable credible Allegation of Compliance (AOC) on 08/31/15, which alleged removal of the IJ effective 08/29/15. Review of the AOC revealed the facility implemented the following:

1. On 08/15/15, the Director of Nursing (DON) reviewed Resident #1's medical record and care plan with the following areas of concern identified:
  - a. The date and time were missing regarding the

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F 155	<p>Continued From page 8</p> <p>Physician notification on the Nursing Admission Assessment b. the Advance Directive of "Full Code" status was not care planned on the Interim Care Plan. c. CPR was not immediately initiated per Resident #1's/Power of Attorney's (POA's) request as indicated on the Advance Directive.</p> <p>2. Beginning 08/15/15 and concluding on 08/17/15, the DON, Unit Managers, Nursing Supervisors or Medical Records staff audited all resident Advance Directive/Code Status/Physician's orders for code status, Care Plans and State Registered Nurse Aide (SRNA) Care Plans.</p> <p>3. Beginning 08/15/15 and concluding on 08/17/15, the DON, Assistant Director of Nursing (ADON), Unit Managers and Nursing Supervisors assessed all residents for any possible resident rights violations. Residents with a Brief Interview of Mental Status (BIMS) score of eight (8) or greater were interviewed and residents with a BIMS of less than eight (8) were physically assessed for any signs and symptoms of possible quality of life or resident rights violations.</p> <p>4. Compliance audits of the admission process were completed by 08/18/15 of all admissions within the previous thirty (30) days. The audits were performed by the DON, ADON, Unit Managers or Nursing Supervisors of all resident's medical records to include notification of the Attending Physician, review of the Physician Admitting Orders with the Attending Physician and ensuring professional standards were followed.</p> <p>5. The DON, Unit Managers, Nursing Supervisors or Medical Records staff completed</p>	F 155	

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F 155	Continued From page 9 audits of all resident charts by 08/26/15. The Audit included; resident's Advance Directive, Physician's Orders, Assessments, Multidisciplinary Notes and Care Plan to ensure compliance with quality of care delivery.  6. On 08/26/15, all management staff was educated by the Regional Nurse Consultant. Education included: Advance Directive Policy and Procedure, Admission/Physician's Order Policy and Procedure, Care Plan Policy and Procedure, Revised CPR Policy and Procedure, Resident Rights Policy and Procedure, Quality of Care Delivery, Professional Standards and Quality Assurance Performance Improvement (QAPI).  7. Education for all nursing staff was initiated on 08/15/15 and completed by 08/28/15, with the exception of four (4) full-time status staff on leave and twenty-one (21) part-time staff. Certified letters were sent to the twenty-one (21) part-time staff to notify each of the mandatory education prior to returning to duty. Education was provided by the Staff Development Coordinator, Unit Mangers and Nursing Supervisors. Education included Advance Directive Policy and Procedure, Admission/Physician Order Policy and Procedure, Care Plan Policy and Procedure, Revised CPR Policy and Procedure, Resident Rights Policy and Procedure, Quality of Care Delivery, Professional Standards and QAPI. The education related to the policies and procedures was added to the training agenda for New Employee Orientation.  8. Beginning 08/21/15 and concluding on 08/24/15, the Staff Development Coordinator, Unit Managers and Nursing Supervisors conducted education for all licensed staff (with the exception of the part-time staff who were	F 155		
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notified by certified letter they could not work until receiving the required education) on the admission policy and procedure, to include: clarification of the process for Physician notification of new admissions, obtaining Admission Orders, the Interim Care Plan and professional standards. The above education was incorporated into the facility's New Employee Orientation.

9. On 08/25/15, all Physicians with privileges at the facility were educated by the DON in regards to the admission process and expectations with compliance to include: Discharge Summaries or Orders from a discharging facility would be faxed to the Physician's office and the Physician would be called for approval of the Orders with a Telephone Order written stating the Physician's review and approval of the Orders.

10. Human Resources and/or Staff Development performed audits of all personnel files for CPR certifications. Audits were completed by 08/25/15 and given to the Regional Nurse Consultant to review for non-compliance with CPR regulations. Seventeen (17) licensed nurses were noted to have on-line only CPR certifications.

11. Sixteen (16) of the seventeen (17) staff identified to have on-line CPR certifications received CPR instruction with hands on component by 08/27/15, provided by the DON, a certified American Heart CPR Instructor. One (1) employee would not be allowed to work until CPR certification with hands on component was obtained.

12. Beginning 08/25/15, the DON, ADON, Unit Manager, Nursing Supervisor or Medical Records

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NAME OF PROVIDER OR SUPPLIER  FOUNTAIN CIRCLE CARE & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 GLENWAY ROAD WINCHESTER, KY 40391	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (X5) COMPLETION DATE
F 155	<p>Continued From page 11</p> <p>staff will review all new admissions daily during the morning clinical meeting to ensure compliance with Physician notification, Physician Orders, Interim Care Plan, Advance Directive, and Resident Rights. Findings of the review will be reported in the Quality Assurance (QA) committee meeting. The committee consists of the Medical Director, Administrator, DON, Social Services Director and at least two (2) other department managers, different line staff as appropriate, and outside consultants as appropriate. The committee will meet weekly for four (4) weeks then monthly to determine the need for continued education or revision of the plan. Based on evaluation, the QA committee will determine at what frequency the ongoing review of new admissions will need to continue. Concerns identified will be corrected immediately by the DON, ADON, Unit Managers or Nursing Supervisor and reported to the Administrator to ensure any needed investigation initiated and reported guidelines were met.</p> <p>13. The DON, ADON, Unit Managers, or Nursing Supervisor will monitor care delivery as outlined per the care plan on five (5) residents per unit per day until immediacy is removed, beginning 08/25/15, then five (5) residents daily for four (4) weeks, to ensure compliance with care delivery as outlined by the Care Plan along with compliance of Professional Standards requirements. Findings will be reported in the QA committee weekly to determine the further need of continued education or the revision of the plan.</p> <p>14. Mock codes will be conducted by the DON, ADON, Unit Managers, Staff Development Coordinator or Nursing Supervisor twice weekly, on rotating shifts, for four (4) weeks beginning</p>	F 155	

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F 155	<p>Continued From page 12</p> <p>08/18/15, to ensure understanding and compliance with Code Blue Policy and Procedure. The first two (2) mock codes were conducted by Clinical Managers for education on how to conduct a code; the Mock codes will be conducted by the nurses. Findings will be reported to the QA committee weekly to determine compliance and any further need of continued education or revision of the plan.</p> <p>15. The DON, Staff Development Coordinator or Human Resources will track all licensed nurses CPR certification monthly beginning 08/26/15, to ensure compliance with CPR policy, procedure and governing regulations. Findings and compliance will be reported monthly to the QA committee to determine any need for education or revision of the process.</p> <p>16. A Regional Nurse or corporate office staff was on site since 08/19/15 and will remain on site daily until immediacy is removed, then will be on site three (3) times weekly for four (4) weeks. Regional/Corporate staff will review compliance with the plan and will review compliance with policy and procedure of any code blue that occurs and review compliance with new or re-admissions. During weekly follow-up, guidance and recommendations will be provided with compliance validated.</p> <p>17. Administrative oversight of the facility will be completed by the Vice President of Operations, Nurse Consultant, or Special Projects Administrator daily until removal of the immediacy beginning 09/19/15, then weekly for four (4) weeks, then monthly.</p> <p>18. A Quality Assurance meeting will be held</p>	F 155		
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F 155	<p>Continued From page 13</p> <p>weekly until immediacy is removed beginning on 08/21/15, the for four (4) weeks, then monthly for recommendations and further follow up regarding the stated plan. Based on evaluation, the QA committee will determine at what frequency any ongoing audits will need to continue. The Administrator has the oversight to ensure an effective plan is in place to meet resident well-being and ensure resident rights as well as an effective plan to identify facility concerns and implement a plan of correction to involve all staff of the facility. Corporate Administrative oversight of the Quality Assurance meeting will be completed by the Special projects Administrator, the Regional Vice President of Operations, or a member of regional staff three (3) times a week until immediacy is removed beginning 08/15/15, then weekly for four (4) weeks, then monthly.</p> <p>The State Survey Agency validated the implementation of the facility's AOC as follows:</p> <ol style="list-style-type: none"> <li>1. Review of the facility's investigation of the incident revealed an audit of Resident #1's medical record with areas concern noted.</li> </ol> <p>Interview with the DON, on 09/02/15 at 5:20 PM, revealed she audited Resident #1's medical record and identified areas of concern with immediate implementation of education provided to staff.</p> <ol style="list-style-type: none"> <li>2. Review of the facility's audit of all resident's Advance Directive, Care Plans and Physician's Orders revealed the Audit tool was printed on 08/15/15 and signed by the auditor of each resident's documentation on 08/15/15.</li> </ol> <p>Interview with the DON, on 09/02/15 at 5:20 PM,</p>	F 155	

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F 155	<p>Continued From page 14</p> <p>revealed she had participated with other management staff to audit all resident records to verify accuracy of the resident's Advance Directive, Care Plans and Physician's code status order.</p> <p>3. Review of the audit tool utilized to interview and assess all residents for possible resident rights violations revealed management staff interviewed all resident's with a Brief Interview for Mental Status (BIMS) score of eight (8) or greater and a physical assessment was completed for resident's whose BIMS was less than eight (8).</p> <p>Interview with the DON, on 09/02/15 at 5:20 PM, revealed management staff interviewed or assessed each of the facility's residents for any signs or symptoms of resident rights violations. Interview with interviewable residents revealed staff did talk with them regarding their resident rights.</p> <p>4. The audit tool, dated 08/18/15, utilized to audit previous thirty (30) days facility new admissions was reviewed. New admissions were audited for compliance with admission process including: Physician notification, review of New Admission Physician's Orders with Physician and ensuring professional standards were followed. Areas of concern identified with the audit were documentation in relation to missing dates and times on the Nursing Admission Assessment on four (4) residents. Review of the education provided to staff revealed policy and procedures related to accuracy of the admission process and documentation was provided. Review of the staff sign in sheets revealed instruction was provided beginning 08/15/15 with review of policy and procedure. On 08/28/15, a more comprehensive</p>	F 155	

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F 155	<p>Continued From page 15 education was provided to staff related to the policy and procedure.</p> <p>Interview with the DON, on 09/02/15 at 5:20 PM, revealed she initiated education to the nursing staff immediately on 08/15/15. Per the DON, the Regional Nurse provided comprehensive education to the management staff on 08/28/15. Further interview revealed, after receiving the comprehensive education, the management staff were responsible for providing the comprehensive education to the facility's nursing staff.</p> <p>5. Review of the audit of each resident's medical record to include: Advance Directive, Physician's Orders, Assessments, Multidisciplinary Notes and Care Plans was completed by 08/26/15.</p> <p>Interview with the DON, on 09/02/15 at 5:20 PM, revealed she and other management staff audited each resident's medical record to ensure compliance with quality of care delivery.</p> <p>6. Review of education provided by the Regional Nurse to all management staff with the sign in sheet dated 08/28/15 and signed by the Regional Nurse revealed the education provided included: Cardiopulmonary Resuscitation, Advance Directives, Physician Visits and Medical Orders, Admission Criteria, Care Planning - Interdisciplinary Team, Resident Rights, Quality of Care, Professional Standards, and QA.</p> <p>Interview with the Regional Nurse Consultant, on 09/02/15 at 5:20 PM, revealed he provided comprehensive education to management staff related to the facility's policies and procedures stated above. Continued interview revealed the facility revised the CPR policy to include</p>	F 155	

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F 155	<p>Continued From page 16 mandatory hands on skills certification for staff.</p> <p>7. Review of education provided to all nursing staff to include: Cardiopulmonary Resuscitation, Advance Directives, Physician Visits and Medical Orders, Admission Criteria, Care Planning - Interdisciplinary Team, Resident Rights, Quality of Care, Professional Standards, and QA. Review of sign in sheets revealed the education was initiated on 08/26/15 and concluded on 08/28/15. Review of certified letters sent to twenty-one (21) part-time clinical staff related to mandatory education prior to working. Continued review of sign-in sheets revealed education for part-time clinical staff, non-licensed staff and non-nursing staff continued per AOC. Review of New Orientation Agenda for clinical staff, revealed education would be provided with orientation process. Review of audit tool utilized for validation of CPR certification with hands on skills component revealed staff had obtained education with hands on skill component.</p> <p>Interview, on 09/01/15 at 10:20 AM with SRNA #8; at 10:30 AM with SRNA #7; at 10:40 AM with SRNA #4; at 10:50 AM with SRNA #2; and, at 11:00 AM with SRNA #6 revealed they had all been provided education related to Cardiopulmonary Resuscitation, Resident Rights, Quality of Care and Professional Standards between 08/15/15 and 08/28/15 in a verbal lecture setting allowing for question and answers.</p> <p>Interview, on 08/20/15 at 5:50 PM with RN #1 and at 6:12 PM with LPN #1; on 09/01/15 at 11:15 AM with LPN #12; at 11:25 AM with LPN #3; at 4:16 PM with LPN #11; at 4:30 PM with LPN #2; at 4:45 PM with RN #4; at 5:00 PM with RN #2; at 5:17 PM with RN #3; and, Unit Manager #1 at</p>	F 155		

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F 155	Continued From page 17 4:29 PM, revealed they had all been provided education related to Cardiopulmonary Resuscitation, Advance Directives, Physician Visits and Medical Orders, Admission Criteria, Care Planning, Resident Rights, Professional Standards, and Quality of Care in a verbal lecture setting allowing for question and answers.  8. Review of the education provided to all licensed staff related to the admission policy and procedure revealed the education was initiated on 08/21/15 and completed on 08/28/15 after additional education was provided by the Regional Nurse Consultant.  Interview with the DON, on 09/02/15 at 5:20 PM, revealed she had initiated staff education on 08/21/15. After receiving comprehensive education provided by the Regional Nurse Consultant on 08/26/15, the management team re-educated staff with the completion date for full-time clinical staff to be 08/28/15.  9. Review of the education provided to all Physicians with privileges to included; clarification of the process for notifying the Physician of new admits and obtaining orders, and the Interim Care Plan and Professional Standards. Further review, revealed there was follow up letters sent to each Physician related to the educations provided.  10. Review of the Audit of personnel files for CPR certification revealed the Audit was completed on 08/25/15 with the Regional Nurse Consultant review on 08/25/15. Data from the audit revealed seventeen (17) staff without the hands on skill component for CPR certification.  11. Review of the Audit of personnel files for	F 155			

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F 155	<p>Continued From page 18</p> <p>CPR certifications revealed sixteen (16) of the seventeen (17) identified staff without hands on skill component CPR certifications had obtained certifications with the hands on skills component.</p> <p>Interview with the DON, on 9/02/15 at 5:20 PM, revealed she was a Certified American Heart CPR Instructor. Further interview revealed, she had conducted four (4) CPR classes for staff that included the hands on skills component. Per interview, one staff still remained out of compliance with the CPR certification hands on component and would not be allowed to work until appropriate certification was obtained.</p> <p>12. Review of the Daily New Admission Log, revealed new admissions were reviewed daily for compliance with Physician Notification, Physician Orders, Interim Care Plan, Advance Directive, and Resident Rights beginning 08/25/15.</p> <p>Interview with the DON on 09/02/15 at 5:20 PM, revealed areas of concern were identified when the audits were initiated on 08/25/15; however, after staff received education, data collected had improved. Further interview revealed any issues identified would be immediately corrected with data reviewed with the QA committee weekly for four (4) weeks, then monthly with the results of the collected data to determine the need for additional education or the revision of the plan.</p> <p>13. Review of documentation monitoring care delivery as outlined per the resident's care plan, revealed five (5) resident care plans per day per unit were reviewed by management staff beginning 08/25/15.</p> <p>Interview with the DON, on 09/02/15 at 5:20 PM,</p>	F 155	

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F 155	<p>Continued From page 19</p> <p>revealed management staff had audited resident care plans daily. Further interview revealed five (5) care plans were audited on each unit daily since 08/25/15.</p> <p>14. Review of documentation of the Mock codes revealed they were conducted twice weekly on rotating shifts beginning 08/18/15.</p> <p>Interview, on 08/20/15 at 5:50 PM with RN #1 and at 6:12 PM with LPN #1; on 09/01/15 at 11:15 AM with LPN #12; at 11:25 AM with LPN #3; at 4:16 PM with LPN #11; at 4:30 PM with LPN #2; at 4:45 PM with RN #4; at 5:00 PM with RN #2; at 5:17 PM with RN #3; and, Unit Manager #1 at 4:29 PM, revealed they had all been provided education related to Cardiopulmonary Resuscitation and Advance Directives with Mock Codes conducted on different shifts.</p> <p>15. Review of documentation of CPR certification tracking revealed the date the certification was obtained and verification the certification contained a hands on skills component.</p> <p>Interview with the DON, on 09/02/15 at 5:20 PM, revealed the facility had previously been tracking CPR expiration dates; however, the facility added verification of a hands on skills component to their tracking data to ensure compliance.</p> <p>16. Review of the documentation of a calendar, signed by the Regional Nurse and Regional Vice President of Operations revealed the Regional Vice President of Operations was on site 08/21/15 and 08/28/25. Further review revealed, the Regional Nurse was on site daily from 08/16/15 to 09/02/15 with the exception of 08/17/15.</p>	F 155		

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F 155	<p>Continued From page 20</p> <p>Interview with the Regional Nurse, on 09/02/15 at 5:20 PM, revealed he had been in the facility each day with the exception of 08/17/15.</p> <p>Interview with the Administrator on 09/01/15 at 5:20 PM, revealed the Regional Nurse had been on site daily since 08/16/15 with the exception of 08/17/15. Interview with Unit Manager #1, on 09/01/15 at 4:29 PM, revealed the Regional Nurse had been on site "seemed like" daily for over two (2) weeks.</p> <p>17. Review of documentation of a calendar, signed by the Regional Nurse and Regional Vice President of Operations revealed on site Administrative oversight was performed by the Regional Vice President of Operations on 08/21/15 and 08/28/15. Further review revealed, on site Administrative oversight was performed by the Regional Nurse on each day from 08/16/15 to 09/02/15, with the exception of 08/17/15.</p> <p>Interview with the Regional Nurse, on 09/02/15 at 5:20 PM, revealed he had been on site at the facility daily since 08/16/15 with the exception of 08/17/15.</p> <p>Interview with the Administrator on 09/01/15 at 5:20 PM, revealed the Regional Nurse had been on site daily since 08/16/15 with the exception of 08/17/15. Interview with Unit Manager #1, on 09/01/15 at 4:29 PM, revealed the Regional Nurse had been on site "seemed like" daily for over two (2) weeks.</p> <p>18. Review of the QA sign in sheets revealed, meetings were conducted on 08/21/15, 08/26/15, and 08/28/15 with the areas of concern</p>	F 155	

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F 155	Continued From page 21 discussed. The Medical Director was in attendance on 08/26/15.  Interview with the Administrator, on 09/03/15 at 11:15 AM, revealed the data obtained from the audits performed, revealed areas of concern related to the Mock codes which were initially performed. Continued interview revealed, the data was analyzed and it was determined additional education was needed. Further interview revealed the additional education was provided with positive data resulting from ongoing Mock codes and audits.	F 155			
F 281 SS=J	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, review of the facility's policy and review of the Kentucky Board of Nursing's (KBN's), "Accountability & Responsibility of Nurses" document and Advisory Opinion Statements (AOS), it was determined the facility failed to have an effective system to ensure services provided met professional standards of quality for one (1) of twelve (12) sampled residents (Resident #1) regarding ensuring nursing staff honored the resident's Advance Directives and ensuring care planning was sufficient to meet the needs of newly admitted residents related to code status.  On 08/13/15, Resident #1's Responsible Party, signed Advance Directives requesting the	F 281		8-29-15	
		F281	1. The Director of Nursing reviewed Resident #1's medical record on 8/15/15. During the review of the medical record, Resident #1's code status was a full code and the advanced directive was not honored on 8/15/15. The review also revealed that the full code status was not care planned per the advance directive.  2. All residents charts, to include advance directive, physician orders along with Physician order sheet, assessments, multidisciplinary notes and care plan were audited by 8/26/15 by DON, Unit Managers, Nursing Supervisor or Medical Records to		

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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 09/03/2015
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NAME OF PROVIDER OR SUPPLIER  FOUNTAIN CIRCLE CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 200 GLENWAY ROAD WINCHESTER, KY 40391
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F 281 Continued From page 22  
resident have a Full Code status (Full Code specifies life saving measures would be implemented in the event of cardiac or respiratory failure) with life-saving measures to include Cardiopulmonary Resuscitation (CPR). Resident #1 also had a Physician's Order for a Full Code status; however, review of the Interim Care Plan, dated 08/13/15, revealed no documented evidence the resident was care planned to have a Full code status. On 08/15/15 at approximately 7:15 AM, when State Registered Nursing Assistant (SRNA) #1 entered Resident #1's room, found the resident unresponsive, and notified Licensed Practical Nurse (LPN) #1 and #2, the LPN's failed to honor Resident #1's Advance Directives regarding Full Code status. LPN #1 entered Resident #1's room, checked the resident for a pulse, could not obtain a pulse, and failed to initiate CPR as per the resident's Advance Directives. LPN #2, then entered Resident #1's room, observed LPN #1 checking the resident for a pulse, went to the nurse's station, checked the resident's medical record for code status and called Registered Nurse (RN) #1. LPN #2 also failed to initiate CPR as per the resident's Advance Directives. RN #1, who was working on another unit, arrived to Resident #1's room, assessed the resident to have "no heart rate" and "no respirations" and pronounced the resident deceased at 7:23 AM, without prior approval or order obtained by the resident's physician. Per interview, RN #1 determined Resident #1 was a Full Code; however, she did not initiate CPR according to the resident's Advance Directives.

The facility's failure to ensure services provided met professional standards of quality related to Advance Directives regarding residents' requested code status, and ensuring the Interim

F 281 ensure compliance with quality of care delivery.

3. All nursing staff were educated by the SDC, SCC, Nursing Supervisors, or Unit Managers on the advance directive policy and procedure, admission/physician order policy and procedure, care plan policy and procedure, resident rights policy and procedure, quality of care delivery, and professional standards. Education was initiated on 8/15/15 with 100% of full time licensed nurses completed by 8/28/15, except for those on LOA, vacation, or suspension, which consisted of 4 nurses.

4. DON, ADON, Unit Managers, or Nursing Supervisor will monitor care delivery as outlined per care plan on 5 residents per unit per day until immediacy is removed, starting on 8/25/15, then 5 residents daily for 4 weeks, then 5 residents three times per week for 2 weeks, then 5 residents monthly for two months.  
DON, ADONs, Unit Managers Nursing supervisor or Medical Records will review all new admissions daily starting on 8/25/15 during the morning clinical meeting to ensure compliance with physician notification, physician orders, interim care plan, advance directive, and resident rights. Audits will be completed on all new admissions daily for four weeks, then three times per week for two weeks, then 10% of new admissions monthly for 2 months.

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F 281	<p>Continued From page 23</p> <p>Care Plan was sufficient for newly admitted residents, caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 08/25/15, and was determined to exist on 08/15/15. The facility was notified of the Immediate Jeopardy on 08/25/15.</p> <p>The facility provided an acceptable credible Allegation of Compliance (AOC) on 08/31/15 with the facility alleging removal of the Immediate Jeopardy on 08/29/15. The State Survey Agency validated removal of the Immediate Jeopardy as alleged, on 08/29/15, prior to exit on 09/03/15, with remaining non-compliance in the area of 42 CFR 483.20 Resident Assessment, F-281 at a Scope and Severity of a "D" while the facility develops and implements a Plan of Correction and the facility's Quality Assurance (QA) monitors to ensure compliance with systemic changes.</p> <p>The findings include:</p> <p>Review of the facility's policy, titled "Advance Directives - Kentucky" effective 12/2010, revealed it was the policy of the facility to recognize and support the use of Advance Directives through family, staff and community education and to encourage the resident's rights to self-determination through recognition and assistance with executing the directives. Further review revealed, as long as the resident was competent to make decisions, his/her wishes would be followed to the maximum extent possible as dictated by state law and sound medical judgment. If a resident became incompetent, but had provided evidence of a properly executed Advance Directive, the facility would implement the resident's choices as</p>	F 281	<p>DON, ADONs, Unit Managers, Nursing Supervisor or Medical Records will review all deaths that occur in the facility and anytime that a "code blue" is called to ensure advanced directives and code status were followed. This will continue to be monitored for all "code blue" that are called in the facility. This process will be validated by comparing the "Emergency Code" sheet to the residents current advance directive by the DON, ADONs, SDC, or Unit Mangers. The ongoing processes will be discussed in the Quality Assurance committee meeting monthly for three months, for recommendations and for further follow up as indicated. The members of the Quality Assurance committee include, but not limited to the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, SDC, Social Services Director, Dietician, Quality of Life Director, and Unit Managers.</p>	

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F 281	<p>Continued From page 24</p> <p>outlined in the document or expressed to the appointed agent to the same extent the competent resident's wishes would be followed. Continued review revealed, all residents would receive full resuscitative measures unless a "Do Not Resuscitate" (DNR) directive was written in the resident's medical record and was identified in the resident's Advance Directive.</p> <p>Review of the facility's policy, titled "Resident Rights", reviewed 06/01/15, revealed residents had the right to choose a physician, treatment, and participate in decisions and care planning. Further review revealed, residents were entitled to exercise their rights and privileges to the fullest extent possible. According to the policy, employees had a duty to read and learn the residents' rights.</p> <p>Review of the facility's policy, titled "Cardiopulmonary Resuscitation", undated, revealed CPR would be attempted for a resident who was found to have no palpable pulse and/or no discernible respirations, unless there was a written Physician's Order to the contrary and/or written Advance Directives. Further review revealed, should a resident be found unresponsive and without respirations, a licensed staff member who was certified in CPR would promptly initiate CPR for residents who requested CPR in their advance directive; who had not formulated an advance directive; or who did not have a valid "DNR" order, unless it would pose a danger to self or others to initiate CPR.</p> <p>Review of the facility's policy, titled "Death of Resident, Documenting", undated, revealed a resident may be declared dead by a Licensed Physician or Registered Nurse with Physician</p>	F 281			

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F 281	<p>Continued From page 25 authorization in accordance with state law.</p> <p>Review of the KBN's, "Accountability &amp; Responsibility of Nurses" document revealed KRS 314.021 (2) held nurses individually responsible and accountable for rendering safe, effective nursing care to clients and for judgements exercised and actions taken in the course of providing care.</p> <p>Review of the KBN's Advisory Opinion Statement (AOS) #36, "Resuscitation", approved February 2008, revealed nurses were "required" to honor the Advance Directives of "patients" who had the Advance Directives documented in the medical record, unless a Physician or healthcare facility refused to comply, and the "patient" and surrogate were informed of the refusal.</p> <p>Review of the facility's policy, titled "Care Planning - Interdisciplinary Team", undated, revealed the facility's Care Planning/Interdisciplinary Team was responsible for the development of an individualized comprehensive care plan for each resident, incorporating goals and objectives that lead to the residents' highest obtainable level of independence. Continued review revealed, the resident, the resident's family and/or the resident's legal representative/guardian or surrogate were encouraged to participate in the development of and revisions to the resident's care plan.</p> <p>Review of Resident #1's medical record revealed the facility admitted the resident on 08/13/15 from the hospital, with diagnoses including; Syncope, Dementia, Alzheimer's Disease and Combativeness. Review of the "Advance</p>	F 281		
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F 281	<p>Continued From page 26</p> <p>Directives/Informed Consent", dated 08/13/15 signed by Resident #1's Responsible Party, revealed the Responsible Party had requested and consented in the event of death for staff to use cardiac compressions or artificial ventilation to resuscitate the resident.</p> <p>Review of the "Nursing Admission Information" document dated 08/13/15, revealed the resident's Advance Directives had been completed. Review of the Physician's Orders, dated 08/13/15, revealed the resident had an order for a Full Code status. However, review of the Interim Care Plan, dated 08/13/15, revealed no documented evidence the resident was care planned to be a Full Code.</p> <p>The State Survey Agency was unable to reach the resident's admitting nurse after multiple attempts.</p> <p>Review of the Nurse's Notes dated 08/15/15, not timed and documented by LPN #1, revealed LPN #1 found Resident #1 sitting on the floor next to the bed with blood on the pillow and ear with no pulse found. Further review of the Note, revealed no documented evidence LPN #1 immediately initiated CPR as per Resident #1's Physician's Order and Advance Directive.</p> <p>Continued review of the Nurse's Notes, revealed a Note dated 08/15/15, at 7:23 AM, documented by LPN #2, which revealed Resident #1 was found sitting beside the bed with his/her back to the bed, leaning to the left side with "wet" fresh blood, from the left ear on the pillow with no pulse, no respirations, no blood pressure and no signs of life. However, there was no documented evidence LPN #2 immediately initiated CPR as.</p>	F 281		

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F 281	Continued From page 27 per Resident #1's Physician's Order and Advance Directive.  Further review of the Nurse's Notes, revealed an entry dated 08/15/15, at 7:30 AM, documented by RN #1, which revealed Resident #1 was sitting on the floor with his/her back to the bed and leaning to the left side with blood from his/her left ear with no heart rate and no respirations. Per the note, Resident #1 was pronounced deceased at 7:23 AM; however, there was no documented evidence RN #1 immediately initiated CPR as per Resident #1's Physician's Order and Advance Directive.  Review of the "Provisional Report of Death" form revealed Resident #1's date and time of death was noted as being on 08/15/15 at 7:23 AM.  Interview with LPN #1, on 08/20/15 at 6:12 PM, revealed on the day shift of 08/15/15, he was the primary nurse for Resident #1. LPN #1 revealed, he was certified to perform CPR; however, when he found Resident #1 on 08/15/15 around 7:15 AM, he did not initiate CPR. He further stated LPN #2 entered the resident's room behind him and did not initiate CPR; however, left the room to call the RN for assistance. Per interview, LPN #1 did not know if Resident #1 had a "Full Code" status and felt the resident required further assessment and the RN was more qualified to complete that assessment. LPN #1 further revealed, he was unfamiliar with the facility's policy; however, he stated he did not know why he didn't initiate CPR.  Interview with LPN #2, on 08/20/15 at 4:31 PM, revealed she was certified in CPR and had entered Resident #1's room behind LPN #1 and	F 281			

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F 281	Continued From page 28 found the resident with no pulse; however, she did not initiate CPR. LPN #2 stated she went to the nurse's station to check the resident's code status and call the RN. Further interview revealed, she identified the resident to be a "Full Code" status and even though she did not immediately initiate CPR, she did inform LPN #1 and RN #1 of the resident's Advance Directive. LPN #2 reported the resident was "just too far gone". Continued interview revealed, she notified the on-call Physician of the resident's death. Per interview, LPN #2 stated she reported to the on-call Physician the resident had expired and the RN had decided the resident was "too far gone" to perform CPR. LPN #2 stated she "thought" she informed the physician of the resident's "Full Code" status with the Physician's verbal response to be "Oh no, OK". LPN #2 further stated, per the facility's policy, CPR should have been initiated for Resident #1.  Interview on 08/24/15 at 8:13 AM with the on-call Physician, revealed the facility did notify him of Resident #1's death; however, he was not informed Resident #1 had a "Full Code" status and he did not give an order for CPR to be withheld.  Interview with RN #1, on 08/20/15 at 5:50 PM, revealed she was certified in CPR and responded to a call from LPN #2 on 08/15/15 around 7:10 AM or 7:15 AM, requesting a nurse to pronounce a resident deceased. Continued interview revealed, upon arrival to Resident #1's room she assessed the resident and without obtaining an order from the resident's physician prior to pronouncing, RN #1, pronounced the resident deceased at 7:23 AM. Per interview, she was not aware Resident #1 was a "Full Code" status until	F 281			

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F 281	Continued From page 29 she went to the nurse's station to document her assessment; however, she did not initiate CPR because "in my nursing opinion, (she/he) had been passed for a while". Further interview revealed, it was the facility's policy to initiate CPR when a resident was found in cardiac arrest or unresponsive and had a "Full Code" status and she stated she should obtain an order from the physician prior to pronouncing a resident deceased. RN #1 reported she did not follow the facility's policy.  Interview with the Director of Nursing (DON), on 08/24/15 at 3:09 PM, revealed should a resident be found unresponsive, staff should verify the resident's Advance Directive, and CPR should be immediately initiated for any resident with a "Full Code" status Advance Directive. The DON stated, per the facility's policy, prior to pronouncing a resident deceased, an order or approval from the resident's physician should be obtained by the RN. Continued interview at 4:02 PM, revealed a resident's code status should be documented on the resident's care plan to ensure appropriate care would be provided. She stated it would be the responsibility of the nurse who admits the resident to ensure the Interim Care Plan related to Advanced Directive was initiated. Further interview revealed her expectation was for staff to follow the facility's policy and staff did not follow the facility's policy.  Interview on 08/24/15 at 4:50 PM, with the Administrator, revealed residents had a right to execute an Advance Directive and it should be honored by the staff. She stated a resident's care plan should include the resident's Advance Directive. Continued interview revealed, LPN #1, LPN #2 and RN #1 should have initiated CPR for	F 281		
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F 281	<p>Continued From page 30</p> <p>Resident #1, who was a Full Code, when they found the resident non-responsive. Per interview, the facility's policy did allow for an RN to pronounce a resident deceased with the approval of the physician. The Administrator reported her expectation was for staff to follow the facility's policies to provide a professional standard of care to the residents.</p> <p>The facility provided an acceptable credible Allegation of Compliance (AOC) on 08/31/15, which alleged removal of the IJ effective 08/29/15. Review of the AOC revealed the facility implemented the following:</p> <ol style="list-style-type: none"> <li>1. On 08/15/15, the Director of Nursing (DON) reviewed Resident #1's medical record and care plan with the following areas of concern identified:             <ol style="list-style-type: none"> <li>a. The date and time were missing regarding the Physician notification on the Nursing Admission Assessment</li> <li>b. the Advance Directive of "Full Code" status was not care planned on the Interim Care Plan.</li> <li>c. CPR was not immediately initiated per Resident #1's/Power of Attorney's (POA's) request as indicated on the Advance Directive.</li> </ol> </li> <li>2. Beginning 08/15/15 and concluding on 08/17/15, the DON, Unit Managers, Nursing Supervisors or Medical Records staff audited all resident Advance Directive/Code Status/Physician's orders for code status, Care Plans and State Registered Nurse Aide (SRNA) Care Plans.</li> <li>3. Beginning 08/15/15 and concluding on 08/17/15, the DON, Assistant Director of Nursing (ADON), Unit Managers and Nursing Supervisors assessed all residents for any possible resident rights violations. Residents with a Brief Interview</li> </ol>	F 281		

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F 281	Continued From page 31 of Mental Status (BIMS) score of eight (8) or greater were interviewed and residents with a BIMS of less than eight (8) were physically assessed for any signs and symptoms of possible quality of life or resident rights violations.  4. Compliance audits of the admission process were completed by 08/18/15 of all admissions within the previous thirty (30) days. The audits were performed by the DON, ADON, Unit Managers or Nursing Supervisors of all resident's medical records to include notification of the Attending Physician, review of the Physician Admitting Orders with the Attending Physician and ensuring professional standards were followed.  5. The DON, Unit Managers, Nursing Supervisors or Medical Records staff completed audits of all resident charts by 08/26/15. The Audit included; resident's Advance Directive, Physician's Orders, Assessments, Multidisciplinary Notes and Care Plan to ensure compliance with quality of care delivery.  6. On 08/26/15, all management staff was educated by the Regional Nurse Consultant. Education included: Advance Directive Policy and Procedure, Admission/Physician's Order Policy and Procedure, Care Plan Policy and Procedure, Revised CPR Policy and Procedure, Resident Rights Policy and Procedure, Quality of Care Delivery, Professional Standards and Quality Assurance Performance Improvement (QAPI).  7. Education for all nursing staff was initiated on 08/15/15 and completed by 08/28/15, with the exception of four (4) full-time status staff on leave and twenty-one (21) part-time staff. Certified	F 281			

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F 281 Continued From page 32

letters were sent to the twenty-one (21) part-time staff to notify each of the mandatory education prior to returning to duty. Education was provided by the Staff Development Coordinator, Unit Mangers and Nursing Supervisors. Education included Advance Directive Policy and Procedure, Admission/Physician Order Policy and Procedure, Care Plan Policy and Procedure, Revised CPR Policy and Procedure, Resident Rights Policy and Procedure, Quality of Care Delivery, Professional Standards and QAPI. The education related to the policies and procedures was added to the training agenda for New Employee Orientation.

8. Beginning 08/21/15 and concluding on 08/24/15, the Staff Development Coordinator, Unit Managers and Nursing Supervisors conducted education for all licensed staff (with the exception of the part-time staff who were notified by certified letter they could not work until receiving the required education) on the admission policy and procedure, to include: clarification of the process for Physician notification of new admissions, obtaining Admission Orders, the Interim Care Plan and professional standards. The above education was incorporated into the facility's New Employee Orientation.

9. On 08/25/15, all Physicians with privileges at the facility were educated by the DON in regards to the admission process and expectations with compliance to include: Discharge Summaries or Orders from a discharging facility would be faxed to the Physician's office and the Physician would be called for approval of the Orders with a Telephone Order written stating the Physician's review and approval of the Orders.

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NAME OF PROVIDER OR SUPPLIER  FOUNTAIN CIRCLE CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 200 GLENWAY ROAD WINCHESTER, KY 40391		
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F 281	Continued From page 33 10. Human Resources and/or Staff Development performed audits of all personnel files for CPR certifications. Audits were completed by 08/25/15 and given to the Regional Nurse Consultant to review for non-compliance with CPR regulations. Seventeen (17) licensed nurses were noted to have on-line only CPR certifications.  11. Sixteen (16) of the seventeen (17) staff identified to have on-line CPR certifications received CPR instruction with hands on component by 08/27/15, provided by the DON, a certified American Heart CPR Instructor. One (1) employee would not be allowed to work until CPR certification with hands on component was obtained.  12. Beginning 08/25/15, the DON, ADON, Unit Manager, Nursing Supervisor or Medical Records staff will review all new admissions daily during the morning clinical meeting to ensure compliance with Physician notification, Physician Orders, Interim Care Plan, Advance Directive, and Resident Rights. Findings of the review will be reported in the Quality Assurance (QA) committee meeting. The committee consists of the Medical Director, Administrator, DON, Social Services Director and at least two (2) other department managers, different line staff as appropriate, and outside consultants as appropriate. The committee will meet weekly for four (4) weeks then monthly to determine the need for continued education or revision of the plan. Based on evaluation, the QA committee will determine at what frequency the ongoing review of new admissions will need to continue. Concerns identified will be corrected immediately by the DON, ADON, Unit Managers or Nursing Supervisor and reported to the Administrator to	F 281			

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F 281	Continued From page 34 ensure any needed investigation initiated and reported guidelines were met.  13. The DON, ADON, Unit Managers, or Nursing Supervisor will monitor care delivery as outlined per the care plan on five (5) residents per unit per day until immediacy is removed, beginning 08/25/15, then five (5) residents daily for four (4) weeks, to ensure compliance with care delivery as outlined by the Care Plan along with compliance of Professional Standards requirements. Findings will be reported in the QA committee weekly to determine the further need of continued education or the revision of the plan.  14. Mock codes will be conducted by the DON, ADON, Unit Managers, Staff Development Coordinator or Nursing Supervisor twice weekly, on rotating shifts, for four (4) weeks beginning 08/18/15, to ensure understanding and compliance with Code Blue Policy and Procedure. The first two (2) mock codes were conducted by Clinical Managers for education on how to conduct a code; the Mock codes will be conducted by the nurses. Findings will be reported to the QA committee weekly to determine compliance and any further need of continued education or revision of the plan.  15. The DON, Staff Development Coordinator or Human Resources will track all licensed nurses CPR certification monthly beginning 08/26/15, to ensure compliance with CPR policy, procedure and governing regulations. Findings and compliance will be reported monthly to the QA committee to determine any need for education or revision of the process.  16. A Regional Nurse or corporate office staff	F 281			

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F 281	Continued From page 35 was on site since 08/19/15 and will remain on site daily until immediacy is removed, then will be on site three (3) times weekly for four (4) weeks. Regional/Corporate staff will review compliance with the plan and will review compliance with policy and procedure of any code blue that occurs and review compliance with new or re-admissions. During weekly follow-up, guidance and recommendations will be provided with compliance validated.  17. Administrative oversight of the facility will be completed by the Vice President of Operations, Nurse Consultant, or Special Projects Administrator daily until removal of the immediacy beginning 09/19/15, then weekly for four (4) weeks, then monthly.  18. A Quality Assurance meeting will be held weekly until immediacy is removed beginning on 08/21/15, the for four (4) weeks, then monthly for recommendations and further follow up regarding the stated plan. Based on evaluation, the QA committee will determine at what frequency any ongoing audits will need to continue. The Administrator has the oversight to ensure an effective plan is in place to meet resident well-being and ensure resident rights as well as an effective plan to identify facility concerns and implement a plan of correction to involve all staff of the facility. Corporate Administrative oversight of the Quality Assurance meeting will be completed by the Special projects Administrator, the Regional Vice President of Operations, or a member of regional staff three (3) times a week until immediacy is removed beginning 08/15/15, then weekly for four (4) weeks, then monthly.  The State Survey Agency validated the	F 281			

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F 281	Continued From page 36 implementation of the facility's AOC as follows:  1. Review of the facility's investigation of the incident revealed an audit of Resident #1's medical record with areas concern noted.  Interview with the DON, on 09/02/15 at 5:20 PM, revealed she audited Resident #1's medical record and identified areas of concern with immediate implementation of education provided to staff.  2. Review of the facility's audit of all resident's Advance Directive, Care Plans and Physician's Orders revealed the Audit tool was printed on 08/15/15 and signed by the auditor of each resident's documentation on 08/15/15.  Interview with the DON, on 09/02/15 at 5:20 PM, revealed she had participated with other management staff to audit all resident records to verify accuracy of the resident's Advance Directive, Care Plans and Physician's code status order.  3. Review of the audit tool utilized to interview and assess all residents for possible resident rights violations revealed management staff interviewed all resident's with a Brief Interview for Mental Status (BIMS) score of eight (8) or greater and a physical assessment was completed for resident's whose BIMS was less than eight (8).  Interview with the DON, on 09/02/15 at 5:20 PM, revealed management staff interviewed or assessed each of the facility's residents for any signs or symptoms of resident rights violations. Interview with interviewable residents revealed staff did talk with them regarding their resident	F 281			

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F 281	Continued From page 37 rights.  4. The audit tool, dated 08/18/15, utilized to audit previous thirty (30) days facility new admissions was reviewed. New admissions were audited for compliance with admission process including: Physician notification, review of New Admission Physician's Orders with Physician and ensuring professional standards were followed. Areas of concern identified with the audit were documentation in relation to missing dates and times on the Nursing Admission Assessment on four (4) residents. Review of the education provided to staff revealed policy and procedures related to accuracy of the admission process and documentation was provided. Review of the staff sign in sheets revealed instruction was provided beginning 08/15/15 with review of policy and procedure. On 08/28/15, a more comprehensive education was provided to staff related to the policy and procedure.  Interview with the DON, on 09/02/15 at 5:20 PM, revealed she initiated education to the nursing staff immediately on 08/15/15. Per the DON, the Regional Nurse provided comprehensive education to the management staff on 08/28/15. Further interview revealed, after receiving the comprehensive education, the management staff were responsible for providing the comprehensive education to the facility's nursing staff.  5. Review of the audit of each resident's medical record to include: Advance Directive, Physician's Orders, Assessments, Multidisciplinary Notes and Care Plans was completed by 08/26/15.  Interview with the DON, on 09/02/15 at 5:20 PM, revealed she and other management staff	F 281			

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F 281	Continued From page 38 audited each resident's medical record to ensure compliance with quality of care delivery.  6. Review of education provided by the Regional Nurse to all management staff with the sign in sheet dated 08/28/15 and signed by the Regional Nurse revealed the education provided included: Cardiopulmonary Resuscitation, Advance Directives, Physician Visits and Medical Orders, Admission Criteria, Care Planning - Interdisciplinary Team, Resident Rights, Quality of Care, Professional Standards, and QA.  Interview with the Regional Nurse Consultant, on 09/02/15 at 5:20 PM, revealed he provided comprehensive education to management staff related to the facility's policies and procedures stated above. Continued interview revealed the facility revised the CPR policy to include mandatory hands on skills certification for staff.  7. Review of education provided to all nursing staff to include: Cardiopulmonary Resuscitation, Advance Directives, Physician Visits and Medical Orders, Admission Criteria, Care Planning - Interdisciplinary Team, Resident Rights, Quality of Care, Professional Standards, and QA. Review of sign in sheets revealed the education was initiated on 08/26/15 and concluded on 08/28/15. Review of certified letters sent to twenty-one (21) part-time clinical staff related to mandatory education prior to working. Continued review of sign-in sheets revealed education for part-time clinical staff, non-licensed staff and non-nursing staff continued per AOC. Review of New Orientation Agenda for clinical staff, revealed education would be provided with orientation process. Review of audit tool utilized for validation of CPR certification with hands on skills	F 281			

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F 281	<p>Continued From page 39</p> <p>component revealed staff had obtained education with hands on skill component.</p> <p>Interview, on 09/01/15 at 10:20 AM with SRNA #8; at 10:30 AM with SRNA #7; at 10:40 AM with SRNA #4; at 10:50 AM with SRNA #2; and, at 11:00 AM with SRNA #6 revealed they had all been provided education related to Cardiopulmonary Resuscitation, Resident Rights, Quality of Care and Professional Standards between 08/15/15 and 08/28/15 in a verbal lecture setting allowing for question and answers.</p> <p>Interview, on 08/20/15 at 5:50 PM with RN #1 and at 6:12 PM with LPN #1; on 09/01/15 at 11:15 AM with LPN #12; at 11:25 AM with LPN #3; at 4:16 PM with LPN #11; at 4:30 PM with LPN #2; at 4:45 PM with RN #4; at 5:00 PM with RN #2; at 5:17 PM with RN #3; and, Unit Manager #1 at 4:29 PM, revealed they had all been provided education related to Cardiopulmonary Resuscitation, Advance Directives, Physician Visits and Medical Orders, Admission Criteria, Care Planning, Resident Rights, Professional Standards, and Quality of Care in a verbal lecture setting allowing for question and answers.</p> <p>8. Review of the education provided to all licensed staff related to the admission policy and procedure revealed the education was initiated on 08/21/15 and completed on 08/28/15 after additional education was provided by the Regional Nurse Consultant.</p> <p>Interview with the DON, on 09/02/15 at 5:20 PM, revealed she had initiated staff education on 08/21/15. After receiving comprehensive education provided by the Regional Nurse Consultant on 08/26/15, the management team</p>	F 281	

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F 281	<p>Continued From page 40</p> <p>re-educated staff with the completion date for full-time clinical staff to be 08/28/15.</p> <p>9. Review of the education provided to all Physicians with privileges to included; clarification of the process for notifying the Physician of new admits and obtaining orders, and the Interim Care Plan and Professional Standards. Further review, revealed there was follow up letters sent to each Physician related to the educations provided.</p> <p>10. Review of the Audit of personnel files for CPR certification revealed the Audit was completed on 08/25/15 with the Regional Nurse Consultant review on 08/25/15. Data from the audit revealed seventeen (17) staff without the hands on skill component for CPR certification.</p> <p>11. Review of the Audit of personnel files for CPR certifications revealed sixteen (16) of the seventeen (17) identified staff without hands on skill component CPR certifications had obtained certifications with the hands on skills component.</p> <p>Interview with the DON, on 9/02/15 at 5:20 PM, revealed she was a Certified American Heart CPR Instructor. Further interview revealed, she had conducted four (4) CPR classes for staff that included the hands on skills component. Per interview, one staff still remained out of compliance with the CPR certification hands on component and would not be allowed to work until appropriate certification was obtained.</p> <p>12. Review of the Daily New Admission Log, revealed new admissions were reviewed daily for compliance with Physician Notification, Physician Orders, Interim Care Plan, Advance Directive, and Resident Rights beginning 08/25/15.</p>	F 281		

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F 281	Continued From page 41  Interview with the DON on 09/02/15 at 5:20 PM, revealed areas of concern were identified when the audits were initiated on 08/25/15; however, after staff received education, data collected had improved. Further interview revealed any issues identified would be immediately corrected with data reviewed with the QA committee weekly for four (4) weeks, then monthly with the results of the collected data to determine the need for additional education or the revision of the plan.  13. Review of documentation monitoring care delivery as outlined per the resident's care plan, revealed five (5) resident care plans per day per unit were reviewed by management staff beginning 08/25/15.  Interview with the DON, on 09/02/15 at 5:20 PM, revealed management staff had audited resident care plans daily. Further interview revealed five (5) care plans were audited on each unit daily since 08/25/15.  14. Review of documentation of the Mock codes revealed they were conducted twice weekly on rotating shifts beginning 08/18/15.  Interview, on 08/20/15 at 5:50 PM with RN #1 and at 6:12 PM with LPN #1; on 09/01/15 at 11:15 AM with LPN #12; at 11:25 AM with LPN #3; at 4:16 PM with LPN #11; at 4:30 PM with LPN #2; at 4:45 PM with RN #4; at 5:00 PM with RN #2; at 5:17 PM with RN #3; and, Unit Manager #1 at 4:29 PM, revealed they had all been provided education related to Cardiopulmonary Resuscitation and Advance Directives with Mock Codes conducted on different shifts.	F 281			

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F 281	Continued From page 42 15. Review of documentation of CPR certification tracking revealed the date the certification was obtained and verification the certification contained a hands on skills component.  Interview with the DON, on 09/02/15 at 5:20 PM, revealed the facility had previously been tracking CPR expiration dates; however, the facility added verification of a hands on skills component to their tracking data to ensure compliance.  16. Review of the documentation of a calendar, signed by the Regional Nurse and Regional Vice President of Operations revealed the Regional Vice President of Operations was on site 08/21/15 and 08/28/25. Further review revealed, the Regional Nurse was on site daily from 08/16/15 to 09/02/15 with the exception of 08/17/15.  Interview with the Regional Nurse, on 09/02/15 at 5:20 PM, revealed he had been in the facility each day with the exception of 08/17/15.  Interview with the Administrator on 09/01/15 at 5:20 PM, revealed the Regional Nurse had been on site daily since 08/16/15 with the exception of 08/17/15. Interview with Unit Manager #1, on 09/01/15 at 4:29 PM, revealed the Regional Nurse had been on site "seemed like" daily for over two (2) weeks.  17. Review of documentation of a calendar, signed by the Regional Nurse and Regional Vice President of Operations revealed on site Administrative oversight was performed by the Regional Vice President of Operations on 08/21/15 and 08/28/15. Further review revealed, on site Administrative oversight was performed by	F 281			

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F 281	Continued From page 43 the Regional Nurse on each day from 08/16/15 to 09/02/15, with the exception of 08/17/15.  Interview with the Regional Nurse, on 09/02/15 at 5:20 PM, revealed he had been on site at the facility daily since 08/16/15 with the exception of 08/17/15.  Interview with the Administrator on 09/01/15 at 5:20 PM, revealed the Regional Nurse had been on site daily since 08/16/15 with the exception of 08/17/15. Interview with Unit Manager #1, on 09/01/15 at 4:29 PM, revealed the Regional Nurse had been on site "seemed like" daily for over two (2) weeks.  18. Review of the QA sign in sheets revealed, meetings were conducted on 08/21/15, 08/26/15, and 08/28/15 with the areas of concern discussed. The Medical Director was in attendance on 08/26/15.  Interview with the Administrator, on 09/03/15 at 11:15 AM, revealed the data obtained from the audits performed, revealed areas of concern related to the Mock codes which were initially performed. Continued interview revealed, the data was analyzed and it was determined additional education was needed. Further interview revealed the additional education was provided with positive data resulting from ongoing Mock codes and audits.	F 281		
F 309 SS-J	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical,	F 309	F309  1. The Director of Nursing reviewed Resident #1's medical record on 8/15/15. During the review of the medical record, Resident #1's	8-29-15

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F 309	<p>Continued From page 44</p> <p>mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</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 have an effective system in place to ensure each resident received Cardiopulmonary Resuscitation (CPR) according to established professional standards, the Advanced Directives, and requested code status, for one (1) of twelve (12) sampled residents (Resident #1).</p> <p>On 08/13/15, Resident #1's Responsible Party (RP) signed Advance Directives requesting the resident have a Full Code status (Full Code indicates life-saving measures were to be implemented in the event of cardiac or respiratory failure), to include CPR. However, on 08/15/15 at approximately 7:15 AM, when State Registered Nursing Assistant (SRNA) #1 entered Resident #1's room and found the resident to be unresponsive, she notified Licensed Practical Nurses (LPNs) #1 and #2, who failed to honor the resident's Advance Directives for Full Code status. LPN #1 entered Resident #1's room, checked Resident #1 for a pulse without success and failed to initiate CPR according to the resident's Advance Directives. LPN #2 entered Resident #1's room, observed LPN #1 checking the resident for a pulse, went to the Nurse's Station and checked the resident's chart for code status and called Registered Nurse (RN) #1. LPN #2 also failed to initiate CPR according to</p>	F 309	<p>code status was a full code and the advanced directive was not honored on 8/15/15. The review also revealed that the full code status was not care planned per the advance directive.</p> <p>2. All residents charts, to include advance directive, physician orders along with Physician order sheet, assessments, multidisciplinary notes and care plan were audited by 8/26/15 by DON, Unit Managers, Nursing Supervisor or Medical Records to ensure compliance with quality of care delivery.</p> <p>3. All nursing staff were educated by the SDC, SCC, Nursing Supervisors, or Unit Managers on the advance directive policy and procedure, CPR policy and procedure, admission/physician order policy and procedure, care plan policy and procedure, resident rights policy and procedure, quality of care delivery, and professional standards. Education was initiated on 8/15/15 with 100% of full time licensed nurses completed by 8/28/15, except for those on LOA, vacation, or suspension, which consisted of 4 nurses. Prior to returning back to work, these 4 nurses will have to complete the education listed above.</p> <p>4. Mock codes will be conducted by the DON, ADON, Unit managers, SDC or Nursing Supervisor to ensure understanding and compliance with Code Blue policy and procedure twice weekly on rotating shifts for</p>	

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F 309 Continued From page 45

the resident's Advance Directives. RN #1, who was on another unit, arrived to Resident #1's room, assessed the resident to have "no heart rate" and "no respirations" and pronounced the resident deceased at 7:23 AM. Per interview, RN #1 determined Resident #1 was Full Code status, but she did not initiate CPR according to the resident's Advance Directives.

The facility's failure to provide the necessary care and services related to the resident's requested Full Code status and the provision of CPR, has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 08/25/15, and was determined to exist on 08/15/15. The facility was notified of the Immediate Jeopardy on 08/25/15.

The facility provided an acceptable credible Allegation of Compliance (AOC) on 08/31/15 with the facility alleging removal of the Immediate Jeopardy on 08/29/15. The State Survey Agency validated removal of the Immediate Jeopardy as alleged, on 08/29/15, prior to exit on 09/03/15, with remaining non-compliance in the area of 42 CFR 483.25 Quality of Care, F-309 at a Scope and Severity of a "D" while the facility develops and implements a Plan of Correction and the facility's Quality Assurance (QA) monitors to ensure compliance with systemic changes.

The findings include:

Review of the facility's policy titled "Advance Directives - Kentucky", effective 12/2010, revealed it was the policy of the facility to recognize and support the use of Advance Directives through family, staff and community education, and to encourage the resident's rights

F 309: 4 weeks starting on 8/18/15, then once per week for 4 weeks, then monthly.

DON, ADON, Unit Managers, or Nursing Supervisor will monitor care delivery as outlined per care plan on 5 residents per unit per day until immediacy is removed, starting on 8/25/15, then 5 residents daily for 4 weeks, then 5 residents three times per week for 2 weeks, then 5 residents monthly for two months.

The ongoing processes will be discussed in the Quality Assurance committee meeting monthly for three months, for recommendations and for further follow up as indicated. The members of the Quality Assurance committee include, but not limited to the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, SDC, Social Services Director, Dietician, Quality of Life Director, and Unit Managers.

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F 309	<p>Continued From page 46</p> <p>to self-determination through recognition and assistance with executing such directives. Further review revealed, all residents would receive full resuscitative measures unless a "Do Not Resuscitate" (DNR) directive was written in the resident's medical record and was identified in the resident's Advance Directive.</p> <p>Review of the facility's policy, titled "Cardiopulmonary Resuscitation", undated, revealed CPR would be attempted for any resident who was found to have no palpable pulse and/or no discernible respirations, unless there was a written Physician's Order to the contrary and/or written Advance Directives. Continued review revealed, should a resident be found unresponsive and without respirations, a licensed staff member who was certified in CPR would promptly initiate CPR for residents who have requested CPR in their advance directive; who have not formulated an advance directive; and, who do not have a valid "DNR" order or unless it would pose a danger to self or others to initiate CPR.</p> <p>Review of Resident #1's clinical record revealed the facility admitted the resident on 08/13/15, with diagnoses which included Syncope, Dementia, Alzheimer's Disease and Combativeness. Review of the "Advance Directives/Informed Consent", signed by Resident #1's RP on 08/13/15, revealed the RP had requested and consented in the event of death for staff to use cardiac compressions or artificial ventilation to resuscitate the resident. Review of the "Nursing Admission Information" dated 08/13/15, revealed Resident #1's Advance Directives had been completed. Review of the Physician's Order, dated 08/13/15, revealed the resident had an</p>	F 309		

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F 309	<p>Continued From page 47 order for a Full Code status.</p> <p>Review of the Nurse's Note, dated 08/15/15, not timed, completed by LPN #1, revealed LPN #1 found the resident sitting on the floor next to the bed with blood on the pillow and ear, with no pulse found. However, there was no documented evidence LPN #1 immediately initiated CPR for Resident #1's as per Physician's Orders and Advance Directive.</p> <p>Review of LPN #1's "Interviewer Statement", dated 08/18/15, documented by the Director of Nursing (DON), revealed LPN #1 found Resident #1 slumped in a sitting position against the low bed leaning toward his/her left side. According to the statement, LPN #1 immediately checked for a carotid pulse with no pulse found. Further review, revealed LPN #2 came into the room and LPN #1 continued assessing Resident #1 and found blood on his/her pillow and coming from the resident's left ear. Further review of the Statement, revealed LPN #1 called for an RN. According to the Statement, after RN #1 arrived, LPN #1 and RN #1 assessed the resident for any type of injury or trauma with no bruises, abrasions or knots noted. Per the Statement, LPN #2 obtained an order from the on-call Physician to withhold CPR related to the resident being deceased.</p> <p>Interview with LPN #1, on 08/20/15 at 6:12 PM, revealed he was the primary nurse for Resident #1 on the day shift of 08/15/15. LPN #1 revealed he was certified to perform CPR; however, when he found Resident #1 on 08/15/15 around 7:15 AM, he did not initiate CPR. He further stated LPN #2 entered the resident's room behind him and did not initiate CPR, but left the room to call</p>	F 309	

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F 309	<p>Continued From page 48</p> <p>the RN for assistance. LPN #1 revealed, at the time of the incident, he did not know if Resident #1 had a "Full Code" status and felt the resident required further assessment stating the RN was more qualified to complete that assessment. LPN #1 further stated he was unfamiliar with the facility's policy; however, stated he did not know why he didn't initiate CPR.</p> <p>Review of the Nurse's Note dated 08/15/15, at 7:23 AM, completed by LPN #2, revealed the resident was found sitting beside the bed with his/her back to the bed, leaning to the left side with "wet" fresh blood, from the left ear on the pillow, with no pulse, no respirations, no blood pressure and no signs of life. However, there was no documented evidence LPN #2 immediately initiated CPR for Resident #1's as per the resident's Physician's Orders and Advance Directive.</p> <p>Review of LPN #2's "Witness Statement", dated 08/15/15, revealed Resident #1 had been awake and walking up and down the hallway until 2:50 AM. According to the Statement, Resident #1 was seen during rounds at 5:00 AM lying in his/her bed, sleeping with a baby doll in his/her arms. Further review of the Statement revealed LPN #2 was called to Resident #1's room by a SRNA. LPN #2 found the resident deceased at 7:23 AM.</p> <p>Interview with LPN #2, on 08/20/15 at 4:31 PM, revealed she had entered Resident #1's room behind LPN #1 and found the resident with no pulse; and although she was certified in CPR, she did not initiate CPR. LPN #2 stated she left the resident's room to go to the nurse's station to check the resident's code status and call the RN.</p>	F 309	

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F 309	<p>Continued From page 49</p> <p>LPN #2 revealed, she identified the resident to be a "Full Code" status and even though she did not immediately initiate CPR, she did inform LPN #1 and RN #1 of the resident's Advance Directive. LPN #2 stated, the resident was "just too far gone". Per interview LPN #2 notified the on-call Physician the resident had expired and the RN had decided the resident was "too far gone" to perform CPR. LPN #2 further stated she "thought" she informed the physician of the resident's "Full Code" status with the Physician's verbal response to be "Oh no, OK". Continued interview revealed the Physician did not state to her to "withhold CPR". LPN #2 revealed per the facility's policy, CPR should have been initiated for Resident #1.</p> <p>Interview with the on-call Physician, on 08/24/15 at 8:13 AM, revealed he was notified by the facility of Resident #1's death; however, he was not informed Resident #1 had a "Full Code" status and he did not give an order for CPR to be withheld, further stating "that is not an order I would give".</p> <p>Further review of the Nurse's Notes, revealed a Note dated 08/15/15, at 7:30 AM, completed by RN #1, which revealed Resident #1 was sitting on the floor with his/her back to the bed and leaning to the left side with blood from his/her left ear with no heart rate and no respirations. According to the Note, Resident #1 was pronounced deceased at 7:23 AM; however, there was no documented evidence RN #1 immediately initiated CPR as per Resident #1's Physician's Order and Advance Directive.</p> <p>Review of RN #1's "Witness Statement", dated 08/15/15, revealed the nurse was called to</p>	F 309		

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F 309	<p>Continued From page 50</p> <p>another unit at approximately 7:15 AM to pronounce the passing of a resident. Per the Statement, upon entering Resident #1's room, the resident was observed to be in a sitting position on the floor with his/her back against the bed. The Statement revealed Resident #1 was cold to touch with no respirations, no audible or palpable heart rate, color was pale and mottled with no obvious injuries. According to the Statement, RN #1 pronounced death at 7:23 AM.</p> <p>Interview with RN #1, on 08/20/15 at 5:50 PM, revealed she was working on another unit and responded to a call from LPN #2 on 08/15/15 around 7:10 AM or 7:15 AM, requesting a nurse to pronounce a resident deceased. Continued interview revealed with RN #1 revealed on arrival to Resident #1's room she assessed the resident and pronounced the resident deceased at 7:23 AM. RN #1 revealed she was not aware Resident #1 was a "Full Code" status until she went to the nurse's station to document her assessment; however, she did not initiate CPR because "in my nursing opinion, (she/he) had been passed for a while". Continued interview revealed, it was the facility's policy to initiate CPR when a resident was found in cardiac arrest or unresponsive and was a "Full Code" status. However, RN #1 revealed she did not follow the facility's policy.</p> <p>Interview with the Director of Nursing (DON), on 08/24/15 at 3:09 PM, revealed the facility's policy related to resuscitation of a resident was to immediately initiate CPR for a resident found unresponsive without a pulse or respirations and to continue CPR until the Physician gave an order to stop, or Emergency Medical Services (EMS) arrived to transport the resident to the hospital. Continued interview revealed, staff should not</p>	F 309		

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F 309	<p>Continued From page 51</p> <p>with hold CPR while attempting to contact the resident's Physician. Per interview, staff did not follow the facility's policies and CPR should have been immediately initiated for Resident #1 when he/she was found unresponsive.</p> <p>Interview with the Administrator, on 08/24/15 at 4:50 PM, revealed staff did not follow the facility's policy related to the initiation of CPR. Per interview, her expectation was for staff to initiate CPR immediately for any "Full Code" status resident found to be unresponsive and without signs of life. The Administrator stated LPN #1, LPN #2 and RN #1 should have initiated CPR for Resident #1, who was a Full Code, when they found the resident non-responsive.</p> <p>The facility provided an acceptable credible Allegation of Compliance (AOC) on 08/31/15, which alleged removal of the IJ effective 08/29/15. Review of the AOC revealed the facility implemented the following:</p> <ol style="list-style-type: none"> <li>1. On 08/15/15, the Director of Nursing (DON) reviewed Resident #1's medical record and care plan with the following areas of concern identified:             <ol style="list-style-type: none"> <li>a. The date and time were missing regarding the Physician notification on the Nursing Admission Assessment</li> <li>b. the Advance Directive of "Full Code" status was not care planned on the Interim Care Plan.</li> <li>c. CPR was not immediately initiated per Resident #1's/Power of Attorney's (POA's) request as indicated on the Advance Directive.</li> </ol> </li> <li>2. Beginning 08/15/15 and concluding on 08/17/15, the DON, Unit Managers, Nursing Supervisors or Medical Records staff audited all resident Advance Directive/Code Status/Physician's orders for code status, Care</li> </ol>	F 309	

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F 309	<p>Continued From page 52</p> <p>Plans and State Registered Nurse Aide (SRNA) Care Plans.</p> <p>3. Beginning 08/15/15 and concluding on 08/17/15, the DON, Assistant Director of Nursing (ADON), Unit Managers and Nursing Supervisors assessed all residents for any possible resident rights violations. Residents with a Brief Interview of Mental Status (BIMS) score of eight (8) or greater were interviewed and residents with a BIMS of less than eight (8) were physically assessed for any signs and symptoms of possible quality of life or resident rights violations.</p> <p>4. Compliance audits of the admission process were completed by 08/18/15 of all admissions within the previous thirty (30) days. The audits were performed by the DON, ADON, Unit Managers or Nursing Supervisors of all resident's medical records to include notification of the Attending Physician, review of the Physician Admitting Orders with the Attending Physician and ensuring professional standards were followed.</p> <p>5. The DON, Unit Managers, Nursing Supervisors or Medical Records staff completed audits of all resident charts by 08/26/15. The Audit included; resident's Advance Directive, Physician's Orders, Assessments, Multidisciplinary Notes and Care Plan to ensure compliance with quality of care delivery.</p> <p>6. On 08/26/15, all management staff was educated by the Regional Nurse Consultant. Education included: Advance Directive Policy and Procedure, Admission/Physician's Order Policy and Procedure, Care Plan Policy and Procedure, Revised CPR Policy and Procedure, Resident</p>	F 309		

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F 309	<p>Continued From page 53</p> <p>Rights Policy and Procedure, Quality of Care Delivery, Professional Standards and Quality Assurance Performance Improvement (QAPI).</p> <p>7. Education for all nursing staff was initiated on 08/15/15 and completed by 08/28/15, with the exception of four (4) full-time status staff on leave and twenty-one (21) part-time staff. Certified letters were sent to the twenty-one (21) part-time staff to notify each of the mandatory education prior to returning to duty. Education was provided by the Staff Development Coordinator, Unit Mangers and Nursing Supervisors. Education included Advance Directive Policy and Procedure, Admission/Physician Order Policy and Procedure, Care Plan Policy and Procedure, Revised CPR Policy and Procedure, Resident Rights Policy and Procedure, Quality of Care Delivery, Professional Standards and QAPI. The education related to the policies and procedures was added to the training agenda for New Employee Orientation.</p> <p>8. Beginning 08/21/15 and concluding on 08/24/15, the Staff Development Coordinator, Unit Managers and Nursing Supervisors conducted education for all licensed staff (with the exception of the part-time staff who were notified by certified letter they could not work until receiving the required education) on the admission policy and procedure, to include: clarification of the process for Physician notification of new admissions, obtaining Admission Orders, the Interim Care Plan and professional standards. The above education was incorporated into the facility's New Employee Orientation.</p> <p>9. On 08/25/15, all Physicians with privileges at the facility were educated by the DON in regards</p>	F 309		

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F 309	<p>Continued From page 54</p> <p>to the admission process and expectations with compliance to include: Discharge Summaries or Orders from a discharging facility would be faxed to the Physician's office and the Physician would be called for approval of the Orders with a Telephone Order written stating the Physician's review and approval of the Orders.</p> <p>10. Human Resources and/or Staff Development performed audits of all personnel files for CPR certifications. Audits were completed by 08/25/15 and given to the Regional Nurse Consultant to review for non-compliance with CPR regulations. Seventeen (17) licensed nurses were noted to have on-line only CPR certifications.</p> <p>11. Sixteen (16) of the seventeen (17) staff identified to have on-line CPR certifications received CPR instruction with hands on component by 08/27/15, provided by the DON, a certified American Heart CPR Instructor. One (1) employee would not be allowed to work until CPR certification with hands on component was obtained.</p> <p>12. Beginning 08/25/15, the DON, ADON, Unit Manager, Nursing Supervisor or Medical Records staff will review all new admissions daily during the morning clinical meeting to ensure compliance with Physician notification, Physician Orders, Interim Care Plan, Advance Directive, and Resident Rights. Findings of the review will be reported in the Quality Assurance (QA) committee meeting. The committee consists of the Medical Director, Administrator, DON, Social Services Director and at least two (2) other department managers, different line staff as appropriate, and outside consultants as appropriate. The committee will meet weekly for</p>	F 309		

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

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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 09/03/2015
NAME OF PROVIDER OR SUPPLIER  FOUNTAIN CIRCLE CARE & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 GLENWAY ROAD WINCHESTER, KY 40391		
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F 309	<p>Continued From page 55</p> <p>four (4) weeks then monthly to determine the need for continued education or revision of the plan. Based on evaluation, the QA committee will determine at what frequency the ongoing review of new admissions will need to continue. Concerns identified will be corrected immediately by the DON, ADON, Unit Managers or Nursing Supervisor and reported to the Administrator to ensure any needed investigation initiated and reported guidelines were met.</p> <p>13. The DON, ADON, Unit Managers, or Nursing Supervisor will monitor care delivery as outlined per the care plan on five (5) residents per unit per day until immediacy is removed, beginning 08/25/15, then five (5) residents daily for four (4) weeks, to ensure compliance with care delivery as outlined by the Care Plan along with compliance of Professional Standards requirements. Findings will be reported in the QA committee weekly to determine the further need of continued education or the revision of the plan.</p> <p>14. Mock codes will be conducted by the DON, ADON, Unit Managers, Staff Development Coordinator or Nursing Supervisor twice weekly, on rotating shifts, for four (4) weeks beginning 08/18/15, to ensure understanding and compliance with Code Blue Policy and Procedure. The first two (2) mock codes were conducted by Clinical Managers for education on how to conduct a code; the Mock codes will be conducted by the nurses. Findings will be reported to the QA committee weekly to determine compliance and any further need of continued education or revision of the plan.</p> <p>15. The DON, Staff Development Coordinator or Human Resources will track all licensed nurses</p>	F 309		

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F 309	<p>Continued From page 56</p> <p>CPR certification monthly beginning 08/26/15, to ensure compliance with CPR policy, procedure and governing regulations. Findings and compliance will be reported monthly to the QA committee to determine any need for education or revision of the process.</p> <p>16. A Regional Nurse or corporate office staff was on site since 08/19/15 and will remain on site daily until immediacy is removed, then will be on site three (3) times weekly for four (4) weeks. Regional/Corporate staff will review compliance with the plan and will review compliance with policy and procedure of any code blue that occurs and review compliance with new or re-admissions. During weekly follow-up, guidance and recommendations will be provided with compliance validated.</p> <p>17. Administrative oversight of the facility will be completed by the Vice President of Operations, Nurse Consultant, or Special Projects Administrator daily until removal of the immediacy beginning 09/19/15, then weekly for four (4) weeks, then monthly.</p> <p>18. A Quality Assurance meeting will be held weekly until immediacy is removed beginning on 08/21/15, the for four (4) weeks, then monthly for recommendations and further follow up regarding the stated plan. Based on evaluation, the QA committee will determine at what frequency any ongoing audits will need to continue. The Administrator has the oversight to ensure an effective plan is in place to meet resident well-being and ensure resident rights as well as an effective plan to identify facility concerns and implement a plan of correction to involve all staff of the facility. Corporate Administrative oversight</p>	F 309		