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

PRINTED: 01/05/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	185146		R-C 12/31/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUNTAIN CIRCLE CARE & REHABILITATION CENTER	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 000}	INITIAL COMMENTS	{F 000}		
	An On-Site Revisit was initiated on 12/23/14 and concluded on 12/31/14. Based on the facility's acceptable Plan of Correction it was determined the facility had corrected the deficient practice as alleged on 11/19/14.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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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PRINTED: 11/04/2014
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	185146		C 10/21/2014

NAME OF PROVIDER OR SUPPLIER: FOUNTAIN CIRCLE CARE & REHABILITATION CENTER

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

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F 000	INITIAL COMMENTS An Abbreviated Survey, investigating KY00022304, was initiated on 10/07/14 and concluded on 10/09/14 with no deficiencies cited. However, after Supervisory review KY00022304 was reopened on 10/21/14 and concluded on 10/21/14. KY00022304 was unsubstantiated with an unrelated deficiency cited at a highest Scope and Severity of "D".	F 000		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy and Final Investigation Report, it was determined the facility failed to maintain complete and accurately documented medical records for one (1) of four (4) sampled residents (Resident #1).	F 514	F514 1. On 10/22/2014, Resident #1 was assessed by DON and assessment was documented in Resident #1's medical record. No issues were identified during the assessment that was completed on Resident #1. 2. A 100% review of each resident's medical record was completed on 10/22/2014 to ensure that the medical record was complete and accurate by reviewing all physician orders and comparing the orders to	11/19/14

NOV - 6 2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Silena M. Hudson
TITLE: Administrator
(X6) DATE: 11/6/14

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F 514	Continued From page 1 The findings include: Review of the facility's policy titled, "Charting and Documentation", revised April 2008, revealed all assessments were to be documented in the residents' medical record by licensed staff. The Policy revealed the documentation was to include: the date and time of any procedures or treatments; the name of the staff member performing the care; the assessment data; notification of the Physician, family or other staff if indicated; and the signature and title of the staff member who performed the documentation. Review of the facility's Final Investigation Report dated 09/26/14, revealed Resident #1's sister had reported to the Social Worker (SW) on 09/23/14, the resident had a bruise on his/her cheek and a "knot" on his/her forehead on 08/19/14 which she had told a nurse about. Per the Final Investigation Report, Licensed Practical Nurse (LPN) #1 had assessed Resident #1 and had not observed any bruising or a knot on the resident's face. Observation on 10/21/14 at 2:07 PM, of Resident #1's skin assessment performed by the Assistant Director of Nursing, (ADON) revealed no bruising or knots present on the resident's face or forehead. Review of Resident #1's medical record revealed the facility admitted him/her on 07/26/12, with diagnoses which included Hemorrhagic Stroke, Persistent Vegetative State, Chronic Respiratory Failure, Tracheostomy and Muscle Spasms. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 07/31/14, revealed the facility assessed Resident #1 as being severely	F 514	each care plan and the care that is being provided. 3. DON, ADON, SDC, Unit Manager, and other Nursing Supervisors will initiate an in service on 11/12/14 to be complete by 11/18/14 related to complete and accurate medical records to include any assessment completed requires documentation in the medical record. 4. The DON, ADON, Unit Managers, and RN Supervisors will audit all admissions and readmissions for the next 90 days to ensure the medical record is complete and accurate with all assessments completed and documented in the medical record. The ongoing process will be discussed in the Quality Assurance committee meeting monthly for three months, for recommendations and for further follow up as indicated. The members of the Quality Assurance committee include, but not limited to the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, SDC,	

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F 514	Continued From page 2 cognitively impaired. However, further record review revealed no documented evidence of LPN #1's assessment of Resident #1 performed performed on 08/19/14 as per the Final Investigation Report, and no documented evidence of the resident's sister's report of bruising and knot on his/her face. Interview, on 10/09/14 at 9:50 AM, with LPN #1 per telephone, revealed Resident #1's sister had expressed concern on 08/19/14, of a "knot" and "bruise" on his/her face and forehead. She stated she immediately went and did a skin assessment of Resident #1, with the family present in his/her room. Per interview, the skin assessment was negative for any abnormalities so she did not document the assessment in Resident #1's medical record as per facility policy. LPN #1 revealed if there had been abnormalities observed or the family had expressed concerns of possible abuse, she would have reported the concern as per facility policy. LPN #1 stated in hindsight, she should have documented the skin assessment in the medical record as per facility policy, regardless of what the findings were. Interview with State Registered Nursing Assistant (SRNA) #1 on 10/21/14 at 2:00 PM, revealed she was assigned to Resident #1 on 08/19/14, when his/her sister reported the knot and bruising to the resident's face. Continued interview revealed Resident #1 did not have any bumps, bruising or skin tears when she performed walking rounds with the previous shift that morning. She stated if anything abnormal was found on the walking rounds, the SRNAs were to notify the nurse immediately. SRNA #1 revealed she was doing rounds around lunch time and Resident #1's family who were visiting the resident, did not	F 514	Social Services Director, Dietician, Quality of Life Director, and Unit Managers.	

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F 514	Continued From page 3	F 514		

voice concerns when she provided care of him/her at that time. She stated a short time later, Resident #1's call light was on and she went to answer it and the resident's family told her they had already talked to LPN #1 about the "knot" on Resident #1's forehead. SRNA #1 reported the family did not mention a bruise at that time.

Interview with the Certified Respiratory Therapist (CRT) on 10/21/14 at 1:35 PM, revealed he was in Resident #1's room at least six (6) to eight (8) times a day in order to assess the tracheostomy (trach) settings and provide the ordered breathing treatments. He stated he had never observed any bruising or knots on Resident #1's face or forehead.

Interview on 10/21/14 with the ADON at 5:59 PM, and the Director of Nursing (DON) at 6:02 PM, revealed it was their expectation for staff to follow the facility's policy for documentation. They stated LPN #1 should have documented the results of Resident #1's skin assessment and his/her family's concerns in the medical record as per the facility policy.