

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

PRINTED: 10/13/2010
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 09/29/2010
NAME OF PROVIDER OR SUPPLIER FOUNTAIN CIRCLE HEALTH AND REHABILITATION			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)	(X6) COMPLETION DATE
F 000	INITIAL COMMENTS A Standard Recertification and an Abbreviated Survey investigating ARO#KY000148777, ARO#KY00014876, ARO#KY00015011, ARO#KY00015012, ARO#KY00015013, ARO#KY00015383, and ARO#KY00015384 was initiated on 09/26/10 and concluded on 09/29/10. A Life Safety Code Survey was conducted on 09/28/10. Deficiencies were cited with the highest scope and severity of a "G". ARO#KY00014876 was substantiated with deficiencies cited. ARO#KY0001487, ARO#KY00015012, and ARO#KY00015013 were substantiated with unrelated deficiencies cited. ARO#KY00015011, ARO#KY00015383, and ARO#KY00015384 were unsubstantiated with no deficiencies cited.	F 000	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>	
F 159 SS=C	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest bearing account, interest-bearing account, or petty cash fund.	F 159	Fountain Circle Health and Rehabilitation Center will continue to hold, safeguard, manage and account for the personal funds of the residents. A cash box has been purchased and filled with \$50. The Activity Director or Assistant who works weekends and/or holidays will be in charge of distributing money upon request from residents during off hours and/or holidays. A report will be printed out on Fridays and before holidays. The AD or assistant will have access to this report to know who has funds available. They will give money out upon request of the resident between the hours of 11:00 a.m. and 2:00 p.m. Funds in the cash box will be reconciled on Mondays and after holidays by the Executive Director	11/13/10
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE	(X6) DATE

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

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F 139	<p>Continued From page 1</p> <p>The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.</p> <p>The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.</p> <p>The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.</p> <p>The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to have a system in place to ensure residents' personal funds were available and residents had access to petty cash outside normal business hours.</p> <p>The findings include: During a review of the facility's accounting system, interview with the Financial Manager on</p>	F 159	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>and/or Business Office Manager in order to keep a current, accurate accounting of resident trust funds.</p> <p>A letter will go out to all residents who have funds deposited in a resident trust account with the facility.</p> <p>The ED or his designee will discuss this procedure at the next resident council meeting.</p> <p>The Business Office Manager or his designee will explain this procedure as part of the admission process.</p> <p>The process will be reviewed by the IDT in the monthly Performance Improvement meeting and adjustments to the process will be made as needed. Any adjustment made that affects the process will in turn be communicated to the residents/responsible parties via a letter from the Executive Director. This will be brought to the PI meeting by the ED and reviewed monthly for</p>	11/13/10

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F 159	Continued From page 2 09/29/10 at 10:10 AM revealed the facility had no system in place to ensure residents had access to their personal spending money after normal business hours, on weekends, and on holidays. Further interview with the Financial Manager revealed there were a few residents that received petty cash on Fridays, however there was no system to have petty cash available to residents, upon their request, after normal business hours, on weekends, and on holidays. Interview with the Administrator on 09/29/10 at 2:10 PM revealed he did not realize the facility needed to ensure petty cash was available at all times as no resident had asked for money on the weekends.	F 159	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>	
F 272 SS=E	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status;	F 272	three months and as needed thereafter. F272 The Resident Assessment Protocol Summary (RAPS) were revised, to include the required criteria for: Resident #7 on 11-3-10 Resident #1 on 11-1-10 Resident #12 on 10-30-10 Resident #21 on 11-1-10 Resident #29 Closed record Resident #4 on 11-4-10 Resident #9 on 11-3-10 Resident #18 on 11-8-10 Resident #2 on 10-26-10 Resident #27 Closed record	11/13/10

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F 272	<p>Continued From page 3</p> <p>Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to ensure the Resident Assessment Instrument (RAI) process was followed related to covering the required criteria in the Resident Assessment Protocol Summary (RAPS) for thirteen (13) of thirty-two (32) sampled residents, (Residents #7, #1, #12, #21, #29, #4, #9, #18, #2, #27, #14, #20, and #8).</p> <p>The findings include:</p> <p>1. Record review revealed Resident #7 was admitted to the facility on 12/30/07. Review of the latest comprehensive assessment, an annual assessment dated 08/24/10, revealed nutritional status triggered because the resident experienced a weight loss and had a pressure ulcer.</p> <p>Review of the RAPS revealed the resident triggered for nutritional status, however there was no evidence the facility had identified the causal factors or reason the RAP triggered. Review of the Summary revealed the RAPS triggered due to annual review. Review of the RAP Summary</p>	F 272	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>Resident #14 on 10-30-10</p> <p>Resident #20 on 11-8-10</p> <p>Resident #8 on 11-8-10</p> <p>All active patients RAPS in Fountain Circle will be reviewed to ensure all criteria is present, this will be done by the MDS team. Any RAPS that do not meet the four criteria will be rewritten, unless the record is closed. Review will be completed 11/12/10 for all residents.</p> <p>All MDS Nurses, Social Service Department, Activity Department, Registered Dietician, Executive Director, Executive Director Assistant, and the DNS were all educated by the District Director of Case Management on 10-6-10 on the four criteria of RAPS as well as how to write CAAs. Any new staff from 10-6-10 on who are hired that work with the CAAs will be educated by the DDGM on how to write CAAs.</p>	11/13/10	

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F 272	<p>Continued From page 11</p> <p>complications and risk factors, such as diagnosis and cardiac, to be considered in developing an individualized Plan of Care. Further review revealed no mention if referrals were necessary for Resident #8.</p> <p>Review of the communication, ADL function, urinary incontinence, falls, dental care and pressure ulcer revealed no factors that must be considered in developing individualized care plan interventions and no mention if referrals were necessary. There was no evidence of an activity RAP summary in the medical record. The trigger legend did not give dates for the RAP documentation, only the location.</p> <p>Interview with the MDS nurses on 09/29/10 at 3:35 PM revealed they had received some brief training centered on the care plan and some in house training. They were able to describe the required criteria for the RAPS per the guidelines, but could not explain why the criteria was not met.</p>	F 272	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>These findings will be brought to the Performance Improvement Committee (PIC) which includes the Executive Director (ED), Executive Director Assistant (EDA), Director of Nursing Services (DNS), Assistant Director of Nursing (ADNS), Registered Dietician (RD), Activities Director (AD), Social Service Director (SS), Case Manager (CM), Maintenance Director, Medical Director (MD), MDS Nurses, and the Dietary Manager every month for the next three months. The PIC will determine if further action is needed.</p>	
F 274 SS=D	<p>488.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE</p> <p>A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)</p>	F 274	<p>F 315</p> <p>Resident #14's Bladder Assessment was updated on 10-14-10, and continues on a toileting program and is working with the restorative aids with bladder exercises.</p> <p>All patients at Fountain Circle were reviewed by the ADNS for a change in both bladder and bowel</p>	11/13/10

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F 272	<p>Continued From page 4</p> <p>revealed no evidence the facility had identified the weight loss. Further review revealed no documentation to support the decision regarding whether to proceed with a care plan nor the need for referrals or further evaluation.</p> <p>Interview on 09/29/10 at 3:40 PM, with the facility's Registered Dietician, who completed the RAP summary for Resident #7 related to nutritional status, revealed she received training for completing RAP Summaries from Dieticians from other facilities and was not aware the four (4) required criteria had not been met.</p> <p>2. Review of the RAP trigger sheet, dated 03/18/10, for Resident #1 revealed the resident triggered for additional review of ADL Function, Nutrition, and Pressure Ulcers. Additional review revealed the facility documented the location of data used for the RAPS were located in ADL charting, nursing notes, dietary notes, meal charting, intake and output records, and skin audits and treatment sheets. However, there were no dates to identify which documentation was reviewed.</p> <p>Review of the RAP key for ADL Function revealed Resident #1 had impaired decision making skills, impaired balance, and was not independent with ADLs except for eating.</p> <p>Review of the RAP keys for Nutrition revealed the resident triggered secondary to a five (5) day admission assessment, had chewing problems with a mechanically altered diet, left more than twenty-five (25%) percent of meals uneaten. The RAP key did not detail the resident's pressure ulcers. However review of the RAP keys for Pressure Ulcers revealed Resident #1 had</p>	F 272	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>The MDS nurses to ensure all CAAs meet the criteria will review 10 percent of CAAs, per unit, every month.</p> <p>MDS nurses will bring the audit findings to the Performance Improvement Committee (PIC) which includes the Executive Director (ED), Executive Director Assistant (EDA), Director of Nursing Services (DNS), Assistant Director of Nursing (ADNS), Registered Dietician (RD), Activities Director (AD), Social Service Director (SS), Case Manager (CM), Maintenance Director, Medical Director (MD), MDS Nurses, and the Dietary Manager every month for the next three months. These audits will include whether or not the CAAs are meeting the criteria. The PIC will review the findings of the audits and will determine if further action is needed.</p>	11/13/10	

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F 272	<p>Continued From page 5 nutritional intervention for skin problems.</p> <p>The RAP keys did not detail how these complications/factors were used in the decision to proceed and develop an individualized plan of care.</p> <p>3. Review of the RAP Trigger Sheet, dated 02/09/10, for Resident #12 revealed the resident triggered for restraints. Review of the RAP key for restraints revealed no details regarding the risk related to the use of the restraint. Additionally, there was no information related to referrals.</p> <p>4. Review of the RAP Trigger Sheet, dated 03/15/10, for Resident #21 revealed the resident triggered for restraints. Review of the RAP key for restraints revealed the key detailed information related to the resident's use of anti-anxiety medication, continuous oxygen, mood state, and the resident's behavior management program. The RAP key did not detail how these factors affected the decision to proceed to an individualized care plan. Nor did the RAP key address the risk factors associated with restraint use.</p> <p>5. Review of the RAP Trigger Sheet for Resident #29, dated 02/03/10 revealed the resident triggered for visual function, comminution, ADL function, urinary incontinency, falls, and psychotropic drug use.</p> <p>The RAP key did not detail how the facility used the information to proceed to and develop an individualized plan of care for the resident.</p> <p>6. Review of Resident #4's medical record</p>	F 272	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>F274</p> <p>Resident #28 no longer lives at Fountain Circle and the record is closed.</p> <p>All active residents of Fountain Circle will be reviewed by the CM and DNS checking for any missed significant changes. The review will compare the last Annual Assessment or Significant Change Assessment and comparing it to the last quarterly assessment for any significant changes. If any significant changes are found then the MDS RNs will conduct a Significant Change Assessment. Review will be completed 11/12/10 for all residents.</p> <p>All MDS Nurses, Social Service Department, Activity Department, Registered Dietician, Executive Director, Executive Director Assistant, and the DNS were all educated by the District Director of Case Management on 10-6-10 on</p>	11/13/10
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F 272	<p>Continued From page 6</p> <p>revealed diagnoses which included Dementia/Alzheimer type, Diabetes Mellitus, Chronic Obstructive Pulmonary Disease (COPD) and Cerebrovascular Accident.</p> <p>Review of the Annual MDS Assessment dated 01/27/10, revealed Resident #4 had triggered for further nutrition assessment due to chewing/swallowing problems and presence of a feeding tube. Based on review of the RAPS it was determined they were not completed in accordance with the utilization guidelines.</p> <p>Review of the RAP Nutrition Summary revealed the complications and risk factors that effect the decision to proceed to care planning were not identified, as well as factors that must be considered in developing individualized care plan interventions were not identified. It was also noted there was no mention if referrals were necessary for Resident #4.</p> <p>Review of the RAP feeding tube summary revealed the complications and risk factors, considerations for individualized care plan interventions and any need for further referrals were not addressed.</p> <p>7. Review of Resident #9's medical record revealed diagnoses which included Seizure Disorder, Morbid Obesity, Chronic Obstructive Pulmonary Disease (COPD), Polio, Emphysema, Gastroesophageal Reflux (GERD), Hyperlipidemia and Hypertension.</p> <p>Review of the Annual MDS Assessment dated 04/19/10 revealed Resident #9 had triggered for further nutrition assessment due to weight loss. Based on review of the RAPS it was determined</p>	F 272	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>Any new staff from 10-6-10 on who are hired that work with the MDS will be educated by the DDCM or by a designee directed by the ED. 10 percent of all MDS, per unit, per month will be audited by the MDS Department for possible significant changes.</p> <p>All audits will be brought to the Performance Improvement Committee (PIC) which includes the Executive Director (ED), Executive Director Assistant (EDA), Director of Nursing Services (DNS), Assistant Director of Nursing (ADNS), Registered Dietician (RD), Activities Director (AD), Social Service Director (SS), Case Manager (CM), Maintenance Director, Medical Director (MD), MDS Nurses, and the Dietary Manager every month for the next three months. The PIC will determine if further action is needed.</p>	11/13/10	

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F 272	<p>Continued From page 7</p> <p>they were not completed in accordance with the utilization guidelines.</p> <p>Review of the RAP nutrition summary review revealed considerations for developing an individualized care plan were not addressed.</p> <p>8. Review of Resident #18's medical record revealed diagnoses which included Dementia, Renal Insufficiency, Diabetes Mellitus, Osteoarthritis and Dyphagia.</p> <p>Review of the Annual MDS Assessment dated 03/26/10 revealed Resident #18 had triggered for further nutrition assessment due to chewing/swallowing difficulty and presence of a feeding tube. Based on review of the RAPS it was determined they were not completed in accordance with the utilization guidelines.</p> <p>Review of the RAP Nutrition Summary revealed complications and risk factors, consideration in developing an Individualized care plan intervention and need for referrals had not been addressed.</p> <p>Review of the RAP Feeding Tube Summary revealed the need for referrals was not addressed.</p> <p>9. Review of Resident #2's clinical record revealed diagnoses which included Chronic Obstructive Pulmonary Disease, Functional Decline, Diverticulosis, Constipation, Coronary Artery Disease, and Depression. Review of the Annual Minimum Data Set (MDS) Assessment dated 07/19/10 revealed nutrition triggered for further assessment due to weight loss. However, review of the Resident Assessment Protocol</p>	F 272	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>F279</p> <p>Resident #14's care plan has been revised, on 10-2-10, to include restorative nursing for urinary exercises and ADLs, which includes a toileting program. As of 10-22-10 the resident has been discontinued from restorative nursing for urinary incontinence.</p> <p>All residents receiving restorative NSG and or are on a toileting program will have updated care plans to include their specific care plan. The ADNS and/or DNS will update all the care plans by 11/12/10.</p> <p>All MD orders will be brought to the daily clinical meeting Monday through Friday for review of the MD order as well as a completed care plans. On the weekends the weekend supervisor will do the same.</p>	11/13/10

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NAME OF PROVIDER OR SUPPLIER FOUNTAIN CIRCLE HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 200 GLENWAY ROAD WINCHESTER, KY 40391		
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F 272	<p>Continued From page 8</p> <p>Summaries (RAPS) revealed they were not completed in accordance with the utilization guidelines.</p> <p>Review of the RAPS revealed the resident had a significant weight loss in thirty days; however, the facility failed to describe the nature of the problem related to the weight loss. In addition, the RAPS failed to describe the complications and risk factors to be considered in developing an individualized Plan of Care such as diagnoses, and cardiac and psychotropic medications.</p> <p>10. Review of Resident #27's medical record revealed diagnoses which included Senile Dementia, Alzheimer, Hypertension, Impaired Renal Function and Hypothyroidism.</p> <p>Review of the Annual MDS Assessment dated 04/20/10 revealed Resident #27 had triggered for further review of delirium, activities of daily living (ADL) function, falls, dehydration/fluid maintenance and pressure ulcers. Based on review of the RAPS it was determined they were not completed in accordance with the utilization guidelines.</p> <p>Review of the RAP delirium summary revealed the complications and risk factors that effect the decision to proceed to care planning were not identified. It was also noted there was no mention if referrals were necessary for Resident #27.</p> <p>Review of the RAPS for ADL function, falls, dehydration/fluid maintenance and pressure ulcers revealed these RAPS were blank and the trigger legend stated "see NN, Fall Assessments, skin sheets and ADL sheets with no dates to</p>	F 272	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>All Licensed Nurses have been educated by the DNS or SDC on 10-18, 19, and 20th for review, revision and completed/implemented care plans per MD orders. No Licensed staff will be allowed to work after the 10-20-10 that have not been re-educated on the revision of care plans and implementation of care plans.</p> <p>All physician orders are reviewed Monday through Friday by the DNS and/or ADNS and on Saturday and Sunday by the Weekend Supervisor. At the time of physician order review, the DNS, ADNS and/or Weekend Supervisor will review the care plan and validate revision.</p> <p>Every month, all residents with restorative orders, will be audited by either the ADNS or DNS or DNS designee, to validate care plan revision and by observing the resident to validate implementation of the care plan. In addition, each month, the DNS, ADNS or DNS</p>	11/13/10	

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F 272	<p>Continued From page 9 identify the information used.</p> <p>11. Review of Resident #14's medical record revealed diagnoses which included Peripheral Edema, Venous Stasis and Insufficiency, Diabetes, Status Post Brain Infarct and Hypertension.</p> <p>Review of the Significant Change MDS Assessment dated 07/20/10, revealed Resident #14 had triggered for further review of cognitive loss, urinary incontinence, behavior, falls and pressure ulcers. Based on review of the RAPS it was determined they were not completed in accordance with the utilization guidelines.</p> <p>Review of the RAPS for falls, behavior, pressure ulcers and urinary incontinence revealed considerations for developing an individualized care plan were not discussed. Review of the RAPS for behavior and cognitive loss revealed there was no mention if referrals were necessary for Resident #14.</p> <p>12. Review of Resident #20's medical record revealed diagnoses which included Chronic Kidney Disease, Left Below Knee Amputation, Peripheral Vascular Disease, Congestive Heart Failure, Hypertension, Stage II stasis ulcer.</p> <p>Review of the Initial MDS Assessment dated 12/11/09, revealed Resident #20 had triggered for further nutrition, ADL function, dehydration/fluid maintenance and pressure ulcer assessment. Based on review of the RAPS it was determined they were not completed in accordance with the utilization guidelines.</p> <p>Review of the nutrition RAPS revealed the</p>	F 272	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>designee will review 10 percent of residents on each unit to validate care plan revision and by observing the resident to validate implementation of the care plan.</p> <p>The audits will be brought to the Performance Improvement Committee (PIC) which includes the Executive Director (ED), Executive Director Assistant (EDA), Director of Nursing Services (DNS), Assistant Director of Nursing (ADNS), Registered Dietician (RD), Activities Director (AD), Social Service Director (SS), Case Manager (CM), Maintenance Director, Medical Director (MD), MDS Nurses, and the Dietary Manager every month for the next three months. The PIC will determine if further action is needed.</p> <p>F281</p> <p>Resident # 19s care plan was updated on 10-14-10, to include the appropriate of precautions.</p>	11/13/10

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F 272	<p>Continued From page 10</p> <p>resident triggered secondary to a five (5) day admission assessment and receiving a therapeutic diet. The RAPS did not detail the resident's stasis ulcer, complications and risk factors, consideration in developing an individualized care plan intervention and the need for referrals had not been discussed.</p> <p>Review of the RAPS for ADL function, dehydration/fluid maintenance and pressure ulcer revealed no mention if referrals were necessary for Resident #20. Review of the RAP trigger legend for ADL function, dehydration/fluid maintenance and pressure ulcers revealed the trigger legend stated "see NN, skin sheets and ADL sheets", with no dates to identify the information used.</p> <p>18. Review of Resident #8's clinical record revealed diagnoses which included Alzheimer, Dementia, Diabetes, Hypertension, Behavioral Disturbance, Peg Placement and Heel ulcer.</p> <p>Review of the Significant Change Minimum Data Set (MDS) Assessment dated 03/09/10, revealed nutrition, feeding tube, communication, ADL function, urinary incontinence, activities, falls, dental care and pressure ulcer triggered for further assessment. However, review of the Resident Assessment Protocol Summaries (RAPS) revealed they were not completed in accordance with the utilization guidelines.</p> <p>Review of the nutritional and tube feeding RAPS revealed the resident had a significant weight loss in thirty days and new peg tube placement. However, the facility failed to describe the nature of the problem related to the weight loss. In addition, the RAPS failed to describe the</p>	F 272	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law</i></p> <p>All residents admitted with in the last 30 days, 9/21-10/21/10, have been audited, checking their Interim care plans. The audits were conducted by the DNS or designee to ensure the care plans meet the residents overall needs.</p> <p>All new admissions will be reviewed with in 24 hours of admission by the DNS or designee Monday through Friday and on the weekends by the weekend supervisor ensuring all resident needs have been care planed. All Licensed Nurses have been educated by the DNS or SDC on 10-18, 19, and 20th for completed/implemented care plans per MD orders. No Licensed staff will be allowed to work after the 10-20-10 that have not been re-educated on care plans and implementation of care plans.</p> <p>Ten percent of new admissions per month will be reviewed for a complete interim care plan by the weekend supervisor and the DNS.</p>	11/13/10
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F 274	<p>Continued From page 12</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to complete a comprehensive assessment of a resident within fourteen (14) days after the facility should have determined there had been a significant change in the resident's condition for one (1) of thirty-two (32) sampled residents (Resident #28).</p> <p>The findings include:</p> <p>Review of Resident #28's clinical record revealed diagnoses which included Constipation, Osteoporosis, and Dementia. Per the resident's clinical record, the resident was hospitalized on 04/05/10 and diagnosed with Hyponatremia, due to poor oral intake. Resident #28 was readmitted to the facility on 04/28/10 with a gastric feeding tube (G-tube), Stage IV Pressure Ulcer and, an indwelling catheter. Further review revealed Resident #28 had a significant weight change (from 118 pound to 102 pounds in 90 days, 10% decrease). Resident #28 was hospitalized on 05/07/10 due to a malfunctioning G-tube, and was readmitted to the facility on 05/14/10 with a Dobhoff (Naso-gastric) feeding tube, Stage IV Pressure Ulcer, an indwelling catheter, and significant weight change.</p> <p>Review of the Minimum Data Sets (MDS) revealed the facility completed Quarterly MDS assessments on 02/24/10 and 05/26/10. There was no documented evidence the facility identified a significant change to Resident #28's condition requiring a comprehensive assessment, on 04/28/10 or 05/14/10.</p>	F 274	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statements of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>10-15-10. Residents identified were repatterned and placed on a toileting plan if appropriate and or willing. Also rehabilitation referrals for the Urinary Incontinent Program were sent to the rehabilitation department if needed.</p> <p>All residents with foley catheters were reviewed on 11/8/10 to validate appropriate use. All were determined to be appropriate.</p> <p>All new admissions will be reviewed by the DNS Monday through Friday to ensure bowel and bladder patterns are in place and bowel and bladder assessments are completed, if appropriate. On the weekends the weekend supervisor will do the same. Monday through Friday the Interdisciplinary Team will review all SRNA flow sheets to audit for any resident who has a change in continence, i.e., bowel and bladder. If a change in continence is found then Unit Managers will be notified.</p>	11/13/10
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F 274	<p>Continued From page 13</p> <p>Interviews on 09/29/10 at 3:35 PM, with the three (3) MDS nurses (Registered Nurses) (RNs) #5, #6, and #7 revealed Resident #28 should have had a Significant Change Assessment completed upon readmission with the above cited changes. The MDS nurses were unable to explain why someone had not recognized the need to complete a Significant Change Assessment. In additional interview RN #6 stated they would review any resident who may need a Significant Change Assessment during their monthly meeting. The MDS nurses stated the resident had moved around a lot between the two (2) quarterly assessments and perhaps that was why the Significant Change Assessment was missed. They explained a nurse from Cooperate Office came in and reviewed MDSs to ensure the facility's MDS nurses were completing MDSs correctly.</p> <p>Interview on 09/29/10 at 3:35 PM, with the Director of Nursing (DON) revealed he did review MDSs and if he identified concerns he would call for the Corporate MDS Nurse to come and conduct an audit.</p> <p>Review of the facility's policy "PRO 61003-01 Condition Change of a Resident" revealed the facility defined a Significant Change as a decline or improvement in a resident's status that will not normally resolve itself without interventions by staff or by implementing clinical interventions, impacts more than one area of the resident's health status, and requires interdisciplinary review and/or revision of the care plan.</p>	F 274	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>family notification will occur. Then repatterned and new assessments will occur if the incontinence continues. All residents with a foley catheter will be reviewed on a quarterly basis to validate appropriate use.</p> <p>All nursing staff have been re-educated by the DNS or SDC on 10-18, 19, and 20th on bowel and bladder patterns, bowel and bladder assessments. They were also educated on MD and family notification regarding incontinence. Education of toileting programs are placed on the care plan and the SRNA assignment sheets. No nursing staff will be allowed to work on the floor after 10-20-10 unless they have had this education. The ADNS or designee by the DNS will review monthly any newly incontinent patients by reviewing the SRNA flow sheets, 24 hour reports, IDT will audit daily the SRNA flow sheets and will place on the white boards anyone with a change of</p>	11/13/10
F 279 SS-D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS	F 279		

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F 279	<p>Continued From page 14</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to review and revise the comprehensive plan of care for one (1) of thirty two (32) sampled residents (Resident #14). Resident #14 was to receive restorative nursing for urinary exercise and activities of daily living (ADLs). In addition, Resident #14 was to be placed on a toileting program.</p> <p>The findings include: Review of Resident #14's medical record revealed the resident was admitted to the facility on 04/22/10, with diagnoses which included</p>	F 279	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>incontinence.</p> <p>The ADNS or DNS designee will bring these findings to the Performance Improvement Committee (PIC) which includes the Executive Director (ED), Executive Director Assistant (EDA), Director of Nursing Services (DNS), Assistant Director of Nursing (ADNS), Registered Dietician (RD), Activities Director (AD), Social Service Director (SS), Case Manager (CM), Maintenance Director, Medical Director (MD), MDS Nurses, and the Dietary Manager every month for the next three months. The PIC will determine if further action is needed</p> <p>F 318</p> <p>Resident #8's MD was notified on 9-27-10. OT assessed the residents' right hand on 9-27-10. OT is working with the resident at this time. MD saw the resident and changed the residents' medications.</p>	11/13/10

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F 279	<p>Continued From page 15</p> <p>Diabetes, Hypertension, Peripheral Edema, Venous Stasis and Insufficiency and Chronic Obstructive Pulmonary Disease.</p> <p>Interview with Resident #14 on 09/27/10 at 10:00 AM, revealed the resident did use a urinal at times and did recognize the urge at times. The resident further stated it bothers him/her to have to use this bathroom, and pointed to the bathroom in the hallway.</p> <p>Interview with State Registered Nurse Aide (SRNA) #7, on 09/27/10 at 2:00 PM, revealed she was assigned to provide care for Resident #14. She stated the resident was totally incontinent, and we check and change him/her every 2 hours during the day. She further stated that she does not ask the resident if he/she needs to go to the bathroom because he/she gets agitated and upset.</p> <p>Interview with the Director of Nursing (DON) on 09/27/10 at 4:45 PM, revealed the resident had a decline in incontinence when he/she was moved to the C unit. The DON further stated the incontinence and brief use were discussed with the resident, however, no documented evidence of this conversation was found in the resident's medical record.</p> <p>Review of the Physician's order dated 08/27/10, revealed "Discharge pt from skilled OT services to LTC. Initiate restorative nursing program 6 times per week times 8 weeks for UI (Urinary incontinence) exercise and ADL's".</p> <p>Further interview with the DON on 09/28/10 at 11:15 AM, revealed the restorative nursing care plan would be in the restorative notebook.</p>	F 279	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>All residents of Fountain Circle were assessed by the Rehabilitation Department staff for any increases in muscle tone, decrease in range of motion, and possible contractures. Anyone that was found to have increase in muscle tone, decrease in range of motion, and/or contractures were picked up by the therapists and MD/Family notification occurred. This assessment will be completed by 11/12/10.</p> <p>All nursing staff has been educated by the DNS or SDC on 10-18, 19 and 20, 2010 for identification of decrease range of motion, increase in muscle tone, or contractures. They were also educated on any possible change of resident condition.</p> <p>A change of condition form has been generated for SRNA use to help with change of condition of the residents. These forms will be placed at each nursing station for SRNA use. If the SRNA identifies a change in</p>	11/13/10
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F 279	Continued From page 16 However, he was unable to locate a restorative care plan for the resident. He further stated he updated the resident's Plan of Care (POC) yesterday, and the team talked about the resident's incontinence as a behavior. However, the DON could not find any documentation regarding this discussion. Review of the POC dated 09/24/10, for Resident #14 revealed a problem of incontinent of Bowel and Bladder (B&B) related to history of brain infarct and functional decline. There was no documented evidence of a goal to improve B&B and no evidence of interventions to assist the resident with a toileting schedule. However, review of the Resident Progress Notes dated 08/30/10, revealed the resident was to be placed on a scheduled toileting program due to urinary incontinence per Occupational Therapy (OT) recommendations. Further review of the resident's POC revealed the DON had updated the alteration in elimination POC on 09/27/10, with problem "resident refuses to be toileted and resident would rather use adult briefs is considered a behavior". Interventions: "Restorative Nursing per UI/Rehab Program". Continued review of the resident POC revealed no revision to include a scheduled toileting program or restorative program for ADL's. Interview with the Registered Nurse (RN)/MDS #5 on 09/29/10 at 3:35 PM, revealed he was not sure why the POC was not revised to address the toileting schedule or restorative nursing programs. "I just missed it I guess."	F 279	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i> condition he/she is to fill out this form and give to the nurse to follow up on. Once the nurse assesses the resident he/she is to notify MD, Family of the change. Possible rehabilitation referral is made and info is placed on the 24 hour report. This form also is placed on the 24 hour report for the IDT review. Nursing staff will not be able to work after 10-20-10 unless they have had the education. The rehabilitation department will conduct a quarterly screen, in conjunction with the MDS schedule, on every resident to assess for change of condition by using the MDS assessment calendars, generated by the MDS department. This quarterly review will start 12-1-10 as every resident has been reviewed in October and November of 2010.	11/13/10	
F 281 88=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility	F 281	All condition change forms will be saved and reviewed by the DNS and presented to the PIC every month for		

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NAME OF PROVIDER OR SUPPLIER FOUNTAIN CIRCLE HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 200 GLENWAY ROAD WINCHESTER, KY 40391		
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F 281	<p>Continued From page 17 must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure the Plan of Care was sufficient to meet the needs of newly admitted residents for one (1) of thirty-two (32) sampled residents (Resident #19).</p> <p>The findings include:</p> <p>Review of the facility's Initial Plan of Care Policy, revealed "An initial Plan of Care is initiated within 24 hours of admission that addresses the resident's Initial Individual and Immediate needs until the interdisciplinary team finalizes the comprehensive plan of care". Further review of the Policy revealed the Care Plan identified the resident's centered needs, strengths, weaknesses, and related diagnoses and conditions.</p> <p>Review of Resident #19's medical record revealed the resident was admitted to the facility from the hospital on 09/16/10 with diagnoses which included Staphylococcus Bacteremia and, an Abdominal Wound secondary to Necrotizing Fasciitis. Further record review revealed the Admission Minimum Data Set (MDS) had not been completed due to the recent admission.</p> <p>Observation of the resident on 09/28/10 at 11:30 AM revealed the resident was in his/her room in the bed. Further observation revealed a Contact Precautions Sign on the resident's door and an Isolation cart in the hallway by the resident's door.</p>	F 281	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law</i></p> <p>The case manger will review the quarterly screens that the rehabilitation department will be doing and bring the outcomes of the screens to the Performance Improvement Committee (PIC) which includes the Executive Director (ED), Executive Director Assistant (EDA), Director of Nursing Services (DNS), Assistant Director of Nursing (ADNS), Registered Dietician (RD), Activities Director (AD), Social Service Director (SS), Case Manager (CM), Maintenance Director, Medical Director (MD), MDS Nurses, and the Dietary Manager every month for the next three months. The PIC will determine if further action is needed.</p>	11/13/10	
		F 323	<p>Fountain Circle Health and Rehabilitation Center will continue to ensure that the resident environment remains as free of accident hazards</p>		

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F 281	Continued From page 18 Observation on 09/28/10 at 11:45 AM revealed a nurse and a housekeeper donned a gown and gloves prior to entering the resident's room. Review of the Resident Progress Notes dated 09/17/10 at 4:45 PM revealed the resident had a large wound to the left side of the abdominal groin area secondary to Necrotizing Fasciitis. Review of the Resident weekly Skin Check Sheet dated 09/17/10 revealed the measurement for this area was seven (7) centimeters (cms) x twenty-six (26) cms x two (2) cm's with a one and a half (1.5) cm tunnel secondary to Necrotizing Fasciitis. Review of the Physician's Orders dated 09/17/10 revealed orders to cleanse abdominal wound with Normal Saline and dry gently, then pack the wound with the vac sponge, then cover with wound vac dressing every Monday, Wednesday, and Friday, and as needed due to diagnosis of Necrotizing Fasciitis. Review of the Interim Plan of Care revealed there was no Plan of Care to address the need for Contact Precautions related to the resident's diagnosis of Necrotizing Fasciitis. Interview on 09/29/10 at 9:05 AM with the Registered Nurse (RN)/ Nurse Manager for the 100 Hall where Resident #19 resided, revealed the Initial Care Plans were completed by the admitting nurses, and the Care Plans were revised with new Physician's Orders by the nurse receiving the orders or the MDS Coordinator. She stated there should have been a Plan of Care related to the need for Contact Precautions due to the resident's current diagnosis of Necrotizing Fasciitis.	F 281	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i> receives adequate supervision and assistance devices to prevent accidents. 1) The cabinet in 100 Hall General Bathroom was locked and keys made available to staff. Personal toiletries were labeled with resident names and put in tubs in resident dresser drawers. The Limate Mal-Odor Eliminator was locked in a housekeeping cart. This will be completed on 11/12/10. 2) The 200 Hall Soiled Utility room was locked. Staff have been inserviced regarding the importance of keeping this room and other such rooms locked at all times when unattended. This will be completed on 11/12/10.	11/13/10	
F 315	483.25(d) NO CATHETER, PREVENT UTI,	F 315	3) The cabinet in 200 Hall General Bathroom was		

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F 315 88-D	<p>Continued From page 19 RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary, and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to provide appropriate treatment and services to maintain/restore as much bladder function as possible for one (1) of thirty two (32) sampled residents (Resident #14). Resident #14 had a decline in bladder continence. There was no documented evidence the facility had assessed Resident #14 to identify the causative factors related to the resident's decline in continence.</p> <p>The findings include:</p> <p>Observation of Resident #14 on 09/26/10 at 2:20 PM, revealed the resident sitting in the lobby area in front of the nurse's station in a wheelchair. Resident #14 was wearing an adult brief.</p> <p>Observation of Resident #14's room on 09/26/10 at 3:30 PM, revealed a urinal sitting on the resident's bed side table with approximately 500 milliliters of yellow fluid.</p> <p>Observation of Resident #14 on 09/27/10 at 10:30</p>	F 315	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>removed and has been replaced. Personal toiletry items have been labeled and store in tubs in resident dresser drawers. This bathroom has been thoroughly cleaned and odors eliminated. This will be completed on 11/12/10.</p> <p>4) The cabinet on the wall in 100 Hall General Bathroom has been locked. It contains nursing supplies. No toiletries are to be stored there. All resident personal toiletries are store in tubs in resident dresser drawers. This will be completed on 11/12/10.</p> <p>Safety rounds/observations were conducted, by the ED or the DNS, of all resident rooms, bathrooms, shower rooms, soiled utility rooms and all resident environments to identify any safety hazards. Rounds will be completed on 11/12/10. No</p>	11/13/10
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F 315	<p>Continued From page 20</p> <p>AM, revealed the resident was assisted to his/her room and assisted with incontinence care.</p> <p>Review of Resident #14's medical record revealed the resident was admitted to the facility on 04/22/10, with diagnoses which included Diabetes, Hypertension, Peripheral Edema, Venous Stasis and Insufficiency and Chronic Obstructive Pulmonary Disease.</p> <p>Interview with Resident #14 on 09/27/10 at 10:00 AM, revealed the resident did use a urinal at times and did recognize the urge at times. The resident further stated that it bothers him/her to have to use this bathroom, and pointed to the bathroom in the hallway. The resident continued, stating that he/she had a daper on and they (staff) change me and sometime they take me to the bathroom.</p> <p>Interview with State Registered Nurse Aide (SRNA) #7, on 09/27/10 at 2:00 PM, revealed she was assigned to provide care for Resident #14. She stated the resident was totally incontinent, we check and change him/her every two (2) hours during the day. She further stated that she does not ask the resident if he/she needs to go to the bathroom because he/she gets agitated and upset.</p> <p>Interview with the Director of Nursing (DON) on 09/27/10 at 4:45 PM, revealed the resident had a decline in incontinence when he/she was moved to the C unit. The DON further stated the incontinence and brief use was discussed with the resident. However, no documented evidence of this conversation was found in the resident's medical record. He further stated the facility's procedure for bowel and bladder (B&B)</p>	F 315	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>other safety hazards were identified. In addition, the facility is staffed 24 hours a day, 7 days a week. Facility staff provide supervision to all residents to prevent accidents and ensure the appropriate assistive devices are in place. Supervision has been in place and will continue to be in place at all times.</p> <p>The Housekeeping Supervisor has conducted inservice with the Housekeeping staff regarding locking all chemicals in their carts and not leaving them within resident access. The inservice was conducted on 11-8, 9, 10, 11, 12, 2010.</p> <p>All facility staff has been inserviced by SDC, regarding keeping soiled utility areas locked when unattended. Inservice was conducted on 11-8, 9, 10, 11, and 12, 2010.</p> <p>Nursing staff have been inserviced by the DNS or his designee regarding the proper labeling and storage of resident toiletries and</p>	11/13/10
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F 315	<p>Continued From page 21</p> <p>assessment would be upon admission, annually and when there was a change in continence. However no B&B assessment had been completed since the admission assessment which revealed the resident was continent of B&B.</p> <p>Review of the Physician's order dated 08/27/10, revealed "Discharge pt from skilled OT services to LTC. Initiate restorative nursing program 6x per week times 8 weeks for UI (Urinary incontinence) exercise and ADL's".</p> <p>Further interview with the DON on 09/28/10 at 11:15 AM, revealed the restorative nursing care plan would be in the restorative notebook. However, he was unable to locate a restorative care plan for the resident. He further stated he updated the resident's Plan of Care (POC) yesterday, and the team talked about the resident's incontinence as a behavior, but I don't find any documentation regarding this discussion.</p> <p>Review of the POC dated 09/24/10, for Resident #14 revealed a problem of incontinent of B&B related to history of brain infarct and functional decline. No evidence of a goal to improve B&B and no evidence of interventions to assist the resident with a toileting schedule. However, review of Resident Progress Notes dated 08/30/10, revealed the resident was to be placed on a scheduled toileting program due to urinary incontinence per OT recommendations. Further review of the resident's POC revealed the DON had updated the alteration in elimination POC on 09/27/10, with problem "resident refuses to be toileted and resident would rather use adult briefs is considered a behavior". Interventions: "Restorative Nursing per UI/Rehab Program".</p>	F 315	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>keeping chemicals locked and out of resident access. Inservice was conducted on 10-18, 19, 20, 2010.</p> <p>In addition, the DNS or the SDC conducted inservice to all facility staff on providing a safe environment, providing supervision to prevent accidents and ensuring the appropriate safety devices are in place. Inservice was conducted on 11-8, 9, 10, 11, 12 2010.</p> <p>Daily rounds by the Executive Director Services and/or his designee and weekly rounds by the Director of Nursing or his designee will be made and documented on a rounds tool to ensure areas such as the soiled utility rooms and cabinets in the general baths are locked and that there are no chemicals available for resident access. They will also ensure resident toiletries are not out in the general baths but stored in resident dresser drawers. (See rounds sheet) Any concerns</p>	11/13/10
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F 315 F 318 8S=G	<p>Continued From page 22</p> <p>Continued review of the resident's POC revealed the incontinence and adult brief use were not addressed in any of the behavior problems.</p> <p>483.25(a)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to ensure residents with a limited range of motion received the appropriate treatment and services to prevent further decrease in range of motion for one (1) of thirty two (32) sampled residents (Resident # 8). The resident received Occupational Therapy (OT) until 03/10, and then eight (8) weeks of restorative nursing until 05/10. However, there was no documented evidence the resident received further services to prevent further decline in range of motion or the development of contracture of the right hand.</p> <p>The findings include:</p> <p>Observation of Resident #8 on 09/26/10 at 2:30 PM, and on 09/27/10 at 10:05 AM, revealed the resident to be in the bed with the right hand on his/her chest. The resident's last three (3) fingers were bent down toward the palm. The forefinger and thumb were straight out.</p>	F 315 F 318	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>time. The DNS, ADNS, Unit Manager, Weekend Supervisor and Housekeeping Supervisor will conduct daily rounds/observations of all resident rooms, bathrooms, soiled utility rooms, housekeeping carts and all resident care areas to ensure the environment is safe, without hazards and supervised. Rounds will also validate the appropriate assistive devices are in place.</p> <p>The result of these rounds will be taken to the IDT through the monthly Performance Improvement meeting by the Executive Director for three months and quarterly thereafter.</p> <p>F371</p> <p>Fountain Circle Health and Rehabilitation Center will continue to store, prepare, distribute and serve food under sanitary conditions.</p> <p>1) Eggs found to be in pans in the bottom of the refrigerator</p>	11/13/10

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F 318	<p>Continued From page 23</p> <p>Review of Resident #8's medical record revealed the resident was readmitted to the facility on 02/25/10, with diagnoses which included Alzheimer's Disease, Dementia, Diabetes, Hypertension, Behavioral Disturbances, Heel Ulcer, Peg Placement and Acute Renal Failure. Continued review of the medical record revealed the resident was referred to OT for evaluation secondary to significant decline in functional abilities and was at high risk for contractures. Review of the OT evaluation dated 02/27/10, revealed Passive Range of Motion (PROM): resistance present, high risk for contractures, OT services five (5) times a week for four (4) weeks with short term goal to increase ROM with decreased tone and to implement restorative services. Further review revealed OT discontinued services to the resident on 03/18/10, because Resident #8 had met his/her goal, and was receiving restorative services.</p> <p>Review of the Physician's order dated 03/08/10, revealed the following orders 1) Decrease OT to three (3) times a week for two (2) weeks. 2) Restorative Services six (6) times a week for eight (8) weeks for upper extremity ROM.</p> <p>Review of the Restorative Plan of Care dated 03/08/10, revealed Resident #8 was to receive PROM to fingers, wrist, elbow, and shoulder. "Bend and straighten fingers, wrist and elbow. Raise/lower shoulder".</p> <p>Review of Resident #8's Minimum Data Set (MDS) assessment dated 03/09/10, revealed no limitations in ROM and severely impaired cognition. Continued review of the MDS dated 08/31/10, revealed no limitations in ROM and no</p>	F 318	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>that were not labeled and dated on the initial tour were subsequently labeled and dated by the cook. This was completed on 11/12/10.</p> <p>2) The blender that was stored wet was rewashed and air dried before being reassembled and stored. This will be completed on 11/12/10.</p> <p>3) The lunch items of cook #10 were removed from the refrigerator that is used for resident food items. Cook #10 has been inserviced regarding not keeping personal lunch items in refrigerators meant for resident food. This will be completed on 11/12/10.</p> <p>4) All pans that were found to be wet on the initial tour were rewashed and air dried before being stored. This</p>	11/13/10

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F 318	<p>Continued From page 24 restorative nursing.</p> <p>Review of Resident #8's Comprehensive Care Plan dated 08/31/10, revealed no documented evidence of risk for decreased ROM/contractures and no Interventions to prevent decline in ROM.</p> <p>During an interview with State Registered Nurse Aide (SRNA) #8, who was assigned to provide care for Resident #8 on 09/29/10 at 3:05 PM, she stated she didn't really do ROM on the resident's hands, because he/she holds the fingers down on the right hand and can't really move them except up or down.</p> <p>Interview with SRNA/Restorative Aide #9 on 09/29/10 at 3:00 PM, revealed she had provided PROM for Resident #8 until he/she was discontinued to the nursing floor staff. She further stated she didn't remember any problems with the resident's fingers. The SRNA stated if the fingers would not bend she would have asked therapy to evaluate the resident to see if it was something new. She continued, stating that she did check the resident's right hand and could not complete range of motion for the last two (2) fingers.</p> <p>Interview with the Director of Nursing (DON) on 09/27/10 at 4:30 PM, revealed he was not aware of any ROM changes in Resident #8's right hand. However, on 09/28/10 at 10:55 AM, the DON stated the SRNA caring for the resident should have notified any changes in the resident's ability to perform ROM to the nurse. The nurse should then assess the resident, and refer to therapy as indicated.</p> <p>Medical record review revealed OT evaluated the</p>	F 318	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>was completed on 11/12/10.</p> <p>5) The bottom of the refrigerator located in the kitchen used for resident tray line was thoroughly cleaned. This will be completed on 11/12/10.</p> <p>6) The Registered Dietitian has inserviced all dietary staff regarding procedures for checking food temperatures, particularly foods that have been reheated. This will be completed on 11/12/10.</p> <p>7) The Registered Dietitian has inserviced all dietary staff regarding infection control particularly when taking food temperatures and cleaning thermometers. This will be completed on 11/12/10.</p> <p>8) The physician order for a health shake for the unsampled resident was clarified to "Ensure Plus, 240 ml at breakfast and lunch"</p>	11/13/10
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NAME OF PROVIDER OR SUPPLIER FOUNTAIN CIRCLE HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 200 GLENWAY ROAD WINCHESTER, KY 40391	
(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 318	Continued From page 25 resident on 09/27/10, and placed the resident on the current caseload. Review of the OT Evaluation dated 09/27/10, revealed all joints on the right upper extremity were limited. The left upper extremity was resistant to PROM, but staff could complete the therapy. However, the resident would grimace and change facial expressions with (R) HUET ROM. Short term goals included increase (R) hand/finger extension to within functional limits (WF) in prep (preparation) for hand splint. Potential for achieving goals "Patient did exhibit ROM Awls this year". Review of the "OT Rehab Addendum Note" dated 09/27/10, revealed "evaluation did indicate increased muscle tone affecting PROM and developing (R) hand contracture compared to the OT evaluation in March 2010. Grimacing was present during ROM to (R) hand. OT will treat five (5) times a week to address ROM and contracture management". Interview with the treating OT on 09/29/10 at 3:25 PM, revealed, in her professional opinion, the residents (R) hand/fingers had increased tone and would result in contractures if not treated.	F 318	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i> This resident's tray card was updated to reflect this order change. This will be completed on 11/12/10. 9) Dietary staff has been inserviced regarding handwashing between tasks and infection control procedures in the kitchen. This will be completed on 11/12/10. 10) Dietary staff has been inserviced regarding the procedure for washing and drying dishes and the proper storage of dishes. This will be completed on 11/12/10.	11/13/10
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323	All residents with the exception of those who receive nutrition solely by alternative means have the potential to be affected by this deficiency. Sanitation rounds are conducted daily by the Registered Dietician Nutrition Services Manager or	

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F 323	Continued From page 26 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure the resident environment remained as free of accident hazards as possible. The findings include: Observation of the 100 Hall General Bathroom on initial tour on 09/26/10 at 9:30 AM revealed there was an unlocked cabinet which contained shave gel with a label which stated, keep out of the reach of children, perineal cleanser which stated, for external use only, and a bottle of roll on anti-persprant deodorant with a label which stated, keep out of the reach of children. Also noted was a 3.8 liter jug of Apticare Total Body Shampoo and Conditioner with a label which stated, for external use only. In addition, there was a spray bottle of Limate Mal-Odor Eliminator on the window sill. According to the Material Safety Data Sheet (MSDS), rubber gloves and safety glasses/goggles should be used for protection when using the product. Further review of the MSDS revealed the product was a health hazard and the primary routes of exposure were; eyes, skin, oral, or Inhalation. Observation of the 200 Hall Soiled Utility Room on 09/26/10 at 9:55 AM, revealed the room was unlocked and unattended. The housekeeping cart was in the room and contained a bottle of Germicidal Cleanser. According to the MSDS, a Physician should be called if ingested, and first aide would be needed if the product were to get in the eyes or on the skin.	F 323	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i> Education has been done with all dietary staff regarding the following issues: labeling and dating food items, procedures for washing and drying dishes and equipment, infection control procedures in the kitchen including handwashing between tasks and cleaning equipment such as thermometers before reusing them, and the procedure for taking food temperatures especially when food is reheated. Inservice was conducted by the Nutritional Service Manager on 10-28-10. The Nutritional Services Manager (NSM) has instructed the dietary staff to clean all spills immediately or as they are discovered and to not store personal food items in refrigerators meant to store resident food items. The NSM or designee will complete a Quick Round tool daily to observe for infection control issues.	11/13/10	

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F 323	<p>Continued From page 27</p> <p>Observation of the 200 Hall General Bathroom on initial tour on 09/26/10 at 10:00 AM revealed a cabinet which contained a bottle of Listerine. Review of the MSDS Sheet for Listerine Mouthwash revealed first aide measures were needed if the product were to get into the eyes, on the skin, was inhaled, or ingested. The cabinet also contained a bottle of roll on anti-perspirant deodorant with a label which stated, keep out of the reach of children, eight (8) disposable razors, and a bottle of nail polish remover. According to the MSDS for nail polish remover, inhalation of vapors could cause nasal and respiratory irritation, dizziness, weakness, fatigue, headache, unconsciousness, and coma. Ingestion could cause gastrointestinal irritation, nausea, vomiting, and diarrhea.</p> <p>Observation on 09/27/10 at 6:00 PM of the 100 Hall General Bathroom revealed the cabinet on the wall was unlocked and contained used toiletries including a bottle of roll on deodorant with a label which stated, keep out of reach of children, shave cream with a label which stated, keep out of reach of children and five (5) disposable razors. There was also a spray bottle of Germicidal Cleanser on top of the trash bin. According to the MSDS for the Germicidal Cleanser, a Physician should be called if ingested, and first aide would be needed if the product were to get in the eyes or on the skin.</p> <p>Interview on 09/27/10 at 6:15 PM and on 09/29/10 at 8:45 AM with the Nurse Manager on the 100 Hall, revealed there were no wandering residents at that time; however, due to the unit being a Rehabilitative unit, there were frequent admissions. She stated the cabinet containing the disposable razors was to be kept locked for</p>	F 323	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>cleanliness, proper storage of dishware and equipment, labeling and dating of food items and proper procedures for taking food temperatures. This tool will also be completed weekly by the Registered Dietitian and the Executive Director. (See Quick Round tool attached)</p> <p>Any problems identified will be corrected at that time.</p> <p>Results of these rounds will be reported to the IDT monthly Performance Improvement meeting by the Executive Director, monthly for three months and quarterly thereafter.</p> <p>F441</p> <p>Resident #7's foley catheter was assessed on 10-8-10 for the proper safety device, to ensure foley catheter tubing is kept off the floor at all times.</p>	11/13/10

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F 323	Continued From page 28 the safety of the residents. She also stated there should be no toiletries in the general bathroom. Continued interview revealed the Germicidal Cleanser was not to be left out in the bathroom. The Nurse Manager stated she did rounds three times a day which included looking at environmental concerns; however, she had not noted the items being left out in the bathroom. Interview on 09/29/10 at 9:30 PM with the Nurse Manager for the 200 Hall, revealed no toiletries or razors should be in the general bathroom due to resident safety. She stated there were tubs for the individual resident supplies, and the tubs were to be taken to the bathroom during the resident's bath and taken back to the resident's room to be stored after the bath. She stated she did rounds three (3) times a day and checked the bathrooms during rounds. She further stated the floor staff were also responsible for checking resident rooms and bathrooms and informing her if there was a problem. She stated she was aware there was a problem periodically with toiletries and items being left in the general bathroom. Continued interview revealed the soiled utility room should be closed and locked at all times due to the chemicals and products in the room.	F 323	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i> assessed on 10-8-10 for the proper safety device, to ensure foley catheter tubing is kept off the floor at all times. Resident #1's ankle wound healed on 10-27-10. The DNS assessed all residents with foley catheters to ensure all maintained the proper safety device to prevent tubing from touch the floor. The Unit Managers have assessed nurses' application of treatments to all residents that have wounds for proper handwashing and application of ointments.	11/13/10	
F 371 SS=E	483.35(j) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food	F 371	In addition, on 11/8/10, the DNS reviewed all current infections to validate that no other resident was affected by the deficient practice. No other residents were affected. All nursing staff has been educated by the DNS or SDC on 10/18-20/10 for foley catheter care/infection control, proper handwashing hygiene		

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F 371	<p>Continued From page 29 under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to store, prepare, distribute and serve food under sanitary conditions. This was evidenced by pans stored wet, blender stored wet, three (3) hotel pans containing eggs were stored in the refrigerator without being dated or labeled, multiple trays were observed stored wet and sent out to residents during meal service.</p> <p>The findings include:</p> <ol style="list-style-type: none"> During the initial tour on 09/26/10 at 8:58 AM three (3) hotel pans were observed to be stored in the bottom of a stand alone refrigerator which were not labeled or dated. <p>Interview with the Dietary Manager on 09/29/10 at 2:40 PM revealed the eggs should have been dated and labeled after being removed from their original containers.</p> <ol style="list-style-type: none"> During the initial tour on 09/26/10 at 9:02 AM the blender was observed to be stored wet. <p>Interview with Dietary Aide #9 on 09/26/10 at 9:02 AM revealed the blender should not have been put back together and stored wet secondary to bacteria growth.</p> <ol style="list-style-type: none"> During the initial tour on 09/26/10 at 9:10 AM a 	F 371	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>and applications of ointments to wounds. No licensed nursing staff will be allowed to work after 10/20/10 that have not been reeducated on proper foley catheter care/infection control, hand hygiene and proper application of ointments.</p> <p>Unit Managers will make rounds three times a day to ensure all foley catheter tubing is kept off the floor Monday through Friday. The DNS will designate a licensed nurse on 3-11 shift to make rounds 3 times per shift to ensure all foley catheter tubing is kept off the floor. The Weekend Supervisor will make rounds four times a day to ensure foley catheter tubing is kept off the floor every Saturday and Sunday. Unit managers monitor four dressing changes per day to ensure proper hand hygiene and proper application of ointments. The Weekend Supervisor will monitor three dressing changes per day to ensure proper hand hygiene and proper</p>	11/13/10	

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F 371	<p>Continued From page 30</p> <p>plastic bag containing a plastic container of lettuce and a plastic zipper bag containing chips was noted to be stored in a refrigerator along with gallons of milk and orange juice. An open half liter of bottled water, which was half full, was also noted to be stored in the refrigerator.</p> <p>Interview with Cook #10 on 09/26/10 at 9:10 AM revealed the lettuce and chips were her lunch which were stored in a refrigerator for resident food items. She further indicated the items should not have been stored in the refrigerator.</p> <p>Interview with Registered Dietitian (RD) #3 on 09/29/10 at 9:37 AM revealed staff food items should not be stored in the refrigerator for resident food preparation items.</p> <p>4. Observation during the initial tour on 09/26/10 at 9:20 AM revealed three (3) hotel pans, one (1) deep half-size hotel pan and one (1) quarter size hotel pan stored wet.</p> <p>Interview with Cook #10 on 09/26/10 at 9:22 AM revealed the pans should be air dried and not stored wet due to the growth of bacteria.</p> <p>5. Observation during the initial tour on 09/26/10 at 9:26 AM revealed a thick brown substance of sour cream texture spread across an area of about fifteen (15) inches in the bottom of the refrigerator located in the kitchen used for resident trayline containing cartons of chocolate and white milk.</p> <p>Interview with Registered Dietitian (RD) #3 on 09/29/10 at 9:37 AM revealed any milk which was spilled in the refrigerator should be cleaned up immediately.</p>	F 371	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>months.</p> <p>In addition, during daily rounds, the Unit Managers and Weekend Supervisor will monitor to ensure no deficient practice related to infection control in all areas.</p> <p>The DNS will review Unit Manager Audits, 3-11 shift designee and Weekend Supervisor audits, which consist of Foley catheter, hand hygiene, application of ointments and routine infection control practice.</p> <p>The DNS will present the information to the Performance Improvement Committee (PIC) every month for three months. The PIC includes the Executive Director, the Assistant Executive Director, the Director of Nursing Service, Assistant Director of Nursing Services, Registered Dietician, Activity Director, Social Service Director, Case Manager, Maintenance Director, Medical Director, MDS Nurses and the Dietary Manager. The PIC will</p>	11/13/10

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F 371	<p>Continued From page 31</p> <p>6. Observation during evening meal service on 09/27/10 at 4:35 PM revealed the temperature of the squash was one-hundred (100) degrees Fahrenheit. It was removed and taken back to the steamer to be reheated. When the squash was returned to the trayline at 5:05 PM it was noted the temperature was not retaken to ensure food safety before residents were served.</p> <p>Interview with RD #4 on 09/27/10 at 6:30 PM revealed the temperature should have been retaken before the trayline began to ensure the appropriate temperature had been reached.</p> <p>7. Observation during evening meal service on 09/27/10 at 4:35 PM revealed Cook #7 taking temperatures of foods on resident trayline. It was noted she used a paper towel to wipe the thermometer between food items because she was out of alcohol swabs.</p> <p>Interview with Cook #7 on 09/26/10 at 4:45 PM revealed she believed the paper towel was sufficient to clean the thermometer between foods. She further indicated the point of using the alcohol swabs was to prevent cross contamination.</p> <p>8. Observation during the evening meal service on 09/27/10 at 5:10 PM revealed an unsampled resident's tray card which stated Health Shakes were to be provided with meals. It was noted the Health Shake was not placed on the resident's tray.</p> <p>Interview with Dietary Aide #5 on 09/27/10 at 5:10 PM revealed she was unable to locate the Health Shakes in the trayline refrigerator.</p>	F 371	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law</i></p> <p>F 465</p> <p>Fountain Circle Health and Rehabilitation Center will continue to provide a safe, functional, sanitary and comfortable environment.</p> <p>5) The cabinet in 100 Hall Dining Room with the trash can built in was cleaned during the survey. The cleaning of this cabinet has been added to the daily assignment for cleaning of the dining room on 100 Hall. This will be completed on 11/12/10.</p> <p>6) The cabinet in 100 Hall General Bathroom was locked and keys made available to staff. Personal toiletries were labeled with resident names and put in tubs in resident dresser drawers. This will be</p>	11/13/10
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F 371	<p>Continued From page 32</p> <p>Interview with Cook #7 on 09/27/10 at 5:10 PM revealed the Health Shakes were in containers like the milk cartons only smaller and were to be sent out if they were listed on the tray card.</p> <p>Interview with RD #3 on 09/29/10 at 9:37 AM revealed if the tray card lists Health Shakes they should be sent out with the meal.</p> <p>9. Observation during the evening meal service on 09/27/10 at 5:15 PM revealed Dietary Aide #8 entered from the dining area into the kitchen and proceeded to put lids on resident trays without having washed her hands.</p> <p>Observation on 09/27/10 at 5:30 PM revealed Dietary Aide #8 exited the kitchen and brought two (2) carts back into the kitchen for the resident trays. She was noted to begin putting lids on plates and handled the edges on the food contact surface of the plates without having washed her hands.</p> <p>Interview with RD #4 on 09/27/10 at 6:30 PM revealed the Dietary Aides should wash hands between tasks when working on resident trayline.</p> <p>10. Observation during the evening meal service on 09/27/10 from 5:20 PM through 6:22 PM revealed twenty-two (22) trays were stored wet, eight (8) of which were wiped off, all with the same towel.</p> <p>Interview with Dietary Aide #5 on 09/27/10 at 5:20 PM revealed the trays should not have been stored wet due to bacteria.</p> <p>Interview with RD #4 on 09/27/10 at 6:30 PM</p>	F 371	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>7) The cabinet in 200 Hall General Bathroom was removed and has been replaced. Personal toiletry items have been labeled and store in tubs in resident dresser drawers. This bathroom has been thoroughly cleaned and odors eliminated. This will be completed on 11/12/10.</p> <p>8) The 200 Hall Soiled Utility room has been thoroughly cleaned, including the hopper and the floor. The mops have been properly stored. This will be completed on 11/12/10.</p> <p>9) The 300 Hall General Bathroom has been thoroughly cleaned and odors eliminated. This will be completed on 11/12/10.</p>	11/13/10
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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 _____		(X6) DATE SURVEY COMPLETED C 09/29/2010
NAME OF PROVIDER OR SUPPLIER FOUNTAIN CIRCLE HEALTH AND REHABILITATION			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)	(X6) COMPLETION DATE	
F 371	Continued From page 33 revealed trays should have been allowed to air dry secondary to the possible transfer of bacteria from being stored wet.	F 371	<i>This Plan of Correction is the center's credible allegation of compliance.</i>		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of	F 441	<i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i> rounds/observations were conducted, by the DNS and/or ED of all resident rooms, bathrooms, shower rooms, soiled utility rooms, dining rooms and all resident environments to identify any safety hazards or sanitation concerns. Rounds were completed on 11/12/10. No other safety hazards or sanitation concerns were identified. The Housekeeping Supervisor conducted inservice on 11-8, 9, 10, 11, 12 2010, with the Housekeeping staff regarding the cleaning of the facility, including built in cabinets that contain trash, daily cleaning of the general bathroom areas including tile and grout, the elimination of odors in general bath areas, and the regular cleaning of soiled utility areas. They were also inserviced regarding locking all chemicals in their carts and not leaving them within resident access.	11/13/10	

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F 441	<p>Continued From page 34 infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to ensure the Infection Control Program and Practices were followed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>The findings include:</p> <ol style="list-style-type: none"> Record review revealed Resident #7 was admitted to the facility on 12/30/07 with diagnoses which included Renal Insufficiency and Neurogenic Bladder. Observation of Resident #7 on 09/26/10 at 12:05 PM revealed a "Foley" indwelling catheter to bedside drain. <p>Observation on 09/27/10 at 9:00 AM revealed Resident #7 was sitting in front of the shower room in a wheelchair. Observation revealed the indwelling catheter tubing was in direct contact with the floor.</p> <p>Observation on 09/27/10 at 10:10 AM revealed Resident #7 was being wheeled down the hall by State Registered Nurse Aide (SRNA) #7. Observation revealed the indwelling catheter tubing was dragging on the floor.</p> <p>Observation on 09/29/10 at 12:45 PM revealed Resident #7 was in a wheelchair in the dining room. Observation revealed the "Foley" catheter tubing was in direct contact with the floor.</p>	F 441	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>regarding keeping soiled utility areas locked when unattended. Inservice was conducted by SDC on 11-8, 9, 10, 11, 12 2010.</p> <p>Nursing staff have been inserviced by the DNS or his designee regarding the proper labeling and storage of resident toiletries and keeping chemicals locked and out of resident access. Inservice was conducted on 10-18, 19, 20 2010.</p> <p>Daily rounds by the Housekeeping Supervisor will be made to ensure bathrooms and dining rooms, as well as other areas of the facility are cleaned daily and soiled utility areas are locked and secure. A round sheet will be completed and turned in to the Executive Director. Any concerns identified will be addressed at that time.</p> <p>The Executive Director or his designee will make a weekly environmental round. Any concerns identified will be addressed at that</p>	11/13/10	

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NAME OF PROVIDER OR SUPPLIER FOUNTAIN CIRCLE HEALTH AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 200 GLENWAY ROAD WINCHESTER, KY 40391
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F 441	<p>Continued From page 35</p> <p>Interview with SRNA #7 on 09/27/10 at 11:00 AM revealed the "Foley" catheter tubing was not supposed to be on the floor for sanitary reasons.</p> <p>Interview with the Assistant Director of Nursing (ADON) on 09/29/10 at 10:00 AM revealed the catheter tubing being in direct contact with the floor was a problem due to the increased risk of infection.</p> <p>Interview with Registered Nurse (RN) #2, the Infection Control Nurse, on 09/29/10 at 4:00 PM revealed the facility had provided no recent training on catheter care.</p> <p>Review of the facility's policy Urinary Incontinence/Indwelling Catheters revealed infection control practices should be followed in the care of indwelling catheters.</p> <p>2. Review of Resident #18's medical record revealed the resident had diagnoses which included Dementia, Renal Insufficiency, Urinary Retention, Psychosis and Diabetes Mellitus.</p> <p>Observation on 09/26/10 at 1:00 PM revealed Resident #18 sitting up in a wheel chair transporting self down a hallway with catheter tubing in contact with the floor.</p> <p>Observation on 09/26/10 at 2:50 PM revealed Resident #18 sitting up in a wheel chair in the dining area with catheter tubing in direct contact with the floor.</p> <p>Observation on 09/27/10 at 8:48 AM revealed Resident #18 sitting up in a wheel chair in the dining area putting a puzzle together, catheter</p>	F 441	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>time.</p> <p>The Executive Director will take the result of these rounds to the IDT through the monthly Performance Improvement meeting for three months and quarterly thereafter.</p> <p>F514</p> <p>Medical records for resident #28 and #32 have been reviewed to ensure only their medical records are in the record. Also the medical records have proper identification on each and every page. This was done by the Medical Record clerk on 11-8-10.</p> <p>Every entire active medical record has been reviewed by the Medical Record clerk, Staff Development clerk, Admission Coordinator Assistant, and the Social Service Assistant to ensure only the correct medical record is in that record and that each and every page of the medical record has proper</p>	<p>11/13/10</p> <p>Enter Date Here.</p>
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F 441	<p>Continued From page 36</p> <p>tubing was noted to be in direct contact with the floor.</p> <p>Observation on 09/27/10 at 6:45 PM revealed Resident #18 sitting up in a wheel chair in front of the nurse's station, catheter tubing was noted to be in contact with the floor.</p> <p>Interview with Licensed Practical Nurse (LPN) #6 on 09/27/10 at 6:45 PM revealed Resident #18's catheter tubing should not be in contact with the floor due to bacteria being able to transfer to the tubing.</p> <p>3. Observation of a dressing change, on 09/27/10 at 8:40 AM, revealed LPN #4 performed a dressing change on Resident #1's ankle. The LPN gathered the needed supplies with ungloved hands and entered the room. After opening the needed supplies the LPN washed her hands and proceeded to clean the site of the resident's wound. Once the wound site was cleaned the LPN applied the prescribed ointment to the wound using her gloved finger and dressed the wound as ordered. The LPN did not wash her hands and change her gloves after cleansing the wound.</p> <p>Interview, on 09/27/10 at 8:40 AM, with LPN #1 revealed she should have washed her hands and changed her gloves after cleaning the wound. The LPN stated she always used her gloved finger to apply the ointment to the wound. LPN #1 stated she had contaminated the glove by touching everything she had opened prior to putting the gloves on her hands.</p> <p>Review of the facility's policy "Clean Dressing Change PRO 66103" revealed after cleaning the</p>	F 441	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>validation that the medical record was complete, accurately documented, readily accessible and organized. Review will be completed on 11/12/10.</p> <p>The facility has posted a second full time Medical Record clerk position in house. All medical records will be reviewed by the Medical Record Department after admission, on day 14, day 30 and after discharge for correct medical records and proper identification. The review will validate that all records are specific to the resident and validate that the medical record is complete, accurately documented, readily accessible and organized.</p> <p>The Medical record clerk and all licensed nurses have been educated by the DNS and/or SDC on 10-18, 19, and 20th on proper identification of each piece of the medical record and to ensure the correct medical record goes into the correct medical</p>	11/13/10

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NAME OF PROVIDER OR SUPPLIER FOUNTAIN CIRCLE HEALTH AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 200 GLENWAY ROAD WINCHESTER, KY 40391
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F 441	<p>Continued From page 37</p> <p>wound the gloves were to be removed, hand hygiene performed and open dressing packages. Then put on gloves, apply the medication and dressing as ordered. Remove gloves and discard with all soiled supplies in plastic bag.</p> <p>4. Observation on initial tour on 09/26/10 at 9:30 AM revealed the bathroom in Room 201 contained one unbagged bed pan on top of the toilet and another unbagged bed pan which was not labeled with a resident's name positioned between the hand rail and the wall. There was also a soiled pull up which was in an unlined trash can.</p> <p>Room 208-bathroom contained an unbagged bed pan which was not labeled with a resident's name on top of the toilet. There was also a soiled adult brief in an unlined trash can.</p> <p>Room 204-bathroom contained an unbagged bed pan on top of the toilet and an unbagged bed pan positioned between the hand rail and the wall.</p> <p>Room 212-bathroom contained an unbagged bed pan positioned between the hand rail and the wall.</p> <p>Interview on 09/29/10 at 9:30 AM with the Nurse Manager on the 200 Hall revealed bed pans were to be labeled with the resident's name, bagged, and stored in the resident's room in a drawer. She further stated, staff were to replace trash can liners, and were not to leave soiled pull ups and adult briefs in the bathroom trash cans.</p> <p>Interview with the Director of Nursing (DON) on 09/29/10 at 10:15 AM, revealed the Certified Nursing Assistants (CNAs) were to clean the bed</p>	F 441	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law</i></p> <p>records are to be specific to the resident, complete, accurately documented, readily accessible and organized. No licensed nurses will be allowed to work until they have received this education.</p> <p>The medical record clerks will bring copies of their audits, which include that all records are specific to the resident and that the medical record is complete, accurately documented, readily accessible and organized, from admission, 14 day, 30 day, and discharge to the Performance Improvement Committee (PIC) which includes the Executive Director (ED), Executive Director Assistant (EDA), Director of Nursing Services (DNS), Assistant Director of Nursing (ADNS), Registered Dietician (RD), Activities Director (AD), Social Service Director (SS), Case Manager (CM), Maintenance Director, Medical Director (MD), MDS Nurses, and the Dietary Manager every month for the next three months. These audits will</p>	11/13/10

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F 441 F 465 SS=E	<p>Continued From page 38</p> <p>pans after use, place them in a trash bag, and store them in the bottom drawer of the bedside table. Further interview revealed the CNAs were not to leave soiled adult briefs in the bathroom trash cans.</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRONMENT</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents and staff.</p> <p>The findings include:</p> <p>Observation on initial tour on 09/26/10 at 9:45 AM, revealed the dining room on the 100 hall had a cabinet with the trash can built in, which was soiled with dirt, with loose trash inside the cabinet and around the trash can. The other side of the cabinet had a brown dried spill inside the cabinet. Interview at that time with Housekeeper #1, revealed he cleaned the cabinet one (1) or two (2) times a week and it needed cleaning at that time.</p> <p>Observation of the 100 Hall General Bathroom on initial tour on 09/26/10 at 9:30 AM, revealed there was an unlocked cabinet which contained used toiletries including shave gel, perineal cleanser, a bottle of roll on anti-perspirant deodorant and used combs and brushes. In addition, there was a</p>	F 441 F 465	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>Include whether the correct medical records information is in the correct medical record and if all pieces of the medical record have correct resident identification. The PIC will review the findings of the audits and will determine if further action is needed.</p>	11/13/10

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F 465	<p>Continued From page 39</p> <p>spray bottle of Limate Mal-Odor Eliminator on the window sill. There was a foul odor in the bathroom as well as dirty black grout along the floor next to the wall.</p> <p>Observation of the 200 Hall General Bathroom on initial tour 09/28/10 at 10:00 AM, revealed a cabinet with one door missing. The door was noted to be on top of the cabinet. The cabinet contained a bottle of open Listerine Mouthwash, a bottle of used roll on anti-perspirant deodorant, eight (8) disposable razors, a bottle of nail polish remover, and used brushes and combs. Also, a foul odor was noted in the bathroom.</p> <p>Observation of the 200 Hall Soiled Utility Room on 09/28/10 at 9:55 AM, revealed the room was unlocked and unattended. There was a wet mop head which had been placed on top of a cabinet, and the mop sink and hopper were soiled with a build up of black dirt. The floor was also soiled with dried dirt.</p> <p>Observation of the 300 Hall General Bathroom on 09/26/10 at 10:10 AM, revealed a foul odor was noted.</p> <p>Interview on 09/27/10 at 6:15 PM and on 09/29/10 at 6:45 AM with the Nurse Manager on the 100 Hall, revealed there should be no toiletries in the general bathroom, and the toiletries, brushes, and combs were not to be shared between residents. Continued interview revealed the Germicidal Cleanser was not to be left out in the bathroom. The Nurse Manager stated she did rounds three times a day which included looking at environmental concerns; however, she had not noted the items being left out in the bathroom. She further stated she had not noticed the</p>	F 465			

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F 465	Continued From page 40 general bathroom having a foul smell or dirty black grout on the tile floor. Interview on 09/29/10 at 9:30 PM with the Nurse Manager for the 200 Hall, revealed the toiletries or razors should not be kept in the general bathroom due to resident safety. Continued interview, revealed there were tubs for the individual resident supplies, and the tubs were to be taken to the bathroom during the resident's bath and taken back to the resident's room to be stored after the bath. She stated she was aware there was a problem periodically with toiletries and items being left in the general bathroom; however she was unaware of a foul smell in the bathroom. Interview with the Director of Nursing on 09/29/10 at 10:15 AM, revealed it was an ongoing issue to ensure staff labeled and stored toiletries. He stated the tubs of toiletries were to be stored in the resident's dresser drawer. Interview on 09/29/10 at 10:30 AM with the Housekeeping/Laundry Supervisor, revealed he did rounds every morning and tried to check the shower rooms. He further stated the shower rooms were cleaned daily from 12:00 PM until 12:30 PM. Further interview, revealed he knew it was an issue with the foul smells in the shower rooms and the dirty grout on the tile floors. He further stated the Soiled Utility Rooms should be locked at all times and he had identified a problem with the soiled utility rooms having dirty hoppers and mop sinks. Continued interview revealed he was new to the facility and had only been there a month. He stated he had not had time to re-educate and in-service the staff.	F 485			
F 514	483.75(l)(1) RES	F 514			

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F 514 SS=D	<p>Continued From page 41</p> <p>RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to maintain accurate and complete clinical records for two (2) of thirty-two (32) sampled residents (Resident #28 and #32).</p> <p>The finding include:</p> <p>1. Review of the clinical record for Resident #28 revealed an "Individual Resident Meal Intake Record" which belonged to another resident. Both residents had the same first name. The facility was unable to find Resident Assessment Protocols for Resident #28.</p> <p>Interview, on 09/29/10 at 2:07 PM, with the Medical Records Clerk revealed she was unable to locate the RAPS for Resident #28 which had been requested by the surveyor.</p>	F 514		
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NAME OF PROVIDER OR SUPPLIER FOUNTAIN CIRCLE HEALTH AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 200 GLENWAY ROAD WINCHESTER, KY 40391
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F 514	<p>Continued From page 42</p> <p>2. Review of the clinical record for Resident #32 revealed the record contained the dividers for the Medication Administration Record and Treatment Administration Record for an unsampled Resident. These dividers displayed personal information and pictures of the unsampled resident. Additionally, the record contained a "Nurse's Note" detailing the death of a resident other than Resident #32. The "Nurse's Note" had no resident identifying information.</p> <p>Interview, on 09/29/10 at 1:25 PM, with the Medical Records Clerk revealed she was responsible for the residents' records. The clerk explained her assistant had been on medical leave since January 2010 and other staff had been assisting in maintaining the records. She stated some of the staff who assisted her were not as attentive as they should be. The clerk explained there would have been one additional review of the clinical record before it was shipped to the facility's long term storage area. The Clerk stated, she would have found the misfiled documentation at that time. In additional interview, on 09/29/10 at 2:07 PM, the Records Clerk stated the facility had policies and procedures to conduct routine audits of the clinical record to ensure completeness.</p> <p>Review of the facility's policies revealed they had policies to address audits of the medical record on admission, quarterly, at discharge, and at 14 and 30 days after admission. Per the policies the facility conducted audits to identify trends and problem area to be addressed by the quality assurance committee in order to develop and implement plans of correction to address identified problems.</p>	F 514		
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K 000	INITIAL COMMENTS A Life Safety Code survey was initiated and concluded on 09/28/2010. The facility was found to not meet the minimal requirements with 400 Code of the Federal Regulations, Part 483.70. The highest scope and severity deficiency identified was an "F".	K 000	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>	
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1 1/2 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. RECEIVED 10/1/2010 This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure there were no impediments to the closing of resident room doors or cross corridor smoke doors, according to NFPA standards.	K 018	K 018 NFPA 101 LIFE SAFETY CODE STANDARD Fountain Circle Health and Rehabilitation will continue to ensure that no impediments to the closing of resident room doors or cross corridor smoke doors. 1) The bed in room 202 was moved during the center tour and the Med Cart was also moved away from the cross corridor smoke doors 2) All residents had potential to be affected by this deficiency. 3) All staff will be inserviced on the importance of proper bed placement and a letter will be sent to all families telling them of the importance of not moving beds that could block the door from closing properly. Signs will be placed behind all smoke doors to direct staff not to block these door.	11/12/2010

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dennis [Signature] TITLE: Executive Director 11/1/10

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

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K 018	Continued From page 1 The findings include: Observation on 09/28/10 at 9:18 AM, revealed that a bed in resident room #202 was positioned so that it prevented the closing of the door. Further observation revealed that on the 400 Short Hall there was a medicine cart blocking the cross corridor smoke doors. The observations were confirmed with the Maintenance Director. Interview on 09/28/10 at 9:18 AM, with the maintenance Director revealed that he was unaware of the bed preventing the resident room door from shutting or that the medicine cart was placed in front of the cross corridor smoke doors.	K 018	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>	11/12/2010
K 052 SS=D	NFFA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFFA 70 National Electrical Code and NFFA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFFA 70 and 72. 9.8.1.4 This STANDARD is not met as evidenced by: Based on Interview and record review it was determined the facility failed to ensure smoke	K 052	4) The Maintenance Director during daily rounds will ensure that the tape is present and that the signs are keeping items back from the smoke doors. This will be reported to Executive Director on a rounds sheet. The Executive Director will do weekly rounds to validate the daily rounds. The Executive Director will present the rounds to the IDT at Performance Improvement for three months. K 052 NFFA 101 LIFE SAFETY CODE STANDARD Fountain Circle Health and Rehabilitation will continue to ensure smoke detectors were maintained according to NFFA Standards.	11/12/2010

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K 052	<p>Continued From page 2</p> <p>detectors were maintained according to NFPA standards.</p> <p>The findings include:</p> <p>Record review on 09/28/10 at 11:18 AM, revealed the facility could only produce a partial list of smoke detectors that had sensitivity testing.</p> <p>Interview on 09/28/10 at 11:18 AM, with the Maintenance Director, revealed that the company that provided the testing of the smoke detectors had only completed half of the sensitivity testing for the smoke detectors. Further interview revealed the facility had failed to follow up with the company to have sensitivity testing performed on the other half of the smoke detectors.</p> <p>Reference: NFPA 25 (1999 edition) 7-3.2.1* Detector sensitivity shall be checked within 1 year after installation and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate that the detector has remained within its listed and marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked), the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector-caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or in areas where nuisance alarms show</p>	K 052	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <ol style="list-style-type: none"> 1) The facility had only had a partial list smoke detectors that had sensitivity testing. The vendor was contacted to complete a complete sensitivity test. 2) All residents had potential to be affected by this deficiency. 3) The vendor will complete the test on November 1st. 4) The Maintenance Director will place a copy of the test in the center Preventive Maintenance binder. The Executive Director will present a copy of the completed test to the IDT Performance Improvement committee in November. 	11/12/2010	

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K 052	<p>Continued From page 3</p> <p>any increase over the previous year, calibration tests shall be performed.</p> <p>To ensure that each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the following methods:</p> <ol style="list-style-type: none"> (1) Calibrated test method (2) Manufacturer's calibrated sensitivity test instrument (3) Listed control equipment arranged for the purpose (4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range (5) Other calibrated sensitivity test methods approved by the authority having jurisdiction <p>Detectors found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced.</p> <p>Exception No. 1: Detectors listed as field adjustable shall be permitted to be either adjusted within the listed and marked sensitivity range and cleaned and recalibrated, or they shall be replaced.</p> <p>Exception No. 2: This requirement shall not apply to single station detectors referenced in 7-3.3 and Table 7-2.2.</p> <p>The detector sensitivity shall not be tested or measured using any device that administers an unmeasured concentration</p>	K 052		

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K 052 K 062 SS=E	Continued From page 4 of smoke or other aerosol into the detector. NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure sprinkler heads were maintained, according to NFPA standards. The findings include: Observation on 09/28/10 at 8:15 AM, revealed in the Therapy Department there were (2) sprinkler heads dirty with a buildup of lint, and (1) sprinkler head had paint and drywall mud on it. Further observation revealed (4) sprinkler heads in the Laundry Room were dirty with a buildup of lint. The observation was confirmed with the Maintenance Director. Interview on 09/28/10 at 8:15 AM, with the Maintenance Director revealed that the sprinkler heads are cleaned once a week using a can of compressed air. Reference: NFPA 25 (1998 edition) 2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed	K 052 K 062	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i> K 062 NFPA 101 LIFE SAFETY CODE STANDARD Fountain Circle Health and Rehabilitation will continue ensure that sprinkler heads are free of paint or lint build up. 1) The (2) sprinkler heads in the thrapy department with lint buildup and (4) sprinkler heads with lint build up in the laundry were cleaned during the center tour. (1) sprinkler head with paint was replaced. 2) All residents had potential to be affected by this deficiency. 3) The Maintenance Director will inspect sprinklers from floor level weekly and will record on rounds form. The Executive	11/12/2010

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K 062	Continued From page 5 in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation. Exception No. 1:* Sprinklers installed in concealed spaces such as above suspended ceilings shall not require inspection. Exception No. 2: Sprinklers installed in areas that are inaccessible for safety considerations due to process operations shall be inspected during each scheduled shutdown.	K 062	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>	11/12/2010	
K 072 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure that corridors were maintained free from obstructions to full instant use in the case of fire or other emergency, according to NFPA standards. The findings include:	K 072	4) The rounds will be recorded and the Executive Director will present to the IDT Performance Improvement committee monthly for three months.		

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K 072	Continued From page 6 Observation on 09/28/10 at 1:30 PM, revealed that in the South 100 Hall there were two (2) medication carts and (1) patient lift unattended and not in use. Further observation revealed other medication carts and patient lifts found not in use and unattended in all hallways of the facility. The medication carts and lifts were also found to be blocking the handrails, causing them to be not be accessible for resident use. The observation was confirmed with the Maintenance Director and the Administrator. Interview on 09/28/10 at 1:30 PM, with the Administrator, revealed the medication carts and patient lifts were routinely stored in the hallways due to lack of storage space.	K 072	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i> K 072 NFPA 101 LIFE SAFETY CODE STANDARD Fountain Circle Health and Rehabilitation will continue ensure that means of egress are maintained free of all obstruction or impediments to full instant use in the case of fire or other emergency. 1) The center has been in serviced staff about the need to keep equipment, linen carts, etc. off the halls when not in use. Areas have been designated for storage. 2) All residents had the potential to be affected by this deficiency 3) The Maintenance Director and the Executive Director will do daily rounds to ensure items are removed after use. These rounds will be recorded and reviewed weekly to ensure compliance. 4) The Executive Director will report the findings to the IDT Performance Committee monthly for three months.	11/12/2010	