STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185146	A. BUILDING _____ B. WING _____	R 09/24/2013

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 An on-site revisit was initiated on 09/23/13 and concluded on 09/24/13. The facility was found to be in compliance as alleged on 09/13/13.	{F 000}		

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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	185146	A. BUILDING _____ B. WING _____	08/08/2013

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F 000	INITIAL COMMENTS A Recertification Survey was initiated on 08/06/13 and concluded on 08/08/13. Deficiencies were cited with the highest Scope and Severity of a "D".	F 000	RECEIVED SEP - 9 2013 BY:	
F 160 SS=D	483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy, it was determined the facility failed to convey the deceased resident's (Unsampled Resident E) personal funds and a final accounting to the individual or probate jurisdiction administering the individual's estate within 30 (thirty) days. The findings include: Review of the facility's policy, "Conveyance of Funds upon a Resident's Death", dated June 2007, revealed within thirty (30) days of the death of a resident, the facility would convey the deceased resident's personal funds and final accounting of those funds to the individual or probate jurisdiction administering the resident's estate. Review of Unsampled Resident E's medical	F 160	**F 160** **Fountain Circle is committed to ensure that upon the discharge of a resident with a personal fund deposited with the facility, the facility will convey within thirty (30) days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate.** **Immediate Corrective Action For Residents Found To Be Affected** ♦ Resident #E was refunded on 06/12/13 as indicated by surveyor. This was a direct result of transfer of funds from previous owner. **Identification of Other Residents With The Potential to be Affected** ♦ All discharged residents since inception of facility on 04/01/13 were reviewed with no other residents identified. **Measures Taken To Assure There Will Not Be a Recurrence** ♦ Business Office Manager (BOM) will report to Administrator monthly all	

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

Jeffrey R Sill | ADMINISTRATOR | AMENDED 09/06/2013

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F 160	Continued From page 1 record, on 08/08/13, revealed the facility admitted the resident on 12/26/12 and the resident expired on 04/02/13. Review of Unsampled Resident E's financial record, on 08/08/13, revealed the facility recorded the death of the resident on 04/02/13 and the final accounting of the account was on 06/12/13. Interview with the Business Office Manager, on 08/08/13 at 5:10 PM, revealed current ownership of the facility was initiated on 04/01/13. The Business Office Manager stated the current owner did not receive residents' account and funds from the prior owner until June 2013. The Business Office Manager further stated the current owner was able to provide current residents residing in the facility access to their personal accounts and were able to provide funds to these residents starting on 04/01/13. Interview with the Administrator, on 08/08/13 at 6:35 PM, revealed his expectation was to have a decreased resident's final accounting of the account to be completed within the timeframe according to regulations, which was 30 (thirty) days.	F 160	discharged residents along with a record of return of funds for same. **Monitoring Changes To Assure Continuing Compliance** ♦ BOM shall report to the QA committee at least quarterly of all discharged residents along with a record of return of funds for same if applicable. The QA Committee shall determine continuance or cessation relative to substantial compliance. **Date of Completion:** **09-13-13**	
F 252 SS=D	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced	F 252	**F 252** **Fountain Circle is committed to providing a safe, clean, comfortable and homelike environment, allowing residents to use his or her personal belongings to the extent possible.** **Immediate Corrective Action For Residents Found To Be Affected** ♦ Resident #19, and Unsampled Residents B, C and D, experienced no negative outcomes due to the alleged deficient practice of foul odors in Room 409 and in the bathroom for room 409. ♦ Rooms #409, and the bathroom, including the floors, were deep cleaned with a cleanser, on 08/09/13 by the	

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F 252	Continued From page 2 by: Based on observation, interview, and review of facility's policy, it was determined the facility failed to ensure a safe, clean, comfortable and homelike environment for one (1) of twenty-two (22) sampled residents (Resident #19) and three (3) Unsampled Residents (Unsampled Residents B, C, and D). Observation during survey revealed there was a foul odor of urine on the Reflections Unit in Room 409 and in the bathroom which was shared by residents in Room 409 and 410. The findings include: Review of the facility's "Five Step Daily Resident Room Cleaning" Policy, revised 07/08, revealed resident rooms were to have the following completed daily; empty trash, disinfect horizontal surfaces using a germicide, spot clean the walls, dust mop, and damp mop to disinfect. Review of the "Seven Step Daily Washroom Cleaning" Policy, dated 01/05, revealed the bathrooms were to have the following completed; check supplies for toilet paper, paper towels, soap dispensers, empty trash, dust mop the floor, clean and sanitize the sink, tub and commode using a germicide, spot clean the walls, and damp mop the floor using a germicide solution. Review of Resident #19's medical record revealed diagnoses which included Non-Alzheimer's Dementia and Anxiety. Review of the Significant Change Minimum Data Set (MDS) Assessment, dated 06/19/13, revealed the facility assessed the resident as having a Brief Interview of Mental Status (BIMS) of eight (8)	F 252	housekeeping staff. The commode in the bathroom of Room 409 had a cracked flange and was replaced on 08/08/13. **Identification of Other Residents With The Potential to be Affected** ♦ The Director of Plant Operations (DPO) completed walking rounds of all units and residents rooms on 08/09/13, to ensure rooms and bathrooms were clean and free from odors. In addition, all areas utilized by residents, including activity area, lobby, therapy rooms, dining areas, and outdoor areas were included in the rounds by the DPO. No other areas were identified as being affected. None-the-less, all residents' rooms, bathrooms and floors on the Reflections Community (where Room 409 is located) were deep cleaned on 8/9/13 by the housekeeping staff, with focus being on Room #409 and the bathroom therein. ♦ On admission and quarterly, resident interviews are completed and residents are encouraged to use their personal belongings to emphasize a homelike environment within the facility. No resident negative outcomes were identified via review of these interviews by the Administrator. In fact, residents and families have complimented the cleanliness and homelike environment since Signature HealthCARE arrived	

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F 252	Continued From page 3 indicating cognitive impairment. Observation of the Reflections Unit, on 08/06/13 at 1:00 PM, revealed a strong odor of urine in Room 409, in the bathroom shared by Room 409 and Room 410, and in the hallway by Room 409. Further observation revealed Room 409 was shared by Resident #19 and Unsampled Resident C. An adjoining bathroom connected Room 409 to Room 410 and Unsampled Residents B and D resided in Room 410. Observation, on 08/08/13 at 10:20 AM, revealed Resident #19 ambulated from the dining room to Room 409 with a rolling walker. Strong urine odors were noted in Room 409 as well as in the bathroom which adjoined Room 409 and Room 410. Interview with Resident #19 at the time of the observation revealed she/he did not smell any odors. Interview, on 08/08/13 at 10:30 AM, with Certified Nursing Assistant (CNA) #2 revealed she had become desensitized to the odors on the unit; however, could smell a mixture of urine and disinfectant in Room 409 as well as the bathroom. Interview, on 08/08/13 at 10:40 AM, with Housekeeper #1 revealed she always worked the Reflections Unit. She stated she smelled odors on the unit in the mornings and did not smell the odors after cleansing rooms and bathrooms with disinfectants and using air freshener. She further stated her daily routine consisted of cleaning the resident bathrooms with disinfectant including the sinks, toilet, and dusting the rooms as well as mopping residents rooms and bathrooms everyday. Housekeeper #1 revealed she cleaned	F 252	**Measures Taken To Assure There Will Not Be a Recurrence** ♦ The DPO completed re-education of the housekeeping staff on 08/09/13, to ensure residents rooms, bathrooms, and all areas frequently used by residents are clean, homelike and free from odors. ♦ The Staff Development Coordinator (SDC) initiated in-services for all staff on 08/09/13 regarding a clean and odor free environment. The in-service is on-going and all new hires will be provided education during orientation. ♦ An "Environmental Audit Tool" will be completed three (3) times per week for one (1) month, then one (1) time per week on the Reflections Community by the Reflections Program Director or by the facilities department heads, consisting of Director of Nursing (DON), Social Service Director (SSD), MDS Nurse (MDSN), Quality of Life Director (QoLD), Assistant Director of Nursing (ADON), Unit Manager (UM), Medical Records Managers (MRM), SDC, the Restorative Nursing Supervisor (RNS), Dietary Manger (DM) and Registered Dietitian (RD). All remaining residents' rooms will be completed one (1) time per week for one (1) month then at 10% per week thereafter by one of the above named	

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F 252	Continued From page 4 the bathrooms again after lunch, and cleansed the walls two (2) to three (3) times a week. She stated she had cleaned Room 409 and the adjoining bathroom three (3) times so far that day and had to clean that room and bathroom more frequently due to odors. Continued interview revealed she checked the bathrooms again after lunch and sometimes the residents missed the toilet. She stated she occasionally had complaints about odors from staff. The Housekeeper stated she could smell urine odors in Room 409 and in the bathroom adjoining the room at the time of interview. Interview, on 08/08/13 at 2:20 PM, with Licensed Practical Nurse (LPN) #3/Unit Manager during an observation of Room 409, revealed she did smell odors in Room 409 and in the adjoining bathroom; however, did not remember any complaints from staff, residents or families. Intervtew, on 08/08/13 at 3:31 PM, with the Environmental Service Director (ESD), revealed he stated, "yes, I smell it", as he entered Room 409 from the main hallway. He stated, "it is a bad odor and it doesn't smell right". The ESD stated he was unaware of any issues with odor in this room until the survey. Continued interview revealed the process used for odor elimination was to rule out the source of the odor. He stated his plans for Room 409 bathroom would be to pull out the toilet and examine and replace the wax ring and examine the flooring under the toilet. He further stated he audited two (2) rooms each unit per week. Review of the Audit Tool for Environmental Services revealed Room 409 had last been audited on 05/17/13 by the Housekeeping	F 252	positions. The results of the tool will be addressed in the morning meetings (M-F) and discussed with the DPO. The "Environmental Audit Tool" will be given to the facility Administrator in the morning meeting (M-F) for review. **Monitoring Changes To Assure Continuing Compliance** ♦ The Administrator will present the findings of the "Environmental Audit Tool" to the QA Committee at least quarterly for review. ♦ The Director of Nursing will complete a monthly audit of the "Environmental Audit Tool" to ensure compliance. ♦ Results of the DON audits will be submitted to the QA Committee at least quarterly. The QA Committee shall determine continuance or cessation relative to substantial compliance. ♦ Any non-compliance will be addressed by the Administrator. **Date of Completion:** 09-13-13	

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F 252	Continued From page 5 Supervisor and no odors were present at that time. Interview on 08/08/13 at 4:00 PM with the Interim Director of Nursing (DON), revealed she was aware there were ongoing audits for odors and did not realize the odors were a continued problem.	F 252	**F 282 (*Note: There was no negative outcome to resident per surveyor's note. Furthermore as indicated by surveyor heels were floated on pillow while protectors were being laundered.) Fountain Circle Care & Rehabilitation Center is committed to ensure services are provided by the facility that meets professional standards of care.**	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure services provided or arranged by the facility met professional standards of care for one (1) of twenty-two (22) sampled residents (Resident #2). Resident #2 had a Physician's Order for heel protectors to bilateral feet while in bed for prevention. However, observation on 08/07/13 revealed the heel protectors were not applied while Resident #2 was in bed. The findings include: Review of Resident #2's medical record revealed diagnoses which included Dementia, Chronic Renal Insufficiency, and End Stage Cancer of the Colon. Review of the Quarterly Minimum Data	F 282	**Immediate Corrective Action For Residents Found To Be Affected** ♦ Resident # 2 experienced no negative outcomes. ♦ Due to no pressure sores being present for Resident #2, heel protectors were discontinued by the Physician. **Identification of Other Residents With The Potential to be Affected** ♦ *A 100% chart audit of all residents care plans, with focus on all assistive and preventative devices, was completed on 09/06/13, by ADON, UM, and the RNS. Walking rounds were also performed on 09/06/13 by the ADON, UM and RNS, to include visual observations of all residents, to ensure residents care plans were being followed. No other residents were identified as being affected by the alleged deficient practice.* ♦ A 100% chart audit of all residents Physician's orders to include all devices was completed on 8/14/13 by the UM,	

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F 282	Continued From page 6 Set (MDS) dated 07/22/13, revealed the facility assessed the resident as having a Brief Interview of Mental Status (BIMS) of a three (3) indicating cognitive impairment. Further review revealed the facility assessed the resident as requiring total assistance with transfers and bathing, as ambulation not occurring, and as always incontinent of bowel and bladder. The facility also assessed the resident as being at risk of developing pressure ulcers. Review of the Comprehensive Plan of Care, dated 07/30/13, revealed the resident had a blood blister on the left great toe, recurrent excoriation of the buttocks and groin as well as an increased potential for altered skin integrity related to Dermatitis, age, recurrent diarrhea, and a history of skin breakdown. The interventions included heel protectors bilaterally while in the bed. Review of the Physician's Orders dated 08/2013 revealed orders for heel protectors to bilateral feet while in bed for prevention. Observation, on 08/07/13 at 11:00 AM, revealed Resident #2 was in the bed and the resident's heels were on a pillow and the heels were not touching the mattress; however, there were no heel protectors noted. Interview with Certified Nursing Assistant (CNA) #3, who was assigned to the resident at the time of the observation, revealed the resident had no heel protectors ordered but she would check the Assignment Sheet which she carried in her pocket for a reference to be sure. After checking the CNA Assignment Sheet, she stated the resident was to have heel protectors; however, she could not find any in the resident's room.	F 282	ADON, Quality Assurance Nurse (QAN), DON and the RNS. ♦ Walking rounds, which included a visual observation of all residents, was completed on 8/14/13 to ensure all residents Physicians' orders for all devices were in place. The walking rounds were completed by UM, ADON, RNS and the DON. ♦ No residents were identified to be affected by this alleged deficient practice. **Measures Taken To Assure There Will Not Be a Recurrence** ♦ An In-service for all nursing staff *(which included all direct care staff)* was initiated on 8/9/13 and concluded on 8/14/13, by the SDC and the QAN related to following Physicians' orders *and implementing residents care plans.* All new hires *nursing staff, which includes all direct care staff,* will be in-serviced during orientation on following Physicians orders *care plans.* ♦ The UM/ADON will complete audits by doing walking rounds, twice daily for one month, then weekly thereafter, checking each resident's devices, and ensuring that all Physician orders *and care plans* are implemented *and*	

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F 282	Continued From page 7 Interview, on 08/07/13 at 11:05 AM and 2:10 PM with LPN #5, revealed she was assigned to Resident #2 and the heel protectors must have been in the laundry. She stated the heel protectors were listed on the Treatment Administration Record (TAR) as a "For Your Information" (FYI) for the nurses to check to ensure they were in place. However, she had not yet checked for heelboots at 11:00 AM when the resident was observed in bed without the heel boots. Interview, on 08/08/13 at 2:20 PM with LPN #4/Unit Manager (UM) where Resident #2 resided, revealed the heel protectors were important to prevent skin breakdown and the nurses on the floor were to check to ensure they were in place. Further interview revealed as Unit Manager she used the CNA Assignment Sheet and checked to ensure care was being provided and devices were in place every two (2) weeks. LPN #4/UM stated she also ensured the CNA Assignment Sheet was updated daily. Continued interview revealed she did rounds on the unit three (3) times a day to check the residents and ensure devices such as heel boots were in place. Interview, on 08/08/13 at 4:00 PM, with the Interim Director of Nursing (DON), revealed although the staff had talked about possibly discontinuing the heel protectors and just floating the heels for this resident, the heel protectors should have been in place as per the resident's plan of care.	F 282	*followed.* This practice will be on-going. ♦ The weekend Supervisor will complete audits by doing walking rounds twice daily for one month, then weekly thereafter to ensure each resident Physicians orders *and care plans* are ~~in place~~ *implemented and followed.* ♦ All *new* Physicians' orders and *any resident care plans requiring changes in the previous 24 hours* will be reviewed daily in the morning clinical meetings with the UM, ADON, QAN, SDC and DON to ensure all Physicians orders *and care plans* are implemented. ♦ The Weekend Supervisor will review the weekend orders to ensure *Physician* orders *and subsequent care plans* are implemented *and followed* on weekends. **Monitoring Changes To Assure Continuing Compliance** ♦ The DON will review the audits daily for one month, then weekly thereafter, to ensure compliance of all Physicians' orders. ♦ *The Director of Nursing will do weekly walking rounds for one month, then weekly for two weeks, to observe that all residents care plans are implemented and followed.*	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a	F 314		

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F 314	Continued From page 8 resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility's Pressure Ulcer Guideline, it was determined the facility failed to ensure a resident does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable and a resident receives necessary treatment and services to promote healing, prevent infection and prevent new pressure sores from developing for one (1) of twenty-two (22) sampled residents (Resident #2). Resident #2 had a Physician's Order for heel protectors to bilateral feet while in bed for prevention and this was an intervention on the resident's plan of care. However, observation on 08/07/13 revealed the heel protectors were not applied while Resident #2 was in bed. The findings include: Review of the facility's Pressure Ulcers Guideline, effective 12/10, revealed it was the policy of the facility that nursing personnel would identify residents at risk for development of pressure ulcers and implement interventions for prevention of pressure ulcers.	F 314	♦ The Weekend Supervisor will review the audits on Saturday and Sunday to ensure compliance of all Physician orders. ♦ *The weekend Supervisor will complete walking rounds on Saturday and Sunday to ensure care plans are implemented and followed. This practice will be on-going* ♦ The DON/QA Nurse will report audit findings to the QA Committee at least quarterly. The QA Committee shall determine continuance or cessation relative to substantial compliance. **Date of Completion:** **09-13-13** **F 314 (*Note: There was no negative outcome to resident per surveyor's note. Furthermore as indicated by surveyor heels were floated on pillow while protectors were being laundered.)** **Fountain Circle Care & Rehabilitation is committed to ensure that any resident who enters the facility without pressure sores does not develop a pressure sore, and that a resident having a pressure sore receives the necessary treatment and services to promote healing, prevent infection and the prevention of new pressure sores.**	

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F 314	Continued From page 9	F 314	**Immediate Corrective Action For Residents Found To Be Affected** ♦ Resident # 2 was not affected by the alleged deficient practice. In addition, Resident #2 was not found to have pressure sores, as observed and stated by the surveyor. Thus no immediate corrective action was required. **Identification of Other Residents With The Potential to be Affected** ♦ A 100% head to toe, skin assessment of all residents was completed on 8/14/13, by the UM, ADON, RNS and the DON. A 100% audit of all preventative devices ordered by the Physician was audited on 8/14/13 by the same individuals above to ensure all residents were provided devices as ordered. ~~All residents were assessed for the potential for pressure sores and the need of preventative devices.~~ ♦ *All residents were assessed on 8/14/13 by the UM, ADON, RNS and the DON, for the potential for pressure sores and to ensure pressure sore prevention measure were in place.* ♦ No residents were found to be affected by the alleged deficient practice. **Measures Taken To Assure There Will Not Be a Recurrence**	

Review of Resident #2's medical record revealed diagnoses which included Dementia, Chronic Renal Insufficiency, and End Stage Cancer of the Colon. Review of the Quarterly Minimum Data Set (MDS) dated 07/22/13, revealed the facility assessed the resident as having a Brief Interview of Mental Status (BIMS) of a three (3) indicating cognitive impairment. Further review revealed the facility assessed the resident as requiring total assistance with transfers and bathing, as ambulation not occurring, and as always incontinent of bowel and bladder. The facility also assessed the resident as being at risk of developing pressure ulcers.

Review of the Braden Scale for Predicting Pressure Sore Risk dated 07/22/13 revealed the resident was constantly moist, was chairfast, had slightly limited mobility, had adequate nutrition, and had the potential problem of friction and shear. The score indicated a fifteen (15) which was low risk for pressure sores.

Review of the Comprehensive Plan of Care, dated 07/30/13, revealed the resident had a blood blister on the left great toe, recurrent excoriation of the buttocks and groin as well as an increased potential for altered skin integrity related to Dermatitis, age, recurrent diarrhea, and a history of skin breakdown. The interventions included heel protectors bilaterally while in the bed.

Review of the Non-Pressure Skin Condition Record, dated 07/31/13, revealed the resident had a dried blood blister to the bottom of the left great toe measuring one (1) centimeter (cm) x one half (0.5) centimeters.

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	185146	A. BUILDING _____ B. WING _____	08/08/2013

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F 314	Continued From page 10 Review of the Physician's Orders, dated August 2013, revealed orders to ensure the bilateral heels were elevated off the mattress and heel protectors to bilateral feet while in bed for prevention. Observation, on 08/07/13 at 11:00 AM, revealed Resident #2 was in the bed and the resident's heels were off loaded with a pillow; however, there was no heel protectors noted. Interview with Certified Nursing Assistant (CNA) #3 at the time of the observation, revealed she was assigned to the resident and was fairly familiar with the resident as she was assigned to her/him occasionally. The CNA stated the resident had no heel protectors ordered but after checking the Assignment Sheet, she stated the resident was to have heel protectors; however, there was none in the resident's room. Observation of a skin assessment for Resident #2, on 08/07/13 at 11:10 AM, revealed the resident's left ankle had a scab measuring 0.3 x 0.3 cm's and the bottom of the left great toe had an area which LPN #4/Unit Manager described as a healing blood blister which was reddish/black. Interview, on 08/07/13 at 11:05 AM and 2:10 PM, with Licensed Practical Nurse (LPN) #5, revealed she was assigned to Resident #2 today and the heel protectors must be in the laundry. She stated the heel protectors were listed on the Treatment Administration Record (TAR) as a "For Your Information" (FYI) for the nurses to check to ensure they were in place. LPN #5 explained she had not yet checked for heelboots at 11:00 AM when the resident was observed in bed without the heel boots. Continued interview revealed she checked for alarms, heelboots and other devices	F 314	♦ In-services that included, pressure sore prevention, for all nursing staff, *which included direct care staff*, was initiated on 8/9/13 and concluded on 8/14/13, by SDC and the QAN. All new hires, *nurses and direct care staff*, will be in-serviced during orientation. ♦ The UM/ADON will do walking rounds twice daily for all residents to observe each resident has preventative devices in place, *as ordered*, and that residents are repositioned while in bed/chair. ♦ The UM, ADON, 3-11p Supervisor or Weekend Supervisor will assist and observe the weekly skin assessments completed by the Charge Nurse. Any skin concerns will be addressed by the Physician and placed on the Treatment Record. This practice will be ongoing. ♦ The Weekly Skin Assessments completed on all residents, will be reviewed daily in the clinical meetings by the DON/ADON/UM. This practice will be ongoing Monday through Friday. The skin assessments scheduled on weekends, will be reviewed on Monday in the clinical meeting by the DON/ADON/UM. ♦ Any resident with a pressure sore will be assessed and referred to the RD to	

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F 314	Continued From page 11 during the shift and while doing treatments. Interview, on 08/08/13 at 2:20 PM, with LPN #4/Unit Manager where Resident #2 resided, revealed the resident was at nutritional risk as well as at risk for skin breakdown due to End Stage Colon Cancer. She stated the heel protectors were important to prevent skin breakdown and the nurses on the floor were to check to ensure they were in place. Continued interview revealed as Unit Manager she used the CNA Assignment Sheet and checked to ensure care was being provided and devices were in place every two (2) weeks; however, she did not document any specific audit. She stated she also ensured the CNA Assignment Sheet was updated daily. Further interview revealed she did rounds on the unit three (3) times a day to check the residents and ensure cleanliness of residents and of resident's room, devices such as heel boots were in place, alarms were in place, and water was available. She stated staff must have sent the heel protectors to the laundry, and they should have obtained new ones from the laundry or from the central supply immediately. Interview, on 08/08/13 at 4:00 PM, with the Interim Director of Nursing (DON), revealed although the staff had talked about possibly discontinuing the heel protectors and just floating the heels for this resident, the heel protectors should have been in place as per the order for pressure ulcer prevention.	F 314	ensure adequate nutrition and hydration is addressed to enhance wound healing. **Monitoring Changes To Assure Continuing Compliance** ♦ The UM/ADON/DON will complete (3) three random skin assessments daily for two weeks, then (1) one skin assessment daily for 2 weeks to ensure residents have preventative devices in place and that residents are receiving the services and treatment to prevent pressure sores from developing. ♦ The DON will complete wound rounds one (1) time per week to ensure treatment and services are provided to the residents. ♦ The DON will report finding of skin assessments to the QA Committee at least quarterly. The QA Committee shall determine continuance or cessation relative to substantial compliance. **Date of Completion:** **09-13-13**	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a	F 441	**F 441** **Fountain Circle Care & Rehabilitation Center is committed to establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help**	

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F 441	Continued From page 12 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 infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility's policy, it was determined	F 441	**prevent the development and transmission of disease and infection.** **Immediate Corrective Action For Residents Found To Be Affected** ♦ Resident #13 was not found to be affected by the alleged deficient practice. The SRNA that failed to wash her hands when exiting resident #13's room, and re-entered another residents room, without washing her hands, was re-educated by the SDC on 8/9/13. **Identification of Other Residents With The Potential to be Affected** ♦ A review of the facilities Infection Control Program's tracking and trending reports was completed by the DON/SDC on 08/09/13, to identify any break of standard infection control practice. No residents were identified from this review. ♦ A skin audit of all residents was completed on 08/13/13 and 8/14/13, by the UM/ADON, to ensure there were no signs and symptoms of skin infections. No residents were identified from this audit. ♦ A review of the incident reports related to infections for the past 30 days was reviewed on 8/15/13 by the DON to ensure corrective action was implemented for all residents with	

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F 441	Continued From page 13 the facility failed to 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 for one (1) of twenty-two (22) sampled residents (Resident #13). Observation revealed a staff member performed perineal care/incontinence care for Resident #13 and proceeded to bag the soiled wipes and brief, remove her gloves and exit the room without washing her hands. The findings include: Review of the Infection Control and Prevention Policy, revised 10/31/09, revealed an Infection Control and Prevention Program was designed to identify and reduce the risk of acquiring and transmitting infections among residents, staff, volunteers, students and visitors. The Center's Infection Control Program includes but was not limited to proper hand hygiene. Review of Resident #13's medical record revealed diagnoses which included Dementia and Anxiety. Review of the Minimum Data Set (MDS) Assessment dated 07/09/13 revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) of a three (3) indicating cognitive impairment. Observation of perineal care/incontinence care, on 08/07/13 at 3:50 PM, revealed Certified Nursing Assistant (CNA) #1 performed the care and proceeded to bag the soiled wipes and brief, remove her gloves, and exit the room carrying the bag without washing her hands. She opened the	F 441	infections. No residents were identified in the review. ♦ A hand-washing and tray-line audit was completed by the DM on 08/15/13. There were no cross contamination issues identified. ♦ The DPO completed an audit of laundry and housekeeping services on 08/19/13, to review Infection Control Practices in housekeeping and laundry. No issues were identified. ♦ Any resident(s) identified with an infection requiring isolation, will be provided isolation to prevent the spread of infection. ♦ An audit of resident's immunization program was completed on 08/22/13 by the MRM. The audit was reviewed by the Infection Control Nurse on 8/23/13 to determine that all resident(s) immunization was completed timely. **Measures Taken To Assure There Will Not Be a Recurrence** ♦ An In-service for all staff, *including direct care staff*, was initiated on 08/10/13, *and concluded on 8/12/13*, on hand-washing and infection control practices by the SDC, UM and ADON. All new hires, *including direct care staff*, will be in-serviced during orientation on	

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F 441	Continued From page 14 door of the Soiled Utility Room to discard the bag, then exited the Soiled Utility Room and went into another resident's room in which the door was open and washed her hands at the sink. Interview, on 08/07/13 at 3:50 PM, with CNA #1 revealed she should have washed her hands before exiting Resident #13's room after she had performed pericare/incontinence care. Interview, on 08/08/13 at 11:00 AM, with Licensed Practical Nurse (LPN) #3/Unit Manager on the unit where Resident #13 resided, revealed staff should wash their hands after performing resident care and prior to exiting the room.	F 441	infection control practices and hand-washing. Continuing education on the facilities Infection Control Policy will be scheduled monthly for two (2) months by the SDC. Any resident(s) identified with an infection requiring isolation, will be provided isolation to prevent the spread of infection. ♦ Infection Control Rounds will be completed on 10% of the Stakeholder and resident population by the UM/ADON weekly for four (4) weeks, then monthly for two (2) months. Each UM/ADON will observe hand-washing and infection control practices of nursing staff, until all nursing staff, *including direct care staff*, has been observed **Monitoring Changes To Assure Continuing Compliance** ♦ The DON/SDC will complete monthly audits of the Infection Control Rounds to ensure timely compliance of the audits and performance concerns are addressed. ♦ The UM/ADON /SDC will complete daily audits for two (2) weeks, then weekly for four(4) weeks to ensure the Facility's Infection Control Program is followed.	
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 interview, record review and review of the facility's policy, it was determined the facility failed to maintain clinical records on each	F 514		

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F 514	Continued From page 15 resident in accordance with accepted professional standards and practices that are complete, accurately documented and systematically organized for two (2) of twenty-two (22) sampled residents (Residents #4 and #19) and one (1) unsampled resident (Unsampled Resident A). Unsampled A's Consultation Report was inaccurately filed in Resident #4's medical record. In addition, the facility failed to have results of Resident #19's Pneumococcal Vaccine Immunization documented on the "Immunization Record", and failed to have the results documented in the current medical record. Also, the Influenza Immunization was documented in the Pneumococcal Vaccine Section of the "Immunization Record". The findings include: Review of the facility's policy titled, "Patient Medical Records", effective 08/31/11, revealed medical records were maintained on each patient in accordance with accepted professional standards and practice. Medical records provide a basis for determining and managing the patient's progress including response to treatment, change in condition, and changes in treatment, and were complete, accurately documented, clear, concise, and complete, reflecting patient responses and outcomes related to care received. Further review revealed medical records were readily accessible and systematically organized, and confidentiality of the medical record was maintained in accordance with the policy on use and disclosure of protected health information (PHI).	F 514	**(F441 Cont)** ♦ Results of the audits will be submitted to the QA Committee at least quarterly for review. The QA Committee shall determine continuance or cessation relative to substantial compliance. ♦ Any non-compliance will require re-education by the DON/ADON/SDC/UM. **Date of Completion:** **09-13-13** **F 514** **Fountain Circle is committed to maintaining clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.** **Immediate Corrective Action For Residents Found To Be Affected** ♦ No negative outcome was caused for any of the sampled Residents #4, #19 and Unsampled Resident A. Resident #4s chart was audited for further discrepancies with none noted. Unsampled Resident A's consultation report was returned to that respective medical record. Further audit of this	

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1. Review of Resident #4's medical chart on 07/06/13, at 4:45 PM, revealed a Report of Consultation related to Unsampled Resident A was filed in Resident #4's chart under Section entitled "Consultations".

Interview with Licensed Practical Nurse (LPN) #2, on 08/06/13, at 5:22 PM, and again on 08/08/13 at 2:50 PM, revealed usually the nurse on the 11:00 PM to 7:00 AM shift filed any pertinent paperwork left from the day shift or the nurse assigned to the resident filed the correspondence during their shift. LPN #2 stated Medical Records completed chart checks but she was not sure how often this was done. Continued Interview revealed she was assigned to provide care for both residents the evening the Report of Consultation was filled for Unsampled Resident A; however, she was not aware that she had misfiled the information.

Interview with Unit Manager (UM) of the B Unit, on 08/06/13 at 5:30 PM, and on 08/08/13 at 2:20 PM, revealed it was expected the nurse assigned to the resident was to file any correspondence related to the resident in the correct chart. She explained when a resident leaves the facility to go to an appointment outside of the facility, the resident was given the Report of Consultation sheet to give to the doctor, who filled out the information requested and returned it with the resident. She further explained, when a resident returns to the facility, the Consultation Sheet was given to the nurse caring for the resident, who then noted any new orders, appointments or treatments needing to be taken care of. The nurse was then responsible to file the Consultation Sheet in the appropriate area of the record revealed no further discrepancies. Resident #19's medical record review revealed the resident received the pneumococcal vaccine in 2011.

Identification of Other Residents With The Potential to be Affected

- A 100% audit of resident's medical records including the immunization records for all residents was completed on 8/22/13, by the MRM. Any discrepancies were immediately corrected by the MRM/UM/ADON/DON. No other residents were identified.

Measures Taken To Assure There Will Not Be a Recurrence

- All new orders, consultation reports, lab reports, 24 hour report documentation, changes in condition and incident reports are reviewed in morning clinical meeting Monday-Friday to assure timely clinical interventions as well as continuity of individual resident care is achieved.

- A 10% chart audit will be completed monthly for three (3) months by the MRM to ensure accuracy of resident medical records.

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F 514	Continued From page 17 resident's chart. Interview with LPN #3, on 08/08/13, at 2:35 PM, revealed she was assigned to both patients on the dayshift when Unsampled A returned from the appointment of the Consultation. She stated, she had misfiled the information in Resident #4's chart. Further interview revealed Resident #4 and Unsampled Resident A's charts were next to each other in the chart rack in the nurses station and this was the possible reason for the misfiling. She stated, the expectation of the facility was the correct information should be filed in the correct chart. Interview with the Interim Director of Nursing (DON), on 08/08/13 at 4:00 PM, revealed it was the expectation of the staff to be more mindful and more observant as to what was filed into the residents' charts. 2. Review of Resident #19's medical record revealed the resident was admitted to the facility on 12/21/11 with diagnoses which included Non-Alzheimer's Dementia, Anxiety, and Depression. Review of the Significant Change Minimum Data Set (MDS) Assessment dated 06/19/13, revealed the facility had assessed the resident as having a Brief Interview for Mental Status (BIMS) of eight (8) indicating cognitive impairment. Further review revealed the facility assessed the resident as the Pneumococcal Vaccine being up to date. Review of the "Immunization Record" revealed no documentation in the section stating "name of Influenza Vaccine". The section stating "name of Pneumococcal Vaccine" was documented as the manufacturer-fluvirin, expiration date 06/13, dated	F 514	♦ Additionally, 5% of all medical records will be audited for accuracy monthly thereafter by the MRM. ♦ Nursing staff were re-educated by the SDC on 08/09/13 relative to the need for accuracy of resident medical records and the resident immunization record. All new licensed nurses will be educated on the accuracy of the medical record and the immunization record during orientation. **Monitoring Changes To Assure Continuing Compliance** ♦ The ADON/UM will audit five (5) residents' medical records weekly for four (4) weeks, then monthly for two (2) months to ensure ongoing compliance. ♦ The MRM and UM/ADON medical records audits will be reviewed by the QA Committee at least quarterly. The QA Committee shall determine continuance or cessation relative to substantial compliance. **Date of Completion:** **09-13-13**	

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F 514	Continued From page 18 given 10/19/12, and site-left deltoid. Continued review of the medical record revealed there was no documented evidence of the Pneumococcal Vaccine being administered and no documented evidence the Vaccine was not to be administered. Interview, on 08/06/13 at 11:15 AM and 2:15 PM, with Licensed Practical Nurse (LPN) #4/Unit Manager where Resident #19 resided, revealed the Influenza Vaccine was inadvertently documented on the Pneumococcal Vaccine Section of the Immunization Record. She stated she could find no evidence the Pneumococcal Vaccine had been documented on the Immunization Record. After reviewing the clinical record she stated she could find no evidence of the date the Pneumococcal Vaccine had been administered or if the Vaccine had been declined. Continued interview revealed the admitting nurse was to check to see if the Influenza, Pneumococcal Vaccines and the Tuberculin Skin Testing was to be administered and notify the Physician for orders and the nurse who administered the Vaccines was to completed the Immunization Record. Continued interview revealed she did not do tracking and trending of Pneumococcal Vaccines and Resident #4's overflow clinical record was on file in another building. Interview, on 08/08/13 at 1:20 PM, with Medical Records revealed the facility only had the current active medical records in the building. She stated she audited the medical records on admission and quarterly to ensure Physician's Orders and Nursing Notes were filed, Care Plans were timely, the MDS was current, the monthly weight was	F 514		

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F 514	Continued From page 19 documented, and the the allergies, PASRR, and Code Status were on the chart. She stated she had done the last audit in 06/13; however, she stated she did not check for Immunizations other than Tuberculin Testing. Interview, on 08/08/13 at 2:30 PM, with The MDS Coordinator revealed she had reviewed information in Resident #19's medical record in the past which indicated the resident had the Pneumococcal Vaccine. She stated, since the resident was a certain age, the resident would not need another vaccine so she just looked at the past MDS's for information related to the Pneumococcal Vaccines when completing a new MDS. Interview, on 08/08/13 at 5:00 PM, with the Infection Control Nurse, revealed the vaccine information was provided to residents and families on admission by the admitting nurse. She stated on admission, the risks versus benefits and education was done with the residents and families regarding the vaccines. She further stated the Unit Managers were to track the vaccines. Interview, on 08/08/13 at 4:00 PM, with the Interim Director of Nursing (DON) revealed she had been at the facility for two (2) weeks and was also new to the corporation. She stated the results of the Pneumococcal Vaccine should have been documented on the Immunization Record and during the survey, staff had clarified with Resident #19's daughter that the Pneumococcal Vaccine had been received. Continued interview revealed she thought Medical Records had an ongoing audit for all Vaccines.	F 514		

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	185146	A. BUILDING _____ B. WING _____	08/08/2013

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F 514	Continued From page 20 After survey, a Fax was received from the facility of a Patient Transfer Form dated 12/21/11 which stated the resident had received the Pneumococcal Vaccine in 2011.	F 514	**F 520** **(*Note: Fountain Circle Care & Rehabilitation Center contends that its Quality Assurance Program was and is functional given that only one (1) bathroom, 20 square feet, within the facilities 47,883 square feet (equivalent of .04% or 4/100's of 1%) was identified to include resident rooms, bathrooms, shower rooms, soiled utility rooms, storage rooms, etc.)** **Fountain Circle is committed to maintaining a quality assessment assurance committee consisting of the Director of Nursing, Medical Director, and at least three (3) other members of the facility's staff. This committee will meet at least quarterly to identify issues with respect to which quality assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.** **Immediate Corrective Action For Residents Found To Be Affected** ♦ Resident #19, and Unsampled Residents B, C and D, experienced no negative outcomes due to the alleged deficient practice of foul odors in Room 409 and in the bathroom for room 409. ♦ Rooms #409, and the bathroom, including the floors, were deep cleaned with a cleanser, on 08/09/13 by the	
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility's policies and audits, it was determined the facility failed to maintain a Quality Assessment	F 520		

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F 520	Continued From page 21	F 520		

and Assurance (QA) program that developed and imptemented plans of aclion to correcl quallty deficiencies. This was evidenced by repeated deficiencies related to the facility's failure to ensure a safe, clean, comfortable and homelike environment.

The findings include:

Review of the facility "Performance Improvement Plan", Policy, revised 03/10, revealed it was the intent of the facility to conduct an ongoing performance improvement program designed to systematically monitor and evaluate the quality and appropriateness of resident care, pursue opportunities to improve resident care, resolve identified problems and identify opportunities for improvement. Performance improvement supports the overall goals of the facility and examines both outcomes and processes relevant to these outcomes with the objective of improving the organization's overall performance.

Based on observation, interview, and review of facility audits, it was determined the facility failed to ensure a safe, clean, comfortable and homelike environment within the facility.

Review of the facility's Plan of Correction (POC), with a compliance date of 04/29/13 revealed on 03/18/13 the Housekeeping Supervisor conducted an inservice to housekeeping/laundry stakeholders to include; the proper method of sanitizing a bathroom, the seven (7) step daily washroom cleaning, checking of supplies, emptying trash, dust mopping floors, cleaning and sanitizing sinks and tubs, cleaning and sanitizing commodes, spot cleaning walls, checking for cobwebs and debris, and damp mopping. On housekeeping staff. The commode in the bathroom of Room 409 had a cracked flange and was replaced on 08/08/13.

Identification of Other Residents With The Potential to be Affected

- The DPO completed walking rounds of all units and residents rooms on 08/09/13, to ensure rooms and bathrooms were clean and free from odors. In addition, all areas utilized by residents, including activity area, lobby, therapy rooms, dining areas, and outdoor areas were included in the rounds by the DPO. No other areas were identified as being affected. Nonethe-less, all residents' rooms, bathrooms and floors on the Reflections Community (where Room 409 is located) were deep cleaned on 080/9/13 by the housekeeping staff, with focus being on Room #409 and the bathroom therein.

Measures Taken To Assure There Will Not Be a Recurrence

- The DPO completed re-education of the housekeeping staff on 08/09/13, to ensure residents rooms, bathrooms, and all areas frequently used by residents are clean, homelike and free from odors.

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F 520	Continued From page 22 03/19/13 the Staff Development Coordinator conducted education with facility stakeholders on clean home like environment. On 04/12/13 the Quality Assurance Improvement Nurse (QAPIN) and Director of Nursing (DON) conducted an inservice with the environmental stakeholders to include audits that would be completed on a daily basis to validate resident rooms and other areas of the facility had been cleaned. Further review of the POC revealed the ESD would conduct an audit of ten percent (10%) of rooms on each unit as well as spot check general purpose areas to ensure all were properly cleaned and sanitized. The QAPIN, ADON or Unit Manager would oversee the auditing process and validate rooms were being cleaned properly. These audits would continue for a three (3) month period or until substantial compliance had been determined by the Process Improvement Committee (PIC). Observations during this survey revealed Room 409 and the adjoining Bathroom on the Reflections Unit had foul strong urine odors. Interview, on 08/08/13 at 10:30 AM, with Certified Nursing Assistant (CNA) #2 revealed she had become desensitized to the odors on the unit; however, could smell a mixture of urine and disinfectant in Room 409 and in the adjoining bathroom. Interview, on 08/08/13 at 10:40 AM, with Housekeeper #1, who was working the Reflections unit revealed she had cleaned Room 409 three (3) times so far that day and had to clean that room and bathroom more frequently due to continued odors. Further interview	F 520	♦ The SDC initiated in-services for all staff on 08/09/13 regarding a clean and odor free environment. The in-service is on-going and all new hires will be provided education during orientation; ♦ An "Environmental Audit Tool" *which consist of date, room number, trash, sanitizing sinks and commodes, all surfaces cleaned, odors present, and HVAC Units Checked, Items Identified and date of correction* will be completed three (3) times per week for one (1) month, then one (1) time per week *for one month* on the Reflections Community, *consisting of 13 residents rooms or 14% of total facility resident rooms*, by the RPD or by the facilities department heads, consisting of DON, SSD, MDSN, QoLD, ADON, UM, MRM, SDC, RNS, DM and RD. All remaining residents' rooms will be completed one (1) time per week for one (1) month then at 10% *(10 rooms)* per week thereafter by one of the above named positions *until the Quality Assurance Committee determines compliance.* The results of the tool will be addressed in the morning meetings (M-F) and discussed with the DPO. The "Environmental Audit Tool" will	

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F 520	Continued From page 23 revealed she could smell urine odors in Room 409 and in the bathroom adjoining the room at the time of interview. Interview, on 08/08/13 at 3:31 PM, with the Environmental Service Director (ESD), revealed Room 409 had a bad odor, "it doesn't smell right". However, the ESD further stated he was unaware of any issues with odor in this room until the survey. The ESD stated he continued to audit two (2) rooms each unit per week and found no concerns with odors. Review of the Audit Tool for Environmental Services revealed Room 409 had not been audited since 05/17/13 by the Housekeeping Supervisor. Interview, on 08/08/13 at 3:42 PM, with the Quality Assurance Nurse, revealed there had been an ongoing audit done since 03/2013 and the audits included checking two (2) rooms on three (3) units every week for cleanliness and odors. She stated odor/air fresheners were used in each room and no odors were listed as being present on the audits. Further interview revealed there was no reports to QA of lingering odors in the resident rooms/bathrooms. Interview, on 08/08/13 at 4:00 PM, with the Interim Director of Nursing (DON), revealed although she was aware there were ongoing audits for odors, she did not realize the odors were a continued problem.	F 520	be given to the facility Administrator in the morning meeting (M-F) for review. **Monitoring Changes To Assure Continuing Compliance** ♦ The QA Committee meeting was held on 8/22/13 with the Medical Director, DON, ADONs, UMs, SSDs, MDSNs, RNS, SDC, Rehabilitation Services Manager (RSM), RD, DM and QoLD. The Plan of Correction (POC) was discussed and approved by the committee. ♦ The Administrator will present the findings of the "Environmental Audit Tool" to the QA Committee at least quarterly for review. ♦ The Director of Nursing will complete a monthly audit of the "Environmental Audit Tool", ~~to ensure compliance.~~ *until the Quality Assurance Committee determines compliance.* ♦ Results of the DON audits will be submitted to the QA Committee at least quarterly. The QA Committee shall determine continuance or cessation relative to substantial compliance. ♦ Any non-compliance will be addressed by the Administrator. **Date of Completion:** **09-13-13**	

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K 000	INITIAL COMMENTS CFR: 42 CFR 483.70(a) Building: 01 Plan Approval: 2/23/68 SURVEY UNDER: 2000 Existing FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: One Story, Type II (222) Protected with one (1) room basement. SMOKE COMPARTMENTS: Sixteen (16) COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM FULLY SPRINKLERED, SUPERVISED (Wet and Dry SYSTEM) EMERGENCY POWER: Three (3) Type II Natural Gas A life safety code survey was conducted on 08/07/13. The facility was found to not be in compliance with Title 42, Code of Federal Regulations, 483.70 (a) ET seq (Life Safety from Fire). The facility is licensed for one hundred seventy-nine (179) beds and the census was one hundred eight (108) on the day of the survey. The following demonstrate noncompliance, with the highest scope and severity being a "D" level deficiency	K 000		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD	K 029	**K 029** **Immediate Corrective Action For Residents Found To Be Affected**	

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

Jeffrey R Sell — Administrator — Amended 09/08/13

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 029	Continued From page 1 One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure rooms used for storage were equipped with self-closers according to National Fire Protection Association (NFPA) standards. The findings affected one (1) of sixteen (16) smoke compartments. The findings include: Observation on 08/07/2013 at 2:03 PM, revealed rooms 316, 317, 318, 319, and 321 were being used to store various items (boxes, beds, resident furniture). Further observation revealed the doors were not equipped with self-closers. Rooms used for storage must be equipped with self-closers to prevent the spread of smoke and fire. The observation was confirmed with the Maintenance Director. Interview on 08/07/2013 at 2:03 PM, with the Maintenance Director, revealed he was not aware that the rooms needed to be equipped with self-closers.	K 029	♦ No specific resident identified and no specific resident experienced any negative outcome relative to this alleged deficient practice. ♦ Door closures were installed on rooms identified on 08/28/13. **Identification of Other Residents With The Potential to be Affected** ♦ The area identified was closed to residents and utilized for storage purposes. Thus no other residents were identified as this was a non-resident area. ♦ All storage areas were inspected by the Director of plant operations and the Administrator to assure all storage areas were within Life Safety Code requirements. No other residents were identified as being affected. **Measures Taken To Assure There Will Not Be a Recurrence** ♦ Plant Operations Director will perform monthly inspections of	

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K 029	Continued From page 2 The findings were confirmed with the Administrator at the exit conference. Reference: NFPA 101 (2000 edition) 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft2 (9.3 m2) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials	K 029	storage areas with report of any discrepancies to the Quality Assurance (QA) Committee at least quarterly. **Monitoring Changes To Assure Continuing Compliance** ♦ The QA Committee shall monitor the report at least quarterly with recommendations as needed to maintain compliance. The QA Committee shall determine continuance or cessation relative to substantial compliance. **Date of Completion:**	09-13-13

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K 029	Continued From page 3 in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory- or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.	K 029		
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure sprinkler systems were maintained according to National Fire Protection Association (NFPA) standards. The findings affected four (4) of sixteen (16) smoke compartments, twenty six (26) residents, staff and visitors. The findings include:	K 056	**K 056** **Immediate Corrective Action For Residents Found To Be Affected** ♦ No specific resident(s) were identified. **Identification of Other Residents With The Potential to be Affected** ♦ All residents residing on the Cherry Blossom Community have the potential to be affected. However given there were no negative outcomes before the flushing procedure was performed on 08/23/13, no other residents were identified.	

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K 056	Continued From page 4 Record review on 08/07/2013 at 12:38 PM, revealed during the 05/22/2013 inspection of the facility sprinkler system by an outside contractor, the facility would need to have the sprinkler system flushed. The findings were confirmed with the Maintenance Director. Interview on 08/07/2013 at 1:26 PM, with the Maintenance Director and the Administrator, revealed the facility was scheduled to have the inspection done on 08/19/2013. Further interview with the Administrator revealed it had taken this long to have the work performed due to bidding out the job. Sprinkler systems must be flushed to ensure the operationof the sprinkler system. Reference: NFPA 25 (2000 edition) 10-2.1* To ensure that piping remains clear of all obstructive foreign matter, an obstruction investigation shall be conducted for system or yard main piping wherever any of the following conditions exist: (a) Defective intake for fire pumps taking suction from open bodies of water (b) The discharge of obstructive material during routine water tests (c) Foreign materials in fire pumps, in dry pipe valves, or in check valves (d) Foreign material in water during drain tests or plugging of inspector ' s test connection(s)	K 056	♦ The facility had requested an inspection on 05/22/13. Upon receipt of the outcome of this inspection, quotes were immediately sought for corrective action. Upon receipt of bids and selection of contractor, the service was scheduled for the week of 08/19/13. This was in process prior to survey. There were no other resident areas identified and thus no other residents affected. **Measures Taken To Assure There Will Not Be a Recurrence** ♦ Plant Operations Director will present required inspection reports to the Administrator for review upon completion and also the QA Committee at least quarterly. **Monitoring Changes To Assure Continuing Compliance** ♦ The QA committee shall review required inspections at least quarterly to assure conformance with life safety codes. The QA Committee shall determine	

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K 056	Continued From page 5 (e) Plugged sprinklers (f) Plugged piping in sprinkler systems dismantled during building alterations (g) Failure to flush yard piping or surrounding public mains following new installations or repairs (h) A record of broken public mains in the vicinity (i) Abnormally frequent false tripping of a dry pipe valve(s) (j) A system that is returned to service after an extended shutdown (greater than 1 year) (k) There is reason to believe that the sprinkler system contains sodium silicate or highly corrosive fluxes in copper systems (l) A system has been supplied with raw water via the fire department connection. 10-2.3* Flushing Procedure. If an obstruction investigation carried out in accordance with 10-2.1 indicates the presence of sufficient material to obstruct sprinklers, a complete flushing program shall be conducted. The work shall be done by qualified personnel.	K 056	continuance or cessation relative to substantial compliance. **Date of Completion:**	09-13-13
K 103 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD	K 103		

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K 103	Continued From page 6 Interior walls and partitions in buildings of Type I or Type II construction are noncombustible or limited-combustible materials. 19.1.6.3 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to construct a partition wall using noncombustible or limited combustible materials in a noncombustible structure according to National Fire Protection Association (NFPA) standards. The deficient practice affected one (1) of sixteen (16) smoke compartments. The findings include: Observation on 08/07/2013 at 2:18 PM, revealed the facility had constructed two (2) partition walls, 5 (five) feet in height. The observation was confirmed with the Maintenance Director. Interview on 08/07/2013 at 2:18 PM, with the Maintenance Director, revealed the facility had constructed the walls out of ordinary construction (wooden 2x4 studs), further observation revealed the Maintenance Director was unsure of the original construction date due to the walls being constructed before he was employed at the facility. Partition walls in a noncombustible structure must be constructed using noncombustible construction or limited combustible materials to prevent the spread of fire. The findings were confirmed with the Administrator at Exit Conference.	K 103	**K 103 (*Note: The partition walls identified have been in place for approximately 20 years.)** **Immediate Corrective Action For Residents Found To Be Affected** ♦ No specific resident was identified. **Identification of Other Residents With The Potential to be Affected** ♦ Given these walls are outside the satellite kitchen area, any resident within that area has the potential to be affected. However, this area is within the closed area of the facility and has limited access to ambulatory and/or residents utilizing the dining area. No resident was identified as being affected. **Measures Taken To Assure There Will Not Be a Recurrence** ♦ Partition walls identified will be removed and thus present no further issue relative to resident safety.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185146	A. BUILDING 01 B. WING	08/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 103	Continued From page 7 Reference: NFPA 101 (2000 edition) 19.1.6.3 All interior walls and partitions in buildings of Type I or Type II construction shall be of noncombustible or limited-combustible materials. Exception:* Listed, fire-retardant-treated wood studs shall be permitted within non-load bearing 1-hour fire-rated partitions.	K 103	**Monitoring Changes To Assure Continuing Compliance** ♦ Any additions that affect Life Safety Code adherence shall be reviewed by the Corporate Architect for assurance of conformance to Life Safety Code requirements. **Date of Completion:** **09-13-13**	