STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185146	A. BUILDING _____ B. WING _____	09/03/2015

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FOUNTAIN CIRCLE CARE & REHABILITATION CENTER	200 GLENWAY ROAD WINCHESTER, KY 40391

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0155 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Let the resident refuse treatment or refuse to take part in an experiment and formulate advance directives.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review and review of the facility's policy, it was determined the facility failed to have an effective system to ensure the Advance Directives for one (1) of twelve (12) sampled residents (Resident #1) were honored. On [DATE], Resident #1's Responsible Party (RP) signed Advance Directives requesting the resident have a Full Code status (Full Code indicated life-saving measures were to be implemented in the event of cardiac or [MEDICAL CONDITION]), to include Cardiopulmonary Resuscitation (CPR). However, on [DATE] at approximately 7:15 AM, when State Registered Nursing Assistant (SRNA) #1 entered Resident #1's room, found him/her unresponsive and notified Licensed Practical Nurse (LPN) #1 and #2, the LPN's failed to honor the resident's Advance Directives regarding his/her Full Code status. LPN #1 entered Resident #1's room, checked Resident #1 for a pulse, could not obtain a pulse and failed to initiate CPR as per the resident's Advance Directives. LPN #2 entered Resident #1's room, observed LPN #1 checking the resident for a pulse, went to the nurse's station, checked the resident's chart for his/her code status and called Registered Nurse (RN) #1. LPN #2 also failed to initiate CPR as per the resident's Advance Directives. RN #1, who was on another unit, arrived to Resident #1's room, assessed the resident to have no heart rate and no respirations and pronounced the resident deceased at 7:23 AM. Per interview, RN #1 determined Resident #1 was a Full Code, but she did not initiate CPR according to the resident's Advance Directives. The facility's failure to ensure resident's Advance Directives regarding their requested Full Code status was honored has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy (IJ) was identified on [DATE], and was determined to exist on [DATE]. The facility was notified of the Immediate Jeopardy on [DATE]. An acceptable credible Allegation of Compliance (AOC) was received on [DATE] which alleged removal of the Immediate Jeopardy on [DATE]. The Immediate Jeopardy was verified to be removed on [DATE] as alleged, prior to exit on [DATE], with remaining non-compliance in the area of 42 CFR 483.10, Resident Rights, F-155 at a Scope and Severity of a D while the facility develops and implements a Plan of Correction (POC) and the facility's Quality Assurance (QA) monitors to ensure compliance with systemic changes. The findings include: Review of the facility's policy titled Advance Directives - Kentucky, effective ,[DATE], revealed it was the policy of the facility to recognize and support the use of Advance Directives through family, staff and community education, and to encourage the resident's rights to self-determination through recognition and assistance with executing such directives. Continued review revealed, as long as the resident was competent to make decisions, his/her wishes would be followed to the maximum extent possible as dictated by state law and sound medical judgment. If a resident became incompetent, but had provided evidence of a properly executed Advance Directive, the facility would implement the resident's choices as outlined in the document or expressed to the appointed agent to the same extent that the competent resident's wishes would be followed. Further review revealed, all residents would receive full resuscitative measures unless a Do Not Resuscitate (DNR) directive was written in the resident's medical record and was identified in the resident's Advance Directive. Review of the facility's policy titled, Cardiopulmonary Resuscitation, undated, revealed CPR would be attempted for any resident who was found to have no pulse and or no discernible respirations, unless there was a written physician order [REDACTED]. Review of the facility's policy titled Resident Rights, reviewed [DATE], revealed residents had the right to choose a physician, treatment, participation in decisions, and care planning. Further review revealed, residents were entitled to exercise their rights and privileges to the fullest extent possible. Per the policy, employees had a duty to read and learn the residents' rights. Review of Resident #1's medical record, revealed the facility admitted him/her on [DATE], with [DIAGNOSES REDACTED]. Review of Resident #1's Nursing Admission Information, dated [DATE], revealed the resident was alert and oriented to person with independent mobility. Review of the Advance Directives/Informed Consent, dated [DATE], revealed it was signed by the resident's Responsible Party on [DATE]. Continued review of the form revealed the resident wished to be a Full Code. Review of the physician's orders [REDACTED].#1 had an order for [REDACTED].>However, review of the Nurse's Note, dated [DATE], not timed, signed by LPN #1, revealed the nurse found Resident #1 sitting on the floor next to the bed with blood noted to be on the pillow and ear with no pulse found. Continued review revealed no documented evidence LPN #1 immediately initiated CPR according to Resident #1's Advance Directive. Interview with LPN #1, on [DATE] at 6:12 PM, revealed when he found Resident #1 on [DATE] around 7:15 AM, he did not initiate CPR. Continued interview revealed he did not know if Resident #1 was a Full Code status and felt the resident required further assessment, and stated the RN was more qualified. Per interview, LPN #1 was unfamiliar with the facility's policy; however, he stated he did not know why he didn't initiate CPR. Review of the Nurse's Note, dated [DATE] at 7:23 AM, signed by LPN #2, revealed LPN #2 found Resident #1 sitting beside the bed with his/her back to the bed and leaning to his/her left side with fresh wet blood from the left ear on the pillow. Continued review revealed no documented evidence LPN #2 initiated CPR according to Resident #1's Advance Directive. Further review of the Nurse's Note revealed LPN #2 immediately called the RN and the on-call Physician. Continued review of the Note revealed, LPN #2 received an order from the on call Physician to with hold CPR related to no signs of life, no pulse, no respiration and no blood pressure. Interview with the on-call Physician, on [DATE] at 8:13 AM, revealed the facility did notify him of the resident's death. However, per interview, he was not aware Resident #1 was a Full Code status and he would not give an order to withhold CPR. Interview with LPN #2, on [DATE] at 4:31 PM, revealed she had entered Resident #1's room behind LPN #1 and found the resident with no pulse; however, she did not initiate CPR. LPN #2 stated she went to the nurse's station to check the resident's code status and call the RN. Further interview revealed, she identified the resident to be a Full Code status and informed LPN #1 and RN #1 of the resident's Advance Directive; even though she did not initiate CPR. LPN #2 reported the resident was just too far gone. Per interview, LPN #2 stated she reported to the on-call Physician the resident had expired and the RN had decided the resident was too far gone to perform CPR. Review of the Nurse's Note, dated [DATE] at 7:30 AM, signed by RN #1, revealed she found the resident sitting on the floor with his/her back to the bed and leaning to the left side with blood from the left ear with no heart rate and no respirations. Further review of the Note, revealed Resident #1 was pronounced deceased by RN #1 at 7:23 AM. Interview with RN #1, on [DATE] at 5:50 PM, revealed she responded to a call on [DATE] around 7:10 AM or 7:15 AM, from LPN #2 requesting a nurse to pronounce a resident deceased . Per interview, RN #1 was not aware Resident #1 was a Full Code

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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F 0155 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) status until she went to the nurse's station to document her assessment; however, she did not initiate CPR because in my nursing opinion, she had been passed for a while. Further interview revealed, it was the facility's policy to initiate CPR when a resident was found in [MEDICAL CONDITION] or unresponsive and was a Full Code status. RN #1 stated she did not follow the facility's policy. Interview with the Director of Nursing (DON), on [DATE] at 3:09 PM, revealed if a resident was found unresponsive, staff should confirm the resident's Advance Directive, and CPR should be immediately initiated for any resident with a Full Code status Advance Directive. Continued interview revealed staff did not follow the facility's policy for Resident #1. Interview with the Administrator, on [DATE] at 4:50 PM, revealed Resident #1 had the right to an Advance Directive and the resident's wishes should have been honored by the facility and the staff. Continued interview revealed, staff did not follow the facility's policy related to the initiation of CPR. The facility provided an acceptable credible Allegation of Compliance (AOC) on [DATE], which alleged removal of the IJ effective [DATE]. Review of the AOC revealed the facility implemented the following: 1. On [DATE], the Director of Nursing (DON) reviewed Resident #1's medical record and care plan with the following areas of concern identified: a. The date and time were missing regarding the Physician notification on the Nursing Admission Assessment b. the Advance Directive of Full Code status was not care planned on the Interim Care Plan. c. CPR was not immediately initiated per Resident #1's/Power of Attorney's (POA's) request as indicated on the Advance Directive. 2. Beginning [DATE] and concluding on [DATE], the DON, Unit Managers, Nursing Supervisors or Medical Records staff audited all resident Advance Directive/Code Status/physician's orders [REDACTED]. 3. Beginning [DATE] and concluding on [DATE], the DON, Assistant Director of Nursing (ADON), Unit Managers and Nursing Supervisors assessed all residents for any possible resident rights violations. Residents with a Brief Interview of Mental Status (BIMS) score of eight (8) or greater were interviewed and residents with a BIMS of less than eight (8) were physically assessed for any signs and symptoms of possible quality of life or resident rights violations. 4. Compliance audits of the admission process were completed by [DATE] of all admissions within the previous thirty (30) days. The audits were performed by the DON, ADON, Unit Managers or Nursing Supervisors of all resident's medical records to include notification of the Attending Physician, review of the Physician Admitting Orders with the Attending Physician and ensuring professional standards were followed. 5. The DON, Unit Managers, Nursing Supervisors or Medical Records staff completed audits of all resident charts by [DATE]. The Audit included; resident's Advance Directive, physician's orders [REDACTED]. 6. On [DATE], all management staff was educated by the Regional Nurse Consultant. Education included: Advance Directive Policy and Procedure, Admission/physician's orders [REDACTED]. 7. Education for all nursing staff was initiated on [DATE] and completed by [DATE], with the exception of four (4) full-time status staff on leave and twenty-one (21) part-time staff. Certified letters were sent to the twenty-one (21) part-time staff to notify each of the mandatory education prior to returning to duty. Education was provided by the Staff Development Coordinator, Unit Mangers and Nursing Supervisors. Education included Advance Directive Policy and Procedure, Admission/Physician order [REDACTED]. The education related to the policies and procedures was added to the training agenda for New Employee Orientation. 8. Beginning [DATE] and concluding on [DATE], the Staff Development Coordinator, Unit Managers and Nursing Supervisors conducted education for all licensed staff (with the exception of the part-time staff who were notified by certified letter they could not work until receiving the required education) on the admission policy and procedure, to include: clarification of the process for Physician notification of new admissions, obtaining admission orders [REDACTED]. The above education was incorporated into the facility's New Employee Orientation. 9. On [DATE], all Physicians with privileges at the facility were educated by the DON in regards to the admission process and expectations with compliance to include: Discharge Summaries or Orders from a discharging facility would be faxed to the Physician's office and the Physician would be called for approval of the Orders with a Telephone Order written stating the Physician's review and approval of the Orders. 10. Human Resources and/or Staff Development performed audits of all personnel files for CPR certifications. Audits were completed by [DATE] and given to the Regional Nurse Consultant to review for non-compliance with CPR regulations. Seventeen (17) licensed nurses were noted to have on-line only CPR certifications. 11. Sixteen (16) of the seventeen (17) staff identified to have on-line CPR certifications received CPR instruction with hands on component by [DATE], provided by the DON, a certified American Heart CPR Instructor. One (1) employee would not be allowed to work until CPR certification with hands on component was obtained. 12. Beginning [DATE], the DON, ADON, Unit Manager, Nursing Supervisor or Medical Records staff will review all new admissions daily during the morning clinical meeting to ensure compliance with Physician notification, Physician Orders, Interim Care Plan, Advance Directive, and Resident Rights. Findings of the review will be reported in the Quality Assurance (QA) committee meeting. The committee consists of the Medical Director, Administrator, DON, Social Services Director and at least two (2) other department managers, different line staff as appropriate, and outside consultants as appropriate. The committee will meet weekly for four (4) weeks then monthly to determine the need for continued education or revision of the plan. Based on evaluation, the QA committee will determine at what frequency the ongoing review of new admissions will need to continue. Concerns identified will be corrected immediately by the DON, ADON, Unit Managers or Nursing Supervisor and reported to the Administrator to ensure any needed investigation initiated and reported guidelines were met. 13. The DON, ADON, Unit Managers, or Nursing Supervisor will monitor care delivery as outlined per the care plan on five (5) residents per unit per day until immediacy is removed, beginning [DATE], then five (5) residents daily for four (4) weeks, to ensure compliance with care delivery as outlined by the Care Plan along with compliance of Professional Standards requirements. Findings will be reported in the QA committee weekly to determine the further need of continued education or the revision of the plan. 14. Mock codes will be conducted by the DON, ADON, Unit Managers, Staff Development Coordinator or Nursing Supervisor twice weekly, on rotating shifts, for four (4) weeks beginning [DATE], to ensure understanding and compliance with Code Blue Policy and Procedure. The first two (2) mock codes were conducted by Clinical Managers for education on how to conduct a code; the Mock codes will be conducted by the nurses. Findings will be reported to the QA committee weekly to determine compliance and any further need of continued education or revision of the plan. 15. The DON, Staff Development Coordinator or Human Resources will track all licensed nurses CPR certification monthly beginning [DATE], to ensure compliance with CPR policy, procedure and governing regulations. Findings and compliance will be reported monthly to the QA committee to determine any need for education or revision of the process. 16. A Regional Nurse or corporate office staff was on site since [DATE] and will remain on site daily until immediacy is removed, then will be on site three (3) times weekly for four (4) weeks. Regional/Corporate staff will review compliance with the plan and will review compliance with policy and procedure of any code blue that occurs and review compliance with new or re-admissions. During weekly follow-up, guidance and recommendations will be provided with compliance validated. 17. Administrative oversight of the facility will be completed by the Vice President of Operations, Nurse Consultant, or Special Projects Administrator daily until removal of the immediacy beginning [DATE], then weekly for four (4) weeks, then monthly. 18. A Quality Assurance meeting will be held weekly until immediacy is removed beginning on [DATE], the for four (4) weeks, then monthly for recommendations and further follow up regarding the stated plan. Based on evaluation, the QA committee will determine at what frequency any ongoing audits will need to continue. The Administrator has the oversight to ensure an effective plan is in place to meet resident well-being and ensure resident rights as well as an effective plan to identify facility concerns and implement a plan of correction to involve all staff of the facility. Corporate Administrative oversight of the Quality Assurance meeting will be completed by the Special projects Administrator, the Regional Vice President of Operations, or a member of regional staff three (3) times a week until immediacy is removed beginning [DATE], then weekly for four (4) weeks, then monthly. The State Survey Agency validated the implementation of the facility's AOC as follows: 1. Review of the facility's investigation of the incident revealed an audit of Resident #1's medical record with areas concern noted. Interview with the DON, on [DATE] at 5:20 PM, revealed she audited Resident #1's medical record and identified areas of concern with immediate implementation of education provided to staff.

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F 0155 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) 2. Review of the facility's audit of all resident's Advance Directive, Care Plans and physician's orders [REDACTED]. Interview with the DON, on [DATE] at 5:20 PM, revealed she had participated with other management staff to audit all resident records to verify accuracy of the resident's Advance Directive, Care Plans and Physician's code status order. 3. Review of the audit tool utilized to interview and assess all residents for possible resident rights violations revealed management staff interviewed all resident's with a Brief Interview for Mental Status (BIMS) score of eight (8) or greater and a physical assessment was completed for resident's whose BIMS was less than eight (8). Interview with the DON, on [DATE] at 5:20 PM, revealed management staff interviewed or assessed each of the facility's residents for any signs or symptoms of resident rights violations. Interview with interviewable residents revealed staff did talk with them regarding their resident rights. 4. The audit tool, dated [DATE], utilized to audit previous thirty (30) days facility new admissions was reviewed. New admissions were audited for compliance with admission process including: Physician notification, review of New Admission physician's orders [REDACTED]. Areas of concern identified with the audit were documentation in relation to missing dates and times on the Nursing Admission Assessment on four (4) residents. Review of the education provided to staff revealed policy and procedures related to accuracy of the admission process and documentation was provided. Review of the staff sign in sheets revealed instruction was provided beginning [DATE] with review of policy and procedure. On [DATE], a more comprehensive education was provided to staff related to the policy and procedure. Interview with the DON, on [DATE] at 5:20 PM, revealed she initiated education to the nursing staff immediately on [DATE]. Per the DON, the Regional Nurse provided comprehensive education to the management staff on [DATE]. Further interview revealed, after receiving the comprehensive education, the management staff were responsible for providing the comprehensive education to the facility's nursing staff. 5. Review of the audit of each resident's medical record to include: Advance Directive, physician's orders [REDACTED]. Interview with the DON, on [DATE] at 5:20 PM, revealed she and other management staff audited each resident's medical record to ensure compliance with quality of care delivery. 6. Review of education provided by the Regional Nurse to all management staff with the sign in sheet dated [DATE] and signed by the Regional Nurse revealed the education provided included: Cardiopulmonary Resuscitation, Advance Directives, Physician Visits and Medical Orders, Admission Criteria, Care Planning - Interdisciplinary Team, Resident Rights, Quality of Care, Professional Standards, and QA. Interview with the Regional Nurse Consultant, on [DATE] at 5:20 PM, revealed he provided comprehensive education to management staff related to the facility's policies and procedures stated above. Continued interview revealed the facility revised the CPR policy to include mandatory hands on skills certification for staff. 7. Review of education provided to all nursing staff to include: Cardiopulmonary Resuscitation, Advance Directives, Physician Visits and Medical Orders, Admission Criteria, Care Planning - Interdisciplinary Team, Resident Rights, Quality of Care, Professional Standards, and QA. Review of sign in sheets revealed the education was initiated on [DATE] and concluded on [DATE]. Review of certified letters sent to twenty-one (21) part-time clinical staff related to mandatory education prior to working. Continued review of sign-in sheets revealed education for part-time clinical staff, non-licensed staff and non-nursing staff continued per AOC. Review of New Orientation Agenda for clinical staff, revealed education would be provided with orientation process. Review of audit tool utilized for validation of CPR certification with hands on skills component revealed staff had obtained education with hands on skill component. Interview, on [DATE] at 10:20 AM with SRNA #8; at 10:30 AM with SRNA #7; at 10:40 AM with SRNA #4; at 10:50 AM with SRNA #2; and, at 11:00 AM with SRNA #6 revealed they had all been provided education related to Cardiopulmonary Resuscitation, Resident Rights, Quality of Care and Professional Standards between [DATE] and [DATE] in a verbal lecture setting allowing for question and answers. Interview, on [DATE] at 5:50 PM with RN #1 and at 6:12 PM with LPN #1; on [DATE] at 11:15 AM with LPN #12; at 11:25 AM with LPN #3; at 4:16 PM with LPN #11; at 4:30 PM with LPN #2; at 4:45 PM with RN #4; at 5:00 PM with RN #2; at 5:17 PM with RN #3; and, Unit Manager #1 at 4:29 PM, revealed they had all been provided education related to Cardiopulmonary Resuscitation, Advance Directives, Physician Visits and Medical Orders, Admission Criteria, Care Planning, Resident Rights, Professional Standards, and Quality of Care in a verbal lecture setting allowing for question and answers. 8. Review of the education provided to all licensed staff related to the admission policy and procedure revealed the education was initiated on [DATE] and completed on [DATE] after additional education was provided by the Regional Nurse Consultant. Interview with the DON, on [DATE] at 5:20 PM, revealed she had initiated staff education on [DATE]. After receiving comprehensive education provided by the Regional Nurse Consultant on [DATE], the management team re-educated staff with the completion date for full-time clinical staff to be [DATE]. 9. Review of the education provided to all Physicians with privileges to included; clarification of the process for notifying the Physician of new admits and obtaining orders, and the Interim Care Plan and Professional Standards. Further review, revealed there was follow up letters sent to each Physician related to the educations provided. 10. Review of the Audit of personnel files for CPR certification revealed the Audit was completed on [DATE] with the Regional Nurse Consultant review on [DATE]. Data from the audit revealed seventeen (17) staff without the hands on skill component for CPR certification. 11. Review of the Audit of personnel files for CPR certifications revealed sixteen (16) of the seventeen (17) identified staff without hands on skill component CPR certifications had obtained certifications with the hands on skills component. Interview with the DON, on [DATE] at 5:20 PM, revealed she was a Certified American Heart CPR Instructor. Further interview revealed, she had conducted four (4) CPR classes for staff that included the hands on skills component. Per interview, one staff still remained out of compliance with the CPR certification hands on component and would not be allowed to work until appropriate certification was obtained. 12. Review of the Daily New Admission Log, revealed new admissions were reviewed daily for compliance with Physician Notification, Physician Orders, Interim Care Plan, Advance Directive, and Resident Rights beginning [DATE]. Interview with the DON on [DATE] at 5:20 PM, revealed areas of concern were identified when the audits were initiated on [DATE]; however, after staff received education, data collected had improved. Further interview revealed any issues identified would be immediately corrected with data reviewed with the QA committee weekly for four (4) weeks, then monthly with the results of the collected data to determine the need for additional education or the revision of the plan. 13. Review of documentation monitoring care delivery as outlined per the resident's care plan, revealed five (5) resident care plans per day per unit were reviewed by management staff beginning [DATE]. Interview with the DON, on [DATE] at 5:20 PM, revealed management staff had audited resident care plans daily. Further interview revealed five (5) care plans were audited on each unit daily since [DATE]. 14. Review of documentation of the Mock codes revealed they were conducted twice weekly on rotating shifts beginning [DATE]. Interview, on [DATE] at 5:50 PM with RN #1 and at 6:12 PM with LPN #1; on [DATE] at 11:15 AM with LPN #12; at 11:25 AM with LPN #3; at 4:16 PM with LPN #11; at 4:30 PM with LPN #2; at 4:45 PM with RN #4; at 5:00 PM with RN #2; at 5:17 PM with RN #3; and, Unit Manager #1 at 4:29 PM, revealed they had all been provided education related to Cardiopulmonary Resuscitation and Advance Directives with Mock Codes conducted on different shifts. 15. Review of documentation of CPR certification tracking revealed the date the certification was obtained and verification the certification contained a hands on skills component. Interview with the DON, on [DATE] at 5:20 PM, revealed the facility had previously been tracking CPR expiration dates; however, the facility added verification of a hands on skills component to their tracking data to ensure compliance. 16. Review of the documentation of a calendar, signed by the Regional Nurse and Regional Vice President of Operations revealed the Regional Vice President of Operations was on site [DATE] and [DATE]. Further review revealed, the Regional Nurse was on site daily from [DATE] to [DATE] with the exception of [DATE]. Interview with the Regional Nurse, on [DATE] at 5:20 PM, revealed he had been in the facility each day with the exception of [DATE]. Interview with the Administrator on [DATE] at 5:20 PM, revealed the Regional Nurse had been on site daily since [DATE] with the exception of [DATE]. Interview with Unit Manager #1, on [DATE] at 4:29 PM, revealed the Regional Nurse had been on site seemed like daily for over two (2) weeks. 17. Review of documentation of a calendar, signed by the Regional Nurse and Regional Vice President of Operations revealed

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F 0155 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 3) on site Administrative oversight was performed by the Regional Vice President of Operations on [DATE] and [DATE]. Further review revealed, on site Administrative oversight was performed by the Regional Nurse on each day from [DATE] to [DATE], with the exception of [DATE]. Interview with the Regional Nurse, on [DATE] at 5:20 PM, revealed he had been on site at the facility daily since [DATE] with the exception of [DATE]. Interview with the Administrator on [DATE] at 5:20 PM, revealed the Regional Nurse had been on site daily since [DATE] with the exception of [DATE]. Interview with Unit Manager #1, on [DATE] at 4:29 PM, revealed the Regional Nurse had been on site seemed like daily for over two (2) weeks. 18. Review of the QA sign in sheets revealed, meetings were conducted on [DATE], [DATE], and [DATE] with the areas of concern discussed. The Medical Director was in attendance on [DATE]. Interview with the Administrator, on [DATE] at 11:15 AM, revealed the data obtained from the audits performed, revealed areas of concern related to the Mock codes which were initially performed. Continued interview revealed, the data was analyzed and it was determined additional education was needed. Further interview revealed the additional education was provided with positive data resulting from ongoing Mock codes and audits.
F 0281 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Make sure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, review of the facility's policy and review of the Kentucky Board of Nursing's (KBN's), Accountability & Responsibility of Nurses document and Advisory Opinion Statements (AOS), it was determined the facility failed to have an effective system to ensure services provided met professional standards of quality for one (1) of twelve (12) sampled residents (Resident #1) regarding ensuring nursing staff honored the resident's Advance Directives and ensuring care planning was sufficient to meet the needs of newly admitted residents related to code status. On [DATE], Resident #1's Responsible Party, signed Advance Directives requesting the resident have a Full Code status (Full Code specifies life saving measures would be implemented in the event of cardiac or [MEDICAL CONDITION]) with life-saving measures to include Cardiopulmonary Resuscitation (CPR). Resident #1 also had a physician's orders [REDACTED]. On [DATE] at approximately 7:15 AM, when State Registered Nursing Assistant (SRNA) #1 entered Resident #1's room, found the resident unresponsive, and notified Licensed Practical Nurse (LPN) #1 and #2, the LPN's failed to honor Resident #1's Advance Directives regarding Full Code status. LPN #1 entered Resident #1's room, checked the resident for a pulse, could not obtain a pulse, and failed to initiate CPR as per the resident's Advance Directives. LPN #2, then entered Resident #1's room, observed LPN #1 checking the resident for a pulse, went to the nurse's station, checked the resident's medical record for code status and called Registered Nurse (RN) #1. LPN #2 also failed to initiate CPR as per the resident's Advance Directives. RN #1, who was working on another unit, arrived to Resident #1's room, assessed the resident to have no heart rate and no respirations and pronounced the resident deceased at 7:23 AM, without prior approval or order obtained by the resident's physician. Per interview, RN #1 determined Resident #1 was a Full Code; however, she did not initiate CPR according to the resident's Advance Directives. The facility's failure to ensure services provided met professional standards of quality related to Advance Directives regarding residents' requested code status, and ensuring the Interim Care Plan was sufficient for newly admitted residents, caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on [DATE], and was determined to exist on [DATE]. The facility was notified of the Immediate Jeopardy on [DATE]. The facility provided an acceptable credible Allegation of Compliance (AOC) on [DATE] with the facility alleging removal of the Immediate Jeopardy on [DATE]. The State Survey Agency validated removal of the Immediate Jeopardy as alleged, on [DATE], prior to exit on [DATE], with remaining non-compliance in the area of 42 CFR 483.20 Resident Assessment, F-281 at a Scope and Severity of a D while the facility develops and implements a Plan of Correction and the facility's Quality Assurance (QA) monitors to ensure compliance with systemic changes. The findings include: Review of the facility's policy, titled Advance Directives - Kentucky effective ,[DATE], revealed it was the policy of the facility to recognize and support the use of Advance Directives through family, staff and community education and to encourage the resident's rights to self-determination through recognition and assistance with executing the directives. Further review revealed, as long as the resident was competent to make decisions, his/her wishes would be followed to the maximum extent possible as dictated by state law and sound medical judgment. If a resident became incompetent, but had provided evidence of a properly executed Advance Directive, the facility would implement the resident's choices as outlined in the document or expressed to the appointed agent to the same extent the competent resident's wishes would be followed. Continued review revealed, all residents would receive full resuscitative measures unless a Do Not Resuscitate (DNR) directive was written in the resident's medical record and was identified in the resident's Advance Directive. Review of the facility's policy, titled Resident Rights, reviewed [DATE], revealed residents had the right to choose a physician, treatment, and participate in decisions and care planning. Further review revealed, residents were entitled to exercise their rights and privileges to the fullest extent possible. According to the policy, employees had a duty to read and learn the residents' rights. Review of the facility's policy, titled Cardiopulmonary Resuscitation, undated, revealed CPR would be attempted for a resident who was found to have no palpable pulse and/or no discernible respirations, unless there was a written physician's orders [REDACTED]. Further review revealed, should a resident be found unresponsive and without respirations, a licensed staff member who was certified in CPR would promptly initiate CPR for residents who requested CPR in their advance directive; who had not formulated an advance directive; or who did not have a valid DNR order, unless it would pose a danger to self or others to initiate CPR. Review of the facility's policy, titled Death of Resident, Documenting, undated, revealed a resident may be declared dead by a Licensed Physician or Registered Nurse with Physician authorization in accordance with state law. Review of the KBN's, Accountability & Responsibility of Nurses document revealed KRS 314.021 (2) held nurses individually responsible and accountable for rendering safe, effective nursing care to clients and for judgements exercised and actions taken in the course of providing care. Review of the KBN's Advisory Opinion Statement (AOS) #36, Resuscitation, approved February 2008, revealed nurses were required to honor the Advance Directives of patients who had the Advance Directives documented in the medical record, unless a Physician or healthcare facility refused to comply, and the patient and surrogate were informed of the refusal. Review of the facility's policy, titled Care Planning - Interdisciplinary Team, undated, revealed the facility's Care Planning/Interdisciplinary Team was responsible for the development of an individualized comprehensive care plan for each resident, incorporating goals and objectives that lead to the residents' highest obtainable level of independence. Continued review revealed, the resident, the resident's family and/or the resident's legal representative/guardian or surrogate were encouraged to participate in the development of and revisions to the resident's care plan. Review of Resident #1's medical record revealed the facility admitted the resident on [DATE] from the hospital, with [DIAGNOSES REDACTED]. Review of the Advance Directives/Informed Consent, dated [DATE] signed by Resident #1's Responsible Party, revealed the Responsible Party had requested and consented in the event of death for staff to use cardiac compressions or artificial ventilation to resuscitate the resident. Review of the Nursing Admission Information document dated [DATE], revealed the resident's Advance Directives had been completed. Review of the physician's orders [REDACTED]. The State Survey Agency was unable to reach the resident's admitting nurse after multiple attempts. Review of the Nurse's Notes dated [DATE], not timed and documented by LPN #1, revealed LPN #1 found Resident #1 sitting on the floor next to the bed with blood on the pillow and ear with no pulse found. Further review of the Note, revealed no documented evidence LPN #1 immediately initiated CPR as per Resident #1's physician's orders [REDACTED]. Continued review of the Nurse's Notes, revealed a Note dated [DATE], at 7:23 AM, documented by LPN #2, which revealed Resident #1 was found sitting beside the bed with his/her back to the bed, leaning to the left side with wet fresh blood, from the left ear on the pillow with no pulse, no respirations, no blood pressure and no signs of life. However, there was

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	185146	A. BUILDING _____ B. WING _____	09/03/2015

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FOUNTAIN CIRCLE CARE & REHABILITATION CENTER	200 GLENWAY ROAD WINCHESTER, KY 40391

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0281 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 4) no documented evidence LPN #2 immediately initiated CPR as per Resident #1's physician's orders [REDACTED]. Further review of the Nurse's Notes, revealed an entry dated [DATE], at 7:30 AM, documented by RN #1, which revealed Resident #1 was sitting on the floor with his/her back to the bed and leaning to the left side with blood from his/her left ear with no heart rate and no respirations. Per the note, Resident #1 was pronounced deceased at 7:23 AM; however, there was no documented evidence RN #1 immediately initiated CPR as per Resident #1's physician's orders [REDACTED]. Review of the Provisional Report of Death form revealed Resident #1's date and time of death was noted as being on [DATE] at 7:23 AM. Interview with LPN #1, on [DATE] at 6:12 PM, revealed on the day shift of [DATE], he was the primary nurse for Resident #1. LPN #1 revealed, he was certified to perform CPR; however, when he found Resident #1 on [DATE] around 7:15 AM, he did not initiate CPR. He further stated LPN #2 entered the resident's room behind him and did not initiate CPR; however, left the room to call the RN for assistance. Per interview, LPN #1 did not know if Resident #1 had a Full Code status and felt the resident required further assessment and the RN was more qualified to complete that assessment. LPN #1 further revealed, he was unfamiliar with the facility's policy; however, he stated he did not know why he didn't initiate CPR. Interview with LPN #2, on [DATE] at 4:31 PM, revealed she was certified in CPR and had entered Resident #1's room behind LPN #1 and found the resident with no pulse; however, she did not initiate CPR. LPN #2 stated she went to the nurse's station to check the resident's code status and call the RN. Further interview revealed, she identified the resident to be a Full Code status and even though she did not immediately initiate CPR, she did inform LPN #1 and RN #1 of the resident's Advance Directive. LPN #2 reported the resident was just too far gone. Continued interview revealed, she notified the on-call Physician of the resident's death. Per interview, LPN #2 stated she reported to the on-call Physician the resident had expired and the RN had decided the resident was too far gone to perform CPR. LPN #2 stated she thought she informed the physician of the resident's Full Code status with the Physician's verbal response to be Oh no, OK. LPN #2 further stated, per the facility's policy, CPR should have been initiated for Resident #1. Interview on [DATE] at 8:13 AM with the on-call Physician, revealed the facility did notify him of Resident #1's death; however, he was not informed Resident #1 had a Full Code status and he did not give an order for [REDACTED].>Interview with RN #1, on [DATE] at 5:50 PM, revealed she was certified in CPR and responded to a call from LPN #2 on [DATE] around 7:10 AM or 7:15 AM, requesting a nurse to pronounce a resident deceased . Continued interview revealed, upon arrival to Resident #1's room she assessed the resident and without obtaining an order from the resident's physician prior to pronouncing, RN #1, pronounced the resident deceased at 7:23 AM. Per interview, she was not aware Resident #1 was a Full Code status until she went to the nurse's station to document her assessment; however, she did not initiate CPR because in my nursing opinion, (she/he) had been passed for a while. Further interview revealed, it was the facility's policy to initiate CPR when a resident was found in [MEDICAL CONDITION] or unresponsive and had a Full Code status and she stated she should obtain an order from the physician prior to pronouncing a resident deceased . RN #1 reported she did not follow the facility's policy. Interview with the Director of Nursing (DON), on [DATE] at 3:09 PM, revealed should a resident be found unresponsive, staff should verify the resident's Advance Directive, and CPR should be immediately initiated for any resident with a Full Code status Advance Directive. The DON stated, per the facility's policy, prior to pronouncing a resident deceased , an order or approval from the resident's physician should be obtained by the RN. Continued interview at 4:02 PM, revealed a resident's code status should be documented on the resident's care plan to ensure appropriate care would be provided. She stated it would be the responsibility of the nurse who admits the resident to ensure the Interim Care Plan related to Advanced Directive was initiated. Further interview revealed her expectation was for staff to follow the facility's policy and staff did not follow the facility's policy. Interview on [DATE] at 4:50 PM, with the Administrator, revealed residents had a right to execute an Advance Directive and it should be honored by the staff. She stated a resident's care plan should include the resident's Advance Directive. Continued interview revealed, LPN #1, LPN #2 and RN #1 should have initiated CPR for Resident #1, who was a Full Code, when they found the resident non-responsive. Per interview, the facility's policy did allow for an RN to pronounce a resident deceased with the approval of the physician. The Administrator reported her expectation was for staff to follow the facility's policies to provide a professional standard of care to the residents. The facility provided an acceptable credible Allegation of Compliance (AOC) on [DATE], which alleged removal of the IJ effective [DATE]. Review of the AOC revealed the facility implemented the following: 1. On [DATE], the Director of Nursing (DON) reviewed Resident #1's medical record and care plan with the following areas of concern identified: a. The date and time were missing regarding the Physician notification on the Nursing Admission Assessment b. the Advance Directive of Full Code status was not care planned on the Interim Care Plan. c. CPR was not immediately initiated per Resident #1's/Power of Attorney's (POA's) request as indicated on the Advance Directive. 2. Beginning [DATE] and concluding on [DATE], the DON, Unit Managers, Nursing Supervisors or Medical Records staff audited all resident Advance Directive/Code Status/physician's orders [REDACTED]. 3. Beginning [DATE] and concluding on [DATE], the DON, Assistant Director of Nursing (ADON), Unit Managers and Nursing Supervisors assessed all residents for any possible resident rights violations. Residents with a Brief Interview of Mental Status (BIMS) score of eight (8) or greater were interviewed and residents with a BIMS of less than eight (8) were physically assessed for any signs and symptoms of possible quality of life or resident rights violations. 4. Compliance audits of the admission process were completed by [DATE] of all admissions within the previous thirty (30) days. The audits were performed by the DON, ADON, Unit Managers or Nursing Supervisors of all resident's medical records to include notification of the Attending Physician, review of the Physician Admitting Orders with the Attending Physician and ensuring professional standards were followed. 5. The DON, Unit Managers, Nursing Supervisors or Medical Records staff completed audits of all resident charts by [DATE]. The Audit included; resident's Advance Directive, physician's orders [REDACTED]. 6. On [DATE], all management staff was educated by the Regional Nurse Consultant. Education included: Advance Directive Policy and Procedure, Admission/physician's orders [REDACTED]. 7. Education for all nursing staff was initiated on [DATE] and completed by [DATE], with the exception of four (4) full-time status staff on leave and twenty-one (21) part-time staff. Certified letters were sent to the twenty-one (21) part-time staff to notify each of the mandatory education prior to returning to duty. Education was provided by the Staff Development Coordinator, Unit Mangers and Nursing Supervisors. Education included Advance Directive Policy and Procedure, Admission/Physician order [REDACTED]. The education related to the policies and procedures was added to the training agenda for New Employee Orientation. 8. Beginning [DATE] and concluding on [DATE], the Staff Development Coordinator, Unit Managers and Nursing Supervisors conducted education for all licensed staff (with the exception of the part-time staff who were notified by certified letter they could not work until receiving the required education) on the admission policy and procedure, to include: clarification of the process for Physician notification of new admissions, obtaining admission orders [REDACTED]. The above education was incorporated into the facility's New Employee Orientation. 9. On [DATE], all Physicians with privileges at the facility were educated by the DON in regards to the admission process and expectations with compliance to include: Discharge Summaries or Orders from a discharging facility would be faxed to the Physician's office and the Physician would be called for approval of the Orders with a Telephone Order written stating the Physician's review and approval of the Orders. 10. Human Resources and/or Staff Development performed audits of all personnel files for CPR certifications. Audits were completed by [DATE] and given to the Regional Nurse Consultant to review for non-compliance with CPR regulations. Seventeen (17) licensed nurses were noted to have on-line only CPR certifications. 11. Sixteen (16) of the seventeen (17) staff identified to have on-line CPR certifications received CPR instruction with hands on component by [DATE], provided by the DON, a certified American Heart CPR Instructor. One (1) employee would not be allowed to work until CPR certification with hands on component was obtained. 12. Beginning [DATE], the DON, ADON, Unit Manager, Nursing Supervisor or Medical Records staff will review all new admissions daily during the morning clinical meeting to ensure compliance with Physician notification, Physician Orders, Interim Care Plan, Advance Directive, and Resident Rights. Findings of the review will be reported in the Quality Assurance (QA) committee meeting. The committee consists of the Medical Director, Administrator, DON, Social Services Director and at least two (2) other department managers, different line staff as appropriate, and outside consultants as appropriate. The

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F 0281 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 5) committee will meet weekly for four (4) weeks then monthly to determine the need for continued education or revision of the plan. Based on evaluation, the QA committee will determine at what frequency the ongoing review of new admissions will need to continue. Concerns identified will be corrected immediately by the DON, ADON, Unit Managers or Nursing Supervisor and reported to the Administrator to ensure any needed investigation initiated and reported guidelines were met. 13. The DON, ADON, Unit Managers, or Nursing Supervisor will monitor care delivery as outlined per the care plan on five (5) residents per unit per day until immediacy is removed, beginning [DATE], then five (5) residents daily for four (4) weeks, to ensure compliance with care delivery as outlined by the Care Plan along with compliance of Professional Standards requirements. Findings will be reported in the QA committee weekly to determine the further need of continued education or the revision of the plan. 14. Mock codes will be conducted by the DON, ADON, Unit Managers, Staff Development Coordinator or Nursing Supervisor twice weekly, on rotating shifts, for four (4) weeks beginning [DATE], to ensure understanding and compliance with Code Blue Policy and Procedure. The first two (2) mock codes were conducted by Clinical Managers for education on how to conduct a code; the Mock codes will be conducted by the nurses. Findings will be reported to the QA committee weekly to determine compliance and any further need of continued education or revision of the plan. 15. The DON, Staff Development Coordinator or Human Resources will track all licensed nurses CPR certification monthly beginning [DATE], to ensure compliance with CPR policy, procedure and governing regulations. Findings and compliance will be reported monthly to the QA committee to determine any need for education or revision of the process. 16. A Regional Nurse or corporate office staff was on site since [DATE] and will remain on site daily until immediacy is removed, then will be on site three (3) times weekly for four (4) weeks. Regional/Corporate staff will review compliance with the plan and will review compliance with policy and procedure of any code blue that occurs and review compliance with new or re-admissions. During weekly follow-up, guidance and recommendations will be provided with compliance validated. 17. Administrative oversight of the facility will be completed by the Vice President of Operations, Nurse Consultant, or Special Projects Administrator daily until removal of the immediacy beginning [DATE], then weekly for four (4) weeks, then monthly. 18. A Quality Assurance meeting will be held weekly until immediacy is removed beginning on [DATE], the for four (4) weeks, then monthly for recommendations and further follow up regarding the stated plan. Based on evaluation, the QA committee will determine at what frequency any ongoing audits will need to continue. The Administrator has the oversight to ensure an effective plan is in place to meet resident well-being and ensure resident rights as well as an effective plan to identify facility concerns and implement a plan of correction to involve all staff of the facility. Corporate Administrative oversight of the Quality Assurance meeting will be completed by the Special projects Administrator, the Regional Vice President of Operations, or a member of regional staff three (3) times a week until immediacy is removed beginning [DATE], then weekly for four (4) weeks, then monthly. The State Survey Agency validated the implementation of the facility's AOC as follows: 1. Review of the facility's investigation of the incident revealed an audit of Resident #1's medical record with areas concern noted. Interview with the DON, on [DATE] at 5:20 PM, revealed she audited Resident #1's medical record and identified areas of concern with immediate implementation of education provided to staff. 2. Review of the facility's audit of all resident's Advance Directive, Care Plans and physician's orders [REDACTED]. Interview with the DON, on [DATE] at 5:20 PM, revealed she had participated with other management staff to audit all resident records to verify accuracy of the resident's Advance Directive, Care Plans and Physician's code status order. 3. Review of the audit tool utilized to interview and assess all residents for possible resident rights violations revealed management staff interviewed all resident's with a Brief Interview for Mental Status (BIMS) score of eight (8) or greater and a physical assessment was completed for resident's whose BIMS was less than eight (8). Interview with the DON, on [DATE] at 5:20 PM, revealed management staff interviewed or assessed each of the facility's residents for any signs or symptoms of resident rights violations. Interview with interviewable residents revealed staff did talk with them regarding their resident rights. 4. The audit tool, dated [DATE], utilized to audit previous thirty (30) days facility new admissions was reviewed. New admissions were audited for compliance with admission process including: Physician notification, review of New Admission physician's orders [REDACTED]. Areas of concern identified with the audit were documentation in relation to missing dates and times on the Nursing Admission Assessment on four (4) residents. Review of the education provided to staff revealed policy and procedures related to accuracy of the admission process and documentation was provided. Review of the staff sign in sheets revealed instruction was provided beginning [DATE] with review of policy and procedure. On [DATE], a more comprehensive education was provided to staff related to the policy and procedure. Interview with the DON, on [DATE] at 5:20 PM, revealed she initiated education to the nursing staff immediately on [DATE]. Per the DON, the Regional Nurse provided comprehensive education to the management staff on [DATE]. Further interview revealed, after receiving the comprehensive education, the management staff were responsible for providing the comprehensive education to the facility's nursing staff. 5. Review of the audit of each resident's medical record to include: Advance Directive, physician's orders [REDACTED]. Interview with the DON, on [DATE] at 5:20 PM, revealed she and other management staff audited each resident's medical record to ensure compliance with quality of care delivery. 6. Review of education provided by the Regional Nurse to all management staff with the sign in sheet dated [DATE] and signed by the Regional Nurse revealed the education provided included: Cardiopulmonary Resuscitation, Advance Directives, Physician Visits and Medical Orders, Admission Criteria, Care Planning - Interdisciplinary Team, Resident Rights, Quality of Care, Professional Standards, and QA. Interview with the Regional Nurse Consultant, on [DATE] at 5:20 PM, revealed he provided comprehensive education to management staff related to the facility's policies and procedures stated above. Continued interview revealed the facility revised the CPR policy to include mandatory hands on skills certification for staff. 7. Review of education provided to all nursing staff to include: Cardiopulmonary Resuscitation, Advance Directives, Physician Visits and Medical Orders, Admission Criteria, Care Planning - Interdisciplinary Team, Resident Rights, Quality of Care, Professional Standards, and QA. Review of sign in sheets revealed the education was initiated on [DATE] and concluded on [DATE]. Review of certified letters sent to twenty-one (21) part-time clinical staff related to mandatory education prior to working. Continued review of sign-in sheets revealed education for part-time clinical staff, non-licensed staff and non-nursing staff continued per AOC. Review of New Orientation Agenda for clinical staff, revealed education would be provided with orientation process. Review of audit tool utilized for validation of CPR certification with hands on skills component revealed staff had obtained education with hands on skill component. Interview, on [DATE] at 10:20 AM with SRNA #8; at 10:30 AM with SRNA #7; at 10:40 AM with SRNA #4; at 10:50 AM with SRNA #2; and, at 11:00 AM with SRNA #6 revealed they had all been provided education related to Cardiopulmonary Resuscitation, Resident Rights, Quality of Care and Professional Standards between [DATE] and [DATE] in a verbal lecture setting allowing for question and answers. Interview, on [DATE] at 5:50 PM with RN #1 and at 6:12 PM with LPN #1; on [DATE] at 11:15 AM with LPN #12; at 11:25 AM with LPN #3; at 4:16 PM with LPN #11; at 4:30 PM with LPN #2; at 4:45 PM with RN #4; at 5:00 PM with RN #2; at 5:17 PM with RN #3; and, Unit Manager #1 at 4:29 PM, revealed they had all been provided education related to Cardiopulmonary Resuscitation, Advance Directives, Physician Visits and Medical Orders, Admission Criteria, Care Planning, Resident Rights, Professional Standards, and Quality of Care in a verbal lecture setting allowing for question and answers. 8. Review of the education provided to all licensed staff related to the admission policy and procedure revealed the education was initiated on [DATE] and completed on [DATE] after additional education was provided by the Regional Nurse Consultant. Interview with the DON, on [DATE] at 5:20 PM, revealed she had initiated staff education on [DATE]. After receiving comprehensive education provided by the Regional Nurse Consultant on [DATE], the management team re-educated staff with the completion date for full-time clinical staff to be [DATE]. 9. Review of the education provided to all Physicians with privileges to included; clarification of the process for notifying the Physician of new admits and obtaining orders, and the Interim Care Plan and Professional Standards. Further review, revealed there was follow up letters sent to each Physician related to the educations provided.

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F 0281 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	(continued... from page 6) 10. Review of the Audit of personnel files for CPR certification revealed the Audit was completed on [DATE] with the Regional Nurse Consultant review on [DATE]. Data from the audit revealed seventeen (17) staff without the hands on skill component for CPR certification. 11. Review of the Audit of personnel files for CPR certifications revealed sixteen (16) of the seventeen (17) identified staff without hands on skill component CPR certifications had obtained certifications with the hands on skills component. Interview with the DON, on [DATE] at 5:20 PM, revealed she was a Certified American Heart CPR Instructor. Further interview revealed, she had conducted four (4) CPR classes for staff that included the hands on skills component. Per interview, one staff still remained out of compliance with the CPR certification hands on component and would not be allowed to work until appropriate certification was obtained. 12. Review of the Daily New Admission Log, revealed new admissions were reviewed daily for compliance with Physician Notification, Physician Orders, Interim Care Plan, Advance Directive, and Resident Rights beginning [DATE]. Interview with the DON on [DATE] at 5:20 PM, revealed areas of concern were identified when the audits were initiated on [DATE]; however, after staff received education, data collected had improved. Further interview revealed any issues identified would be immediately corrected with data reviewed with the QA committee weekly for four (4) weeks, then monthly with the results of the collected data to determine the need for additional education or the revision of the plan. 13. Review of documentation monitoring care delivery as outlined per the resident's care plan, revealed five (5) resident care plans per day per unit were reviewed by management staff beginning [DATE]. Interview with the DON, on [DATE] at 5:20 PM, revealed management staff had audited resident care plans daily. Further interview revealed five (5) care plans were audited on each unit daily since [DATE]. 14. Review of documentation of the Mock codes revealed they were conducted twice weekly on rotating shifts beginning [DATE]. Interview, on [DATE] at 5:50 PM with RN #1 and at 6:12 PM
F 0309 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	**Provide necessary care and services to maintain the highest well being of each resident** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the facility's policy, it was determined the facility failed to have an effective system in place to ensure each resident received Cardiopulmonary Resuscitation (CPR) according to established professional standards, the Advanced Directives, and requested code status, for one (1) of twelve (12) sampled residents (Resident #1). On [DATE], Resident #1's Responsible Party (RP) signed Advance Directives requesting the resident have a Full Code status (Full Code indicates life-saving measures were to be implemented in the event of cardiac or [MEDICAL CONDITION]), to include CPR. However, on [DATE] at approximately 7:15 AM, when State Registered Nursing Assistant (SRNA) #1 entered Resident #1's room and found the resident to be unresponsive, she notified Licensed Practical Nurses (LPNs) #1 and #2, who failed to honor the resident's Advance Directives for Full Code status. LPN #1 entered Resident #1's room, checked Resident #1 for a pulse without success and failed to initiate CPR according to the resident's Advance Directives. LPN #2 entered Resident #1's room, observed LPN #1 checking the resident for a pulse, went to the Nurse's Station and checked the resident's chart for code status and called Registered Nurse (RN) #1. LPN #2 also failed to initiate CPR according to the resident's Advance Directives. RN #1, who was on another unit, arrived to Resident #1's room, assessed the resident to have no heart rate and no respirations and pronounced the resident deceased at 7:23 AM. Per interview, RN #1 determined Resident #1 was Full Code status, but she did not initiate CPR according to the resident's Advance Directives. The facility's failure to provide the necessary care and services related to the resident's requested Full Code status and the provision of CPR, has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on [DATE], and was determined to exist on [DATE]. The facility was notified of the Immediate Jeopardy on [DATE]. The facility provided an acceptable credible Allegation of Compliance (AOC) on [DATE] with the facility alleging removal of the Immediate Jeopardy on [DATE]. The State Survey Agency validated removal of the Immediate Jeopardy as alleged, on [DATE], prior to exit on [DATE], with remaining non-compliance in the area of 42 CFR 483.25 Quality of Care, F-309 at a Scope and Severity of a D while the facility develops and implements a Plan of Correction and the facility's Quality Assurance (QA) monitors to ensure compliance with systemic changes. The findings include: Review of the facility's policy titled Advance Directives - Kentucky, effective ,[DATE], revealed it was the policy of the facility to recognize and support the use of Advance Directives through family, staff and community education, and to encourage the resident's rights to self-determination through recognition and assistance with executing such directives. Further review revealed, all residents would receive full resuscitative measures unless a Do Not Resuscitate (DNR) directive was written in the resident's medical record and was identified in the resident's Advance Directive. Review of the facility's policy, titled Cardiopulmonary Resuscitation, undated, revealed CPR would be attempted for any resident who was found to have no palpable pulse and/or no discernible respirations, unless there was a written physician's orders [REDACTED]. Continued review revealed, should a resident be found unresponsive and without respirations, a licensed staff member who was certified in CPR would promptly initiate CPR for residents who have requested CPR in their advance directive; who have not formulated an advance directive; and, who do not have a valid DNR order or unless it would pose a danger to self or others to initiate CPR. Review of Resident #1's clinical record revealed the facility admitted the resident on [DATE], with [DIAGNOSES REDACTED]. Review of the Advance Directives/Informed Consent, signed by Resident #1's RP on [DATE], revealed the RP had requested and consented in the event of death for staff to use cardiac compressions or artificial ventilation to resuscitate the resident. Review of the Nursing Admission Information dated [DATE], revealed Resident #1's Advance Directives had been completed. Review of the physician's orders [REDACTED].>Review of the Nurse's Note, dated [DATE], not timed, completed by LPN #1, revealed LPN #1 found the resident sitting on the floor next to the bed with blood on the pillow and ear, with no pulse found. However, there was no documented evidence LPN #1 immediately initiated CPR for Resident #1's as per physician's orders [REDACTED]. Review of LPN #1's Interviewer Statement, dated [DATE], documented by the Director of Nursing (DON), revealed LPN #1 found Resident #1 slumped in a sitting position against the low bed leaning toward his/her left side. According to the statement, LPN #1 immediately checked for a carotid pulse with no pulse found. Further review, revealed LPN #2 came into the room and LPN #1 continued assessing Resident #1 and found blood on his/her pillow and coming from the resident's left ear. Further review of the Statement, revealed LPN #1 called for an RN. According to the Statement, after RN #1 arrived, LPN #1 and RN #1 assessed the resident for any type of injury or trauma with no bruises, abrasions or knots noted. Per the Statement, LPN #2 obtained an order from the on-call Physician to withhold CPR related to the resident being deceased . Interview with LPN #1, on [DATE] at 6:12 PM, revealed he was the primary nurse for Resident #1 on the day shift of [DATE]. LPN #1 revealed he was certified to perform CPR; however, when he found Resident #1 on [DATE] around 7:15 AM, he did not initiate CPR. He further stated LPN #2 entered the resident's room behind him and did not initiate CPR, but left the room to call the RN for assistance. LPN #1 revealed, at the time of the incident, he did not know if Resident #1 had a Full Code status and felt the resident required further assessment stating the RN was more qualified to complete that assessment. LPN #1 further stated he was unfamiliar with the facility's policy; however, stated he did not know why he didn't initiate CPR. Review of the Nurse's Note dated [DATE], at 7:23 AM, completed by LPN #2, revealed the resident was found sitting beside the bed with his/her back to the bed, leaning to the left side with wet fresh blood, from the left ear on the pillow, with no pulse, no respirations, no blood pressure and no signs of life. However, there was no documented evidence LPN #2 immediately initiated CPR for Resident #1's as per the resident's physician's orders [REDACTED]. Review of LPN #2's Witness Statement, dated [DATE], revealed Resident #1 had been awake and walking up and down the hallway until 2:50 AM. According to the Statement, Resident #1 was seen during rounds at 5:00 AM lying in his/her bed, sleeping with a baby doll in his/her arms. Further review of the Statement revealed LPN #2 was called to Resident #1's room by a SRNA. LPN #2 found the resident deceased at 7:23 AM. Interview with LPN #2, on [DATE] at 4:31 PM, revealed she had entered Resident #1's room behind LPN #1 and found the resident with no pulse; and although she was certified in CPR, she did not initiate CPR. LPN #2 stated she left the resident's room to go to the nurse's station to check the resident's code status and call the RN. LPN #2 revealed, she identified the resident to be a Full Code status and even though she did not immediately initiate CPR, she did inform LPN #1 and RN #1 of the resident's Advance Directive. LPN #2 stated, the resident was just too far gone. Per interview LPN #2

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	185146	A. BUILDING _____ B. WING _____	**09/03/2015**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FOUNTAIN CIRCLE CARE & REHABILITATION CENTER	**200 GLENWAY ROAD WINCHESTER, KY 40391**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0309 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 7) notified the on-call Physician the resident had expired and the RN had decided the resident was too far gone to perform CPR. LPN #2 further stated she thought she informed the physician of the resident's Full Code status with the Physician's verbal response to be Oh no, OK. Continued interview revealed the Physician did not state to her to withhold CPR. LPN #2 revealed per the facility's policy, CPR should have been initiated for Resident #1. Interview with the on-call Physician, on [DATE] at 8:13 AM, revealed he was notified by the facility of Resident #1's death; however, he was not informed Resident #1 had a Full Code status and he did not give an order for [REDACTED]. Further review of the Nurse's Notes, revealed a Note dated [DATE], at 7:30 AM, completed by RN #1, which revealed Resident #1 was sitting on the floor with his/her back to the bed and leaning to the left side with blood from his/her left ear with no heart rate and no respirations. According to the Note, Resident #1 was pronounced deceased at 7:23 AM; however, there was no documented evidence RN #1 immediately initiated CPR as per Resident #1's physician's orders [REDACTED]. Review of RN #1's Witness Statement, dated [DATE], revealed the nurse was called to another unit at approximately 7:15 AM to pronounce the passing of a resident. Per the Statement, upon entering Resident #1's room, the resident was observed to be in a sitting position on the floor with his/her back against the bed. The Statement revealed Resident #1 was cold to touch with no respirations, no audible or palpable heart rate, color was pale and mottled with no obvious injuries. According to the Statement, RN #1 pronounced death at 7:23 AM. Interview with RN #1, on [DATE] at 5:50 PM, revealed she was working on another unit and responded to a call from LPN #2 on [DATE] around 7:10 AM or 7:15 AM, requesting a nurse to pronounce a resident deceased . Continued interview revealed with RN #1 revealed on arrival to Resident #1's room she assessed the resident and pronounced the resident deceased at 7:23 AM. RN #1 revealed she was not aware Resident #1 was a Full Code status until she went to the nurse's station to document her assessment; however, she did not initiate CPR because in my nursing opinion, (she/he) had been passed for a while. Continued interview revealed, it was the facility's policy to initiate CPR when a resident was found in [MEDICAL CONDITION] or unresponsive and was a Full Code status. However, RN #1 revealed she did not follow the facility's policy. Interview with the Director of Nursing (DON), on [DATE] at 3:09 PM, revealed the facility's policy related to resuscitation of a resident was to immediately initiate CPR for a resident found unresponsive without a pulse or respirations and to continue CPR until the Physician gave an order to stop, or Emergency Medical Services (EMS) arrived to transport the resident to the hospital. Continued interview revealed, staff should not with hold CPR while attempting to contact the resident's Physician. Per interview, staff did not follow the facility's policies and CPR should have been immediately initiated for Resident #1 when he/she was found unresponsive. Interview with the Administrator, on [DATE] at 4:50 PM, revealed staff did not follow the facility's policy related to the initiation of CPR. Per interview, her expectation was for staff to initiate CPR immediately for any Full Code status resident found to be unresponsive and without signs of life. The Administrator stated LPN #1, LPN #2 and RN #1 should have initiated CPR for Resident #1, who was a Full Code, when they found the resident non-responsive. The facility provided an acceptable credible Allegation of Compliance (AOC) on [DATE], which alleged removal of the IJ effective [DATE]. Review of the AOC revealed the facility implemented the following: 1. On [DATE], the Director of Nursing (DON) reviewed Resident #1's medical record and care plan with the following areas of concern identified: a. The date and time were missing regarding the Physician notification on the Nursing Admission Assessment b. the Advance Directive of Full Code status was not care planned on the Interim Care Plan. c. CPR was not immediately initiated per Resident #1's/Power of Attorney's (POA's) request as indicated on the Advance Directive. 2. Beginning [DATE] and concluding on [DATE], the DON, Unit Managers, Nursing Supervisors or Medical Records staff audited all resident Advance Directive/Code Status/physician's orders [REDACTED]. 3. Beginning [DATE] and concluding on [DATE], the DON, Assistant Director of Nursing (ADON), Unit Managers and Nursing Supervisors assessed all residents for any possible resident rights violations. Residents with a Brief Interview of Mental Status (BIMS) score of eight (8) or greater were interviewed and residents with a BIMS of less than eight (8) were physically assessed for any signs and symptoms of possible quality of life or resident rights violations. 4. Compliance audits of the admission process were completed by [DATE] of all admissions within the previous thirty (30) days. The audits were performed by the DON, ADON, Unit Managers or Nursing Supervisors of all resident's medical records to include notification of the Attending Physician, review of the Physician Admitting Orders with the Attending Physician and ensuring professional standards were followed. 5. The DON, Unit Managers, Nursing Supervisors or Medical Records staff completed audits of all resident charts by [DATE]. The Audit included; resident's Advance Directive, physician's orders [REDACTED]. 6. On [DATE], all management staff was educated by the Regional Nurse Consultant. Education included: Advance Directive Policy and Procedure, Admission/physician's orders [REDACTED]. 7. Education for all nursing staff was initiated on [DATE] and completed by [DATE], with the exception of four (4) full-time status staff on leave and twenty-one (21) part-time staff. Certified letters were sent to the twenty-one (21) part-time staff to notify each of the mandatory education prior to returning to duty. Education was provided by the Staff Development Coordinator, Unit Mangers and Nursing Supervisors. Education included Advance Directive Policy and Procedure, Admission/Physician order [REDACTED]. The education related to the policies and procedures was added to the training agenda for New Employee Orientation. 8. Beginning [DATE] and concluding on [DATE], the Staff Development Coordinator, Unit Managers and Nursing Supervisors conducted education for all licensed staff (with the exception of the part-time staff who were notified by certified letter they could not work until receiving the required education) on the admission policy and procedure, to include: clarification of the process for Physician notification of new admissions, obtaining admission orders [REDACTED]. The above education was incorporated into the facility's New Employee Orientation. 9. On [DATE], all Physicians with privileges at the facility were educated by the DON in regards to the admission process and expectations with compliance to include: Discharge Summaries or Orders from a discharging facility would be faxed to the Physician's office and the Physician would be called for approval of the Orders with a Telephone Order written stating the Physician's review and approval of the Orders. 10. Human Resources and/or Staff Development performed audits of all personnel files for CPR certifications. Audits were completed by [DATE] and given to the Regional Nurse Consultant to review for non-compliance with CPR regulations. Seventeen (17) licensed nurses were noted to have on-line only CPR certifications. 11. Sixteen (16) of the seventeen (17) staff identified to have on-line CPR certifications received CPR instruction with hands on component by [DATE], provided by the DON, a certified American Heart CPR Instructor. One (1) employee would not be allowed to work until CPR certification with hands on component was obtained. 12. Beginning [DATE], the DON, ADON, Unit Manager, Nursing Supervisor or Medical Records staff will review all new admissions daily during the morning clinical meeting to ensure compliance with Physician notification, Physician Orders, Interim Care Plan, Advance Directive, and Resident Rights. Findings of the review will be reported in the Quality Assurance (QA) committee meeting. The committee consists of the Medical Director, Administrator, DON, Social Services Director and at least two (2) other department managers, different line staff as appropriate, and outside consultants as appropriate. The committee will meet weekly for four (4) weeks then monthly to determine the need for continued education or revision of the plan. Based on evaluation, the QA committee will determine at what frequency the ongoing review of new admissions will need to continue. Concerns identified will be corrected immediately by the DON, ADON, Unit Managers or Nursing Supervisor and reported to the Administrator to ensure any needed investigation initiated and reported guidelines were met. 13. The DON, ADON, Unit Managers, or Nursing Supervisor will monitor care delivery as outlined per the care plan on five (5) residents per unit per day until immediacy is removed, beginning [DATE], then five (5) residents daily for four (4) weeks, to ensure compliance with care delivery as outlined by the Care Plan along with compliance of Professional Standards requirements. Findings will be reported in the QA committee weekly to determine the further need of continued education or the revision of the plan. 14. Mock codes will be conducted by the DON, ADON, Unit Managers, Staff Development Coordinator or Nursing Supervisor twice weekly, on rotating shifts, for four (4) weeks beginning [DATE], to ensure understanding and compliance with Code Blue Policy and Procedure. The first two (2) mock codes were conducted by Clinical Managers for education on how to conduct a code; the Mock codes will be conducted by the nurses. Findings will be reported to the QA committee weekly to determine compliance and any further need of continued education or revision of the plan. 15. The DON, Staff Development Coordinator or Human Resources will track all licensed nurses CPR certification monthly

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F 0309 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 8) beginning [DATE], to ensure compliance with CPR policy, procedure and governing regulations. Findings and compliance will be reported monthly to the QA committee to determine any need for education or revision of the process. 16. A Regional Nurse or corporate office staff was on site since [DATE] and will remain on site daily until immediacy is removed, then will be on site three (3) times weekly for four (4) weeks. Regional/Corporate staff will review compliance with the plan and will review compliance with policy and procedure of any code blue that occurs and review compliance with new or re-admissions. During weekly follow-up, guidance and recommendations will be provided with compliance validated. 17. Administrative oversight of the facility will be completed by the Vice President of Operations, Nurse Consultant, or Special Projects Administrator daily until removal of the immediacy beginning [DATE], then weekly for four (4) weeks, then monthly. 18. A Quality Assurance meeting will be held weekly until immediacy is removed beginning on [DATE], the for four (4) weeks, then monthly for recommendations and further follow up regarding the stated plan. Based on evaluation, the QA committee will determine at what frequency any ongoing audits will need to continue. The Administrator has the oversight to ensure an effective plan is in place to meet resident well-being and ensure resident rights as well as an effective plan to identify facility concerns and implement a plan of correction to involve all staff of the facility. Corporate Administrative oversight of the Quality Assurance meeting will be completed by the Special projects Administrator, the Regional Vice President of Operations, or a member of regional staff three (3) times a week until immediacy is removed beginning [DATE], then weekly for four (4) weeks, then monthly. The State Survey Agency validated the implementation of the facility's AOC as follows: 1. Review of the facility's investigation of the incident revealed an audit of Resident #1's medical record with areas concern noted. Interview with the DON, on [DATE] at 5:20 PM, revealed she audited Resident #1's medical record and identified areas of concern with immediate implementation of education provided to staff. 2. Review of the facility's audit of all resident's Advance Directive, Care Plans and physician's orders [REDACTED]. Interview with the DON, on [DATE] at 5:20 PM, revealed she had participated with other management staff to audit all resident records to verify accuracy of the resident's Advance Directive, Care Plans and Physician's code status order. 3. Review of the audit tool utilized to interview and assess all residents for possible resident rights violations revealed management staff interviewed all resident's with a Brief Interview for Mental Status (BIMS) score of eight (8) or greater and a physical assessment was completed for resident's whose BIMS was less than eight (8). Interview with the DON, on [DATE] at 5:20 PM, revealed management staff interviewed or assessed each of the facility's residents for any signs or symptoms of resident rights violations. Interview with interviewable residents revealed staff did talk with them regarding their resident rights. 4. The audit tool, dated [DATE], utilized to audit previous thirty (30) days facility new admissions was reviewed. New admissions were audited for compliance with admission process including: Physician notification, review of New Admission physician's orders [REDACTED]. Areas of concern identified with the audit were documentation in relation to missing dates and times on the Nursing Admission Assessment on four (4) residents. Review of the education provided to staff revealed policy and procedures related to accuracy of the admission process and documentation was provided. Review of the staff sign in sheets revealed instruction was provided beginning [DATE] with review of policy and procedure. On [DATE], a more comprehensive education was provided to staff related to the policy and procedure. Interview with the DON, on [DATE] at 5:20 PM, revealed she initiated education to the nursing staff immediately on [DATE]. Per the DON, the Regional Nurse provided comprehensive education to the management staff on [DATE]. Further interview revealed, after receiving the comprehensive education, the management staff were responsible for providing the comprehensive education to the facility's nursing staff. 5. Review of the audit of each resident's medical record to include: Advance Directive, physician's orders [REDACTED]. Interview with the DON, on [DATE] at 5:20 PM, revealed she and other management staff audited each resident's medical record to ensure compliance with quality of care delivery. 6. Review of education provided by the Regional Nurse to all management staff with the sign in sheet dated [DATE] and signed by the Regional Nurse revealed the education provided included: Cardiopulmonary Resuscitation, Advance Directives, Physician Visits and Medical Orders, Admission Criteria, Care Planning - Interdisciplinary Team, Resident Rights, Quality of Care, Professional Standards, and QA. Interview with the Regional Nurse Consultant, on [DATE] at 5:20 PM, revealed he provided comprehensive education to management staff related to the facility's policies and procedures stated above. Continued interview revealed the facility revised the CPR policy to include mandatory hands on skills certification for staff. 7. Review of education provided to all nursing staff to include: Cardiopulmonary Resuscitation, Advance Directives, Physician Visits and Medical Orders, Admission Criteria, Care Planning - Interdisciplinary Team, Resident Rights, Quality of Care, Professional Standards, and QA. Review of sign in sheets revealed the education was initiated on [DATE] and concluded on [DATE]. Review of certified letters sent to twenty-one (21) part-time clinical staff related to mandatory education prior to working. Continued review of sign-in sheets revealed education for part-time clinical staff, non-licensed staff and non-nursing staff continued per AOC. Review of New Orientation Agenda for clinical staff, revealed education would be provided with orientation process. Review of audit tool utilized for validation of CPR certification with hands on skills component revealed staff had obtained education with hands on skill component. Interview, on [DATE] at 10:20 AM with SRNA #8; at 10:30 AM with SRNA #7; at 10:40 AM with SRNA #4; at 10:50 AM with SRNA #2; and, at 11:00 AM with SRNA #6 revealed they had all been provided education related to Cardiopulmonary Resuscitation, Resident Rights, Quality of Care and Professional Standards between [DATE] and [DATE] in a verbal lecture setting allowing for question and answers. Interview, on [DATE] at 5:50 PM with RN #1 and at 6:12 PM with LPN #1; on [DATE] at 11:15 AM with LPN #12; at 11:25 AM with LPN #3; at 4:16 PM with LPN #11; at 4:30 PM with LPN #2; at 4:45 PM with RN #4; at 5:00 PM with RN #2; at 5:17 PM with RN #3; and, Unit Manager #1 at 4:29 PM, revealed they had all been provided education related to Cardiopulmonary Resuscitation, Advance Directives, Physician Visits and Medical Orders, Admission Criteria, Care Planning, Resident Rights, Professional Standards, and Quality of Care in a verbal lecture setting allowing for question and answers. 8. Review of the education provided to all licensed staff related to the admission policy and procedure revealed the education was initiated on [DATE] and completed on [DATE] after additional education was provided by the Regional Nurse Consultant. Interview with the DON, on [DATE] at 5:20 PM, revealed she had initiated staff education on [DATE]. After receiving comprehensive education provided by the Regional Nurse Consultant on [DATE], the management team re-educated staff with the completion date for full-time clinical staff to be [DATE]. 9. Review of the education provided to all Physicians with privileges to included; clarification of the process for notifying the Physician of new admits and obtaining orders, and the Interim Care Plan and Professional Standards. Further review, revealed there was follow up letters sent to each Physician related to the educations provided. 10. Review of the Audit of personnel files for CPR certification revealed the Audit was completed on [DATE] with the Regional Nurse Consultant review on [DATE]. Data from the audit revealed seventeen (17) staff without the hands on skill component for CPR certification. 11. Review of the Audit of personnel files for CPR certifications revealed sixteen (16) of the seventeen (17) identified staff without hands on skill component CPR certifications had obtained certifications with the hands on skills component. Interview with the DON, on [DATE] at 5:20 PM, revealed she was a Certified American Heart CPR Instructor. Further interview revealed, she had conducted four (4) CPR classes for staff that included the hands on skills component. Per interview, one staff still remained out of compliance with the CPR certification hands on component and would not be allowed to work until appropriate certification was obtained. 12. Review of the Daily New Admission Log, revealed new admissions were reviewed daily for compliance with Physician Notification, Physician Orders, Interim Care Plan, Advance Directive, and Resident Rights beginning [DATE]. Interview with the DON on [DATE] at 5:20 PM, revealed areas of concern were identified when the audits were initiated on [DATE]; however, after staff received education, data collected had improved. Further interview revealed any issues identified would be immediately corrected with data reviewed with the QA committee weekly for four (4) weeks, then monthly with the results of the collected data to determine the need for additional education or the revision of the plan.

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F 0309 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	(continued... from page 9) 13. Review of documentation monitoring care delivery as outlined per the resident's care plan, revealed five (5) resident care plans per day per unit were reviewed by management staff beginning [DATE]. Interview with the DON, on [DATE] at 5:20 PM, revealed management staff had audited resident care plans daily. Further interview revealed five (5) care plans were audited on each unit daily since [DATE]. 14. Review of documentation of the Mock codes revealed they were conducted twice weekly on rotating shifts beginning [DATE]. Interview, on [DATE] at 5:50 PM with RN #1 and at 6:12 PM with LPN #1; on [DATE] at 11:15 AM with LPN #12; at 11:25 AM with LPN #3; at 4:16 PM with LPN #11; at 4:30 PM with LPN #2; at 4:45 PM with RN #4; at 5:00 PM with RN #2; at 5:17 PM with RN #3; and, Unit Manager #1 at 4:29 PM, revealed they had all been provided education related to Cardiopulmonary Resuscitation and Advance Directives with Mock Codes conducted on different shifts. 15. Review of documentation of CPR certification tracking revealed the date the certification was obtained and verification the certification contained a hands on skills component. Interview with the DON, on [DATE] at 5:20 PM, revealed the facility had previously been tracking CPR expiration dates; however, the facility added verification of a hands on skills component to their tracking data to ensure compliance. 16. Review of the documentation of a calendar, signed by the Regional Nurse and Regional Vice President of Operations revealed the Regional Vice President of Operations was on site [DATE] and [DATE]. Further review revealed, the Regional Nurse was on site daily from [DATE] to [DATE] with the exception of [DATE]. Interview with the Regional Nurse, on [DATE] at 5:20 PM, revealed he had been in the facility each day with the exception of [DATE]. Interview with the Administrator on [DATE] at 5:20 PM, revealed the Regional Nurse had been on site daily since [DATE] with the exception of [DATE]. Interview with Unit Manager #1, on [DATE] at 4:29 PM, revealed the Regional Nurse had been on site seemed like daily for over two (2) weeks. 17. Review of documentation of a calendar, signed by the Regional Nurse and Regional Vice President of Operations revealed on site Administrative oversight was performed by the Regional Vice President of Operations on [DATE] and [DATE]. Further review revealed, on site Administrative oversight was performed by the Regional Nurse on each day from [DATE] to [DATE], with the exception of [DATE]. Interview with the Regional Nurse, on [DATE] at 5:20 PM, revealed he had been on site at the facility daily since [DATE] with the exception of [DATE]. Interview with the Ad
F 0385 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	**Make sure that a doctor approves a resident's admission in writing and that each resident remains under the care of a doctor.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review and review of the facility's policy, it was determined the facility failed to have an effective system to ensure a Physician provided written recommendation for admittance to the facility, and failed to ensure each resident was supervised by a physician, for one (1) of twelve (12) sampled residents (Resident #1). Resident #1 was admitted by the facility on [DATE]; however, there was no documented evidence the Physician was aware of the resident's admission. Additionally, on [DATE], Resident #1 was found to be unresponsive, and without a pulse or respirations. Staff notified the on-call Physician of Resident #1's death; however, staff failed to inform the Physician the resident was a Full Code status and CPR was not performed. The facility's failure to notify the Attending Physician of a resident's admission, and failure to provide relative information when the Physician was notified, has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on [DATE], and was determined to exist on [DATE]. The facility was notified of the Immediate jeopardy on [DATE]. The facility provided an acceptable credible Allegation of Compliance (AOC) on [DATE] with the facility alleging removal of the Immediate Jeopardy on [DATE]. The State Survey Agency validated removal of the Immediate Jeopardy as alleged on [DATE], prior to exit on [DATE], with remaining non-compliance in the area of 42 CFR 483.40 Physician Services, F-385 at a Scope and Severity of a D while the facility develops and implements a Plan of Correction and the facility's Quality Assurance (QA) monitors to ensure compliance with systemic changes. The findings include: Review of the facility's policy titled Physician Visits and Medical Orders, effective ,[DATE], revealed all residents admitted to the facility would be under the direct supervision of a member of the active medical staff who had delineated clinical privileges to admit residents to the facility. Continued review revealed the Attending Physician would directly supervise the activities related to treatment of [REDACTED]. Review of the facility's policy titled Admission Criteria, undated, revealed prior to or at the time of admission, the resident's Attending Physician would provide the facility with information needed for the care of the resident, to include at least: diet, medication orders, Advance Directive, allergies [REDACTED]. Review of the facility's policy titled Telephone Orders, undated, revealed each entry should contain the instructions from the Physician, and should include the date, time, and signature and title of the person transcribing the information. Review of the medical record revealed the facility admitted Resident #1 from the hospital on [DATE], with [DIAGNOSES REDACTED]. Review of the Nursing Admission Information form, dated [DATE], revealed Resident #1 was admitted to the facility under the care of Attending Physician (AP) #1, on [DATE] at 6:40 PM; however, there was no documented evidence the AP was notified of the resident's admission. Interview with Registered Nurse (RN) #2, on [DATE] at 3:21 PM, revealed she did assess residents for admission to the facility. Continued interview revealed the facility's practice included notification of the Attending Physician upon the resident's arrival. RN #2 explained when residents were transferred to the facility from an acute care facility (hospital), they arrived with a Discharge Summary from the acute care facility. RN #2 stated this summary was to be faxed to the Attending Physician's office as notification of the resident's arrival. RN #2 further stated staff should follow-up with the Physician via telephone to verify the orders on the Discharge Summary were to be continued at the facility. Interview with AP #1, on [DATE] at 10:37 AM, revealed he was on-call on [DATE] but did not receive notification Resident #1 was admitted to the facility. Further interview revealed Resident #1 was not a previous patient of his and he was not familiar with the resident's medical history. Continued interview revealed AP #1 was not informed of Resident #1's admission until [DATE], after the resident had expired. AP #1 stated it was his expectation for staff to notify him when a resident arrived at the facility in order to verify the admitting orders with staff. AP #1 further stated notification was essential to enable him to have oversight of the resident's care. Continued review of Resident #1's medical record revealed an Advance Directives/Informed Consent, signed and dated [DATE] by Resident #1's Responsible Party (RP). According to the consent form, the RP requested and consented to the use of cardiac compressions or artificial ventilation (Full Code) to resuscitate the resident in the event of death. Review of the physician's orders [REDACTED].#2, revealed a telephone order was received from Resident #1's on-call Physician to withhold CPR (cardiopulmonary resuscitation). Continued review revealed the order was given related to resident already deceased when found, no heart rate, no respirations, and cool to touch. Interview with LPN #2, on [DATE] at 4:31 PM, revealed she contacted the on-call Physician to notify him of Resident #1's death. Continued interview revealed she informed the Physician the RN had decided the resident was too far gone for CPR. She stated she thought she had advised him the resident was a Full Code status. Continued interview revealed the Physician responded, Oh, no .OK, but did not say to withhold CPR. Interview with the on-call Physician, on [DATE] at 12:07 PM, revealed he was notified by the facility on [DATE] around 7:30 AM of Resident #1's death. Continued interview revealed staff did not inform him Resident #1 was a Full Code, and he did not give an order to withhold CPR. Further interview revealed his expectation was for staff to initiate CPR for a resident with a Full Code status, notify Emergency Medical Services (EMS)for transfer to a hospital, and then call to notify him (the Physician) of the resident's change in condition. Interview with the Director of Nursing (DON), on [DATE] at 3:09 PM, revealed she was not aware Resident #1's AP was not notified by staff of the resident's admission on [DATE]. She stated the facility's process for new admissions was for the nurse to notify the AP when the resident arrived at the facility and verify the admission orders [REDACTED]. Per interview,

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	185146	A. BUILDING _____ B. WING _____	09/03/2015

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FOUNTAIN CIRCLE CARE & REHABILITATION CENTER	200 GLENWAY ROAD WINCHESTER, KY 40391

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0385 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 10) staff should completely inform the Physician of a resident's status and document exactly what the physician orders. Interview with the Administrator, on [DATE] at 4:50 PM, revealed her expectation was for staff to notify the Attending Physician to verify orders when the resident arrived to the facility. Continued interview revealed should a resident be transferred from another facility, the Discharge Summary could be utilized as admission orders [REDACTED]. Further interview revealed the Administrator's expectation for staff to fully inform the Physician when making notification of a change in status, and to write orders as stated by the Physician. The facility provided an acceptable credible Allegation of Compliance (AOC) on [DATE], which alleged removal of the IJ effective [DATE]. Review of the AOC revealed the facility implemented the following: 1. On [DATE], the Director of Nursing (DON) reviewed Resident #1's medical record and care plan with the following areas of concern identified: a. The date and time were missing regarding the Physician notification on the Nursing Admission Assessment b. the Advance Directive of Full Code status was not care planned on the Interim Care Plan. c. CPR was not immediately initiated per Resident #1's/Power of Attorney's (POA's) request as indicated on the Advance Directive. 2. Beginning [DATE] and concluding on [DATE], the DON, Unit Managers, Nursing Supervisors or Medical Records staff audited all resident Advance Directive/Code Status/physician's orders [REDACTED]. 3. Beginning [DATE] and concluding on [DATE], the DON, Assistant Director of Nursing (ADON), Unit Managers and Nursing Supervisors assessed all residents for any possible resident rights violations. Residents with a Brief Interview of Mental Status (BIMS) score of eight (8) or greater were interviewed and residents with a BIMS of less than eight (8) were physically assessed for any signs and symptoms of possible quality of life or resident rights violations. 4. Compliance audits of the admission process were completed by [DATE] of all admissions within the previous thirty (30) days. The audits were performed by the DON, ADON, Unit Managers or Nursing Supervisors of all resident's medical records to include notification of the Attending Physician, review of the Physician Admitting Orders with the Attending Physician and ensuring professional standards were followed. 5. The DON, Unit Managers, Nursing Supervisors or Medical Records staff completed audits of all resident charts by [DATE]. The Audit included; resident's Advance Directive, physician's orders [REDACTED]. 6. On [DATE], all management staff was educated by the Regional Nurse Consultant. Education included: Advance Directive Policy and Procedure, Admission/physician's orders [REDACTED]. 7. Education for all nursing staff was initiated on [DATE] and completed by [DATE], with the exception of four (4) full-time status staff on leave and twenty-one (21) part-time staff. Certified letters were sent to the twenty-one (21) part-time staff to notify each of the mandatory education prior to returning to duty. Education was provided by the Staff Development Coordinator, Unit Mangers and Nursing Supervisors. Education included Advance Directive Policy and Procedure, Admission/Physician order [REDACTED]. The education related to the policies and procedures was added to the training agenda for New Employee Orientation. 8. Beginning [DATE] and concluding on [DATE], the Staff Development Coordinator, Unit Managers and Nursing Supervisors conducted education for all licensed staff (with the exception of the part-time staff who were notified by certified letter they could not work until receiving the required education) on the admission policy and procedure, to include: clarification of the process for Physician notification of new admissions, obtaining admission orders [REDACTED]. The above education was incorporated into the facility's New Employee Orientation. 9. On [DATE], all Physicians with privileges at the facility were educated by the DON in regards to the admission process and expectations with compliance to include: Discharge Summaries or Orders from a discharging facility would be faxed to the Physician's office and the Physician would be called for approval of the Orders with a Telephone Order written stating the Physician's review and approval of the Orders. 10. Human Resources and/or Staff Development performed audits of all personnel files for CPR certifications. Audits were completed by [DATE] and given to the Regional Nurse Consultant to review for non-compliance with CPR regulations. Seventeen (17) licensed nurses were noted to have on-line only CPR certifications. 11. Sixteen (16) of the seventeen (17) staff identified to have on-line CPR certifications received CPR instruction with hands on component by [DATE], provided by the DON, a certified American Heart CPR Instructor. One (1) employee would not be allowed to work until CPR certification with hands on component was obtained. 12. Beginning [DATE], the DON, ADON, Unit Manager, Nursing Supervisor or Medical Records staff will review all new admissions daily during the morning clinical meeting to ensure compliance with Physician notification, Physician Orders, Interim Care Plan, Advance Directive, and Resident Rights. Findings of the review will be reported in the Quality Assurance (QA) committee meeting. The committee consists of the Medical Director, Administrator, DON, Social Services Director and at least two (2) other department managers, different line staff as appropriate, and outside consultants as appropriate. The committee will meet weekly for four (4) weeks then monthly to determine the need for continued education or revision of the plan. Based on evaluation, the QA committee will determine at what frequency the ongoing review of new admissions will need to continue. Concerns identified will be corrected immediately by the DON, ADON, Unit Managers or Nursing Supervisor and reported to the Administrator to ensure any needed investigation initiated and reported guidelines were met. 13. The DON, ADON, Unit Managers, or Nursing Supervisor will monitor care delivery as outlined per the care plan on five (5) residents per unit per day until immediacy is removed, beginning [DATE], then five (5) residents daily for four (4) weeks, to ensure compliance with care delivery as outlined by the Care Plan along with compliance of Professional Standards requirements. Findings will be reported in the QA committee weekly to determine the further need of continued education or the revision of the plan. 14. Mock codes will be conducted by the DON, ADON, Unit Managers, Staff Development Coordinator or Nursing Supervisor twice weekly, on rotating shifts, for four (4) weeks beginning [DATE], to ensure understanding and compliance with Code Blue Policy and Procedure. The first two (2) mock codes were conducted by Clinical Managers for education on how to conduct a code; the Mock codes will be conducted by the nurses. Findings will be reported to the QA committee weekly to determine compliance and any further need of continued education or revision of the plan. 15. The DON, Staff Development Coordinator or Human Resources will track all licensed nurses CPR certification monthly beginning [DATE], to ensure compliance with CPR policy, procedure and governing regulations. Findings and compliance will be reported monthly to the QA committee to determine any need for education or revision of the process. 16. A Regional Nurse or corporate office staff was on site since [DATE] and will remain on site daily until immediacy is removed, then will be on site three (3) times weekly for four (4) weeks. Regional/Corporate staff will review compliance with the plan and will review compliance with policy and procedure of any code blue that occurs and review compliance with new or re-admissions. During weekly follow-up, guidance and recommendations will be provided with compliance validated. 17. Administrative oversight of the facility will be completed by the Vice President of Operations, Nurse Consultant, or Special Projects Administrator daily until removal of the immediacy beginning [DATE], then weekly for four (4) weeks, then monthly. 18. A Quality Assurance meeting will be held weekly until immediacy is removed beginning on [DATE], the for four (4) weeks, then monthly for recommendations and further follow up regarding the stated plan. Based on evaluation, the QA committee will determine at what frequency any ongoing audits will need to continue. The Administrator has the oversight to ensure an effective plan is in place to meet resident well-being and ensure resident rights as well as an effective plan to identify facility concerns and implement a plan of correction to involve all staff of the facility. Corporate Administrative oversight of the Quality Assurance meeting will be completed by the Special projects Administrator, the Regional Vice President of Operations, or a member of regional staff three (3) times a week until immediacy is removed beginning [DATE], then weekly for four (4) weeks, then monthly. The State Survey Agency validated the implementation of the facility's AOC as follows: 1. Review of the facility's investigation of the incident revealed an audit of Resident #1's medical record with areas concern noted. Interview with the DON, on [DATE] at 5:20 PM, revealed she audited Resident #1's medical record and identified areas of concern with immediate implementation of education provided to staff. 2. Review of the facility's audit of all resident's Advance Directive, Care Plans and physician's orders [REDACTED]. Interview with the DON, on [DATE] at 5:20 PM, revealed she had participated with other management staff to audit all resident records to verify accuracy of the resident's Advance Directive, Care Plans and Physician's code status order. 3. Review of the audit tool utilized to interview and assess all residents for possible resident rights violations revealed

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0385 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 11) management staff interviewed all resident's with a Brief Interview for Mental Status (BIMS) score of eight (8) or greater and a physical assessment was completed for resident's whose BIMS was less than eight (8). Interview with the DON, on [DATE] at 5:20 PM, revealed management staff interviewed or assessed each of the facility's residents for any signs or symptoms of resident rights violations. Interview with interviewable residents revealed staff did talk with them regarding their resident rights. 4. The audit tool, dated [DATE], utilized to audit previous thirty (30) days facility new admissions was reviewed. New admissions were audited for compliance with admission process including: Physician notification, review of New Admission physician's orders [REDACTED]. Areas of concern identified with the audit were documentation in relation to missing dates and times on the Nursing Admission Assessment on four (4) residents. Review of the education provided to staff revealed policy and procedures related to accuracy of the admission process and documentation was provided. Review of the staff sign in sheets revealed instruction was provided beginning [DATE] with review of policy and procedure. On [DATE], a more comprehensive education was provided to staff related to the policy and procedure. Interview with the DON, on [DATE] at 5:20 PM, revealed she initiated education to the nursing staff immediately on [DATE]. Per the DON, the Regional Nurse provided comprehensive education to the management staff on [DATE]. Further interview revealed, after receiving the comprehensive education, the management staff were responsible for providing the comprehensive education to the facility's nursing staff. 5. Review of the audit of each resident's medical record to include: Advance Directive, physician's orders [REDACTED]. Interview with the DON, on [DATE] at 5:20 PM, revealed she and other management staff audited each resident's medical record to ensure compliance with quality of care delivery. 6. Review of education provided by the Regional Nurse to all management staff with the sign in sheet dated [DATE] and signed by the Regional Nurse revealed the education provided included: Cardiopulmonary Resuscitation, Advance Directives, Physician Visits and Medical Orders, Admission Criteria, Care Planning - Interdisciplinary Team, Resident Rights, Quality of Care, Professional Standards, and QA. Interview with the Regional Nurse Consultant, on [DATE] at 5:20 PM, revealed he provided comprehensive education to management staff related to the facility's policies and procedures stated above. Continued interview revealed the facility revised the CPR policy to include mandatory hands on skills certification for staff. 7. Review of education provided to all nursing staff to include: Cardiopulmonary Resuscitation, Advance Directives, Physician Visits and Medical Orders, Admission Criteria, Care Planning - Interdisciplinary Team, Resident Rights, Quality of Care, Professional Standards, and QA. Review of sign in sheets revealed the education was initiated on [DATE] and concluded on [DATE]. Review of certified letters sent to twenty-one (21) part-time clinical staff related to mandatory education prior to working. Continued review of sign-in sheets revealed education for part-time clinical staff, non-licensed staff and non-nursing staff continued per AOC. Review of New Orientation Agenda for clinical staff, revealed education would be provided with orientation process. Review of audit tool utilized for validation of CPR certification with hands on skills component revealed staff had obtained education with hands on skill component. Interview, on [DATE] at 10:20 AM with SRNA #8; at 10:30 AM with SRNA #7; at 10:40 AM with SRNA #4; at 10:50 AM with SRNA #2; and, at 11:00 AM with SRNA #6 revealed they had all been provided education related to Cardiopulmonary Resuscitation, Resident Rights, Quality of Care and Professional Standards between [DATE] and [DATE] in a verbal lecture setting allowing for question and answers. Interview, on [DATE] at 5:50 PM with RN #1 and at 6:12 PM with LPN #1; on [DATE] at 11:15 AM with LPN #12; at 11:25 AM with LPN #3; at 4:16 PM with LPN #11; at 4:30 PM with LPN #2; at 4:45 PM with RN #4; at 5:00 PM with RN #2; at 5:17 PM with RN #3; and, Unit Manager #1 at 4:29 PM, revealed they had all been provided education related to Cardiopulmonary Resuscitation, Advance Directives, Physician Visits and Medical Orders, Admission Criteria, Care Planning, Resident Rights, Professional Standards, and Quality of Care in a verbal lecture setting allowing for question and answers. 8. Review of the education provided to all licensed staff related to the admission policy and procedure revealed the education was initiated on [DATE] and completed on [DATE] after additional education was provided by the Regional Nurse Consultant. Interview with the DON, on [DATE] at 5:20 PM, revealed she had initiated staff education on [DATE]. After receiving comprehensive education provided by the Regional Nurse Consultant on [DATE], the management team re-educated staff with the completion date for full-time clinical staff to be [DATE]. 9. Review of the education provided to all Physicians with privileges to included; clarification of the process for notifying the Physician of new admits and obtaining orders, and the Interim Care Plan and Professional Standards. Further review, revealed there was follow up letters sent to each Physician related to the educations provided. 10. Review of the Audit of personnel files for CPR certification revealed the Audit was completed on [DATE] with the Regional Nurse Consultant review on [DATE]. Data from the audit revealed seventeen (17) staff without the hands on skill component for CPR certification. 11. Review of the Audit of personnel files for CPR certifications revealed sixteen (16) of the seventeen (17) identified staff without hands on skill component CPR certifications had obtained certifications with the hands on skills component. Interview with the DON, on [DATE] at 5:20 PM, revealed she was a Certified American Heart CPR Instructor. Further interview revealed, she had conducted four (4) CPR classes for staff that included the hands on skills component. Per interview, one staff still remained out of compliance with the CPR certification hands on component and would not be allowed to work until appropriate certification was obtained. 12. Review of the Daily New Admission Log, revealed new admissions were reviewed daily for compliance with Physician Notification, Physician Orders, Interim Care Plan, Advance Directive, and Resident Rights beginning [DATE]. Interview with the DON on [DATE] at 5:20 PM, revealed areas of concern were identified when the audits were initiated on [DATE]; however, after staff received education, data collected had improved. Further interview revealed any issues identified would be immediately corrected with data reviewed with the QA committee weekly for four (4) weeks, then monthly with the results of the collected data to determine the need for additional education or the revision of the plan. 13. Review of documentation monitoring care delivery as outlined per the resident's care plan, revealed five (5) resident care plans per day per unit were reviewed by management staff beginning [DATE]. Interview with the DON, on [DATE] at 5:20 PM, revealed management staff had audited resident care plans daily. Further interview revealed five (5) care plans were audited on each unit daily since [DATE]. 14. Review of documentation of the Mock codes revealed they were conducted twice weekly on rotating shifts beginning [DATE]. Interview, on [DATE] at 5:50 PM with RN #1 and at 6:12 PM with LPN #1; on [DATE] at 11:15 AM with LPN #12; at 11:25 AM with LPN #3; at 4:16 PM with LPN #11; at 4:30 PM with LPN #2; at 4:45 PM with RN #4; at 5:00 PM with RN #2; at 5:17 PM with RN #3; and, Unit Manager #1 at 4:29 PM, revealed they had all been provided education related to Cardiopulmonary Resuscitation and Advance Directives with Mock Codes conducted on different shifts. 15. Review of documentation of CPR certification tracking revealed the date the certification was obtained and verification the certification contained a hands on skills component. Interview with the DON, on [DATE] at 5:20 PM, revealed the facility had previously been tracking CPR expiration dates; however, the facility added verification of a hands on skills component to their tracking data to ensure compliance. 16. Review of the documentation of a calendar, signed by the Regional Nurse and Regional Vice President of Operations revealed the Regional Vice President of Operations was on site [DATE] and [DATE]. Further review revealed, the Regional Nurse was on site daily from [DATE] to [DATE] with the exception of [DATE]. Interview with the Regional Nurse, on [DATE] at 5:20 PM, revealed he had been in the facility each day with the exception of [DATE]. Interview with the Administrator on [DATE] at 5:20 PM, revealed the Regional Nurse had been on site daily since [DATE] with the exception of [DATE]. Interview with Unit Manager #1, on [DATE] at 4:29 PM, revealed the Regional Nurse had been on site seemed like daily for over two (2) weeks. 17. Review of documentation of a calendar, signed by the Regional Nurse and Regional Vice President of Operations revealed on site Administrative oversight was performed by the Regional Vice President of Operations on [DATE] and [DATE]. Further review revealed, on site Administrative oversight was performed by the Regional Nurse on each day from [DATE] to [DATE], with the exception of [DATE]. Interview with the Regional Nurse, on [DATE] at 5:20 PM, revealed he had been on site at the facility daily since [DATE]

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0385 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	(continued... from page 12) with the exception of [DATE]. Interview with the Administrator on [DATE] at 5:20 PM, revealed the Regional Nurse had been on site daily since [DATE] with the exception of [DATE]. Interview with Unit Manager #1, on [DATE] at 4:29 PM, revealed the Regional Nurse had been on site seemed like daily for over two (2) weeks. 18. Review of the QA sign in sheets revealed, meetings were conducted on [DATE], [DATE], and [DATE] with the areas of concern discussed. The Medical Director was in attendance on [DATE]. Interview with the Administrator, on [DATE] at 11:15 AM, revealed the data obtained from the audits performed, revealed areas of concern related to the Mock codes which were initially performed. Continued interview revealed, the data was analyzed and it was determined additional education was needed. Further interview revealed the additional education was provided with positive data resulting from ongoing Mock codes and audits.
F 0490 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	**Be administered in an acceptable way that maintains the well-being of each resident .** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, review of the Job Description for the Administrator, and review of the facility's policy, it was determined the facility's Administration failed to have an effective system to evaluate its policies and staffing requirements, to ensure each resident's Advance Directives and personal choices were honored. Interview and record review revealed the facility failed to ensure all staff trained in CPR received training with a hands-on skills component. Review of the facility's policies revealed they were not specific regarding the requirement related to a mandatory hands-on skill component as part of the CPR training. (Refer to F-155, F-281 and F-309) On [DATE], Resident #1's Responsible Party signed Advance Directives requesting Full Code status for the resident, with life-saving measures to include Cardiopulmonary Resuscitation (CPR), in the event the resident's heart or lungs failed to function. On [DATE] at approximately 7:15 AM, Licensed Practical Nurse (LPN) #1 found Resident #1 to be unresponsive; however, the nurse failed to honor the resident's Advanced Directives related to his/her Full Code status when he did not initiate CPR. LPN #2 entered Resident #1 room behind LPN #1 and found Resident #1 to be unresponsive; however, this nurse also failed to honor the resident's Advanced Directives related to his/her Full Code status when she did not initiate CPR. RN #1 was called to Resident #1's room by LPN #2, and found Resident #1 to be unresponsive; again, this nurse also failed to honor the resident's Advance Directives related to his/her Full Code status when she did not initiate CPR, but pronounced the resident to be deceased . The facility's failure to have an effective Administration with oversight of planned interventions to ensure residents' wishes were honored at end-of-life has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy (IJ) was identified on [DATE], and was determined to exist on [DATE]. The facility was notified of the Immediate Jeopardy on [DATE]. The facility provided an acceptable credible Allegation of Compliance (AOC) on [DATE] with the facility alleging removal of the Immediate Jeopardy on [DATE]. The State Survey Agency validated removal of the Immediate Jeopardy as alleged on [DATE], prior to exit on [DATE], with remaining non-compliance at 42 CFR 483.75 Administration, F-490 at a Scope and Severity of a D while the facility develops and implements a Plan of Corrections and the facility's Quality Assurance (QA) monitors to ensure compliance with systemic changes. The findings include: Review of the Administrator's Job Description, updated [DATE], revealed the Administrator was responsible for leading and directing the overall operations of the facility in accordance with residents' needs, government regulations and company policies. Continued review revealed the Administrator's management duties included, but were not limited to, hiring, training, developing, coaching, counseling and terminating facility staff as deemed necessary. In addition, the Job Description revealed the Administrator's duties included monitoring the delivery of nursing care and ensuring residents' needs were addressed. per the Job Description, the Administrator was responsible for the facility's Quality Assurance (QA) program, and was expected to maintain a working knowledge of, and compliance with, all governmental regulations. Review of the facility's policy, titled Advance Directives - Kentucky, effective ,[DATE], revealed it was the policy of the facility to recognize and support the use of Advance Directives through family, staff and community education and to encourage the resident's rights to self-determination through recognition and assistance with executing such directives. Continued review revealed, as long as the resident was competent to make decisions, his/her wishes would be followed to the maximum extent possible as dictated by state law and sound medical judgment. If a resident became incompetent, but had provided evidence of a properly executed Advance Directive, the facility would implement the resident's choices as outlined in the document or expressed to the appointed agent to the same extent that the competent resident's wishes would be followed. Further review revealed all residents would receive full resuscitative measures unless a Do Not Resuscitate (DNR) directive was written in the resident's medical record and was identified in the resident's Advance Directive. Review of the facility's policy titled Resident Rights, reviewed [DATE], revealed residents had the right to choose a physician, receive treatment, and participate in decision-making and care planning. Continued review revealed residents were entitled to exercise their rights and privileges to the fullest extent possible. Per the policy, employees had a duty to read and learn the residents' rights. Review of the facility's policy titled Cardiopulmonary Resuscitation, undated, revealed CPR would be attempted for any resident who was found to have no palpable pulse and/or no discernible respirations, unless there was a written physician order [REDACTED]. Continued review revealed, should a resident be found unresponsive and without respirations, a licensed staff member who was certified in CPR would promptly initiate CPR in the following circumstances: for residents who have requested CPR in their Advance Directive; for residents who have not formulated an Advance Directive; and for residents who do not have a valid DNR order; and in the event the initiation of CPR would pose a danger to self or others. On [DATE], Resident #1 was found to be unresponsive, with no pulse and no respiratory effort, by LPN #1, LPN #2 and RN #1. Review of the Advance Directives, signed by the Responsible Party on [DATE], and review of the physician's orders [REDACTED].#1, LPN #2 and RN #1 did not initiate CPR in accordance with the resident's wishes. Review of the CPR training records and staffing schedules revealed the facility failed to have an effective system to ensure all staff received CPR training which included the mandatory hands-on skill component, as required by regulation. Review of the facility's CPR certification tracking, revealed seventeen (17) staff had not received the hands-on skill component. Interview with the Administrator, on [DATE] at 4:50 PM, revealed residents had a right to execute an Advance Directive which should be honored by the staff. Continued interview revealed LPN #1, LPN #2 and RN #1 should have initiated CPR for Resident #1, who was a Full Code, when they found the resident non-responsive. Further interview revealed licensed nursing staff were required to be CPR certified; however, the Administrator was not aware CPR training could not be obtained solely on-line. Per interview, the Administrator was not aware staff requiring re-certification were required to have a hands-on skills component included in their CPR training, to ensure competency in the provision of CPR when indicated, per the regulation. The facility provided an acceptable credible Allegation of Compliance (AOC) on [DATE], which alleged removal of the IJ effective [DATE]. Review of the AOC revealed the facility implemented the following: 1. On [DATE], the Director of Nursing (DON) reviewed Resident #1's medical record and care plan with the following areas of concern identified: a. The date and time were missing regarding the Physician notification on the Nursing Admission Assessment b. the Advance Directive of Full Code status was not care planned on the Interim Care Plan. c. CPR was not immediately initiated per Resident #1's/Power of Attorney's (POA's) request as indicated on the Advance Directive. 2. Beginning [DATE] and concluding on [DATE], the DON, Unit Managers, Nursing Supervisors or Medical Records staff audited all resident Advance Directive/Code Status/physician's orders [REDACTED]. 3. Beginning [DATE] and concluding on [DATE], the DON, Assistant Director of Nursing (ADON), Unit Managers and Nursing Supervisors assessed all residents for any possible resident rights violations. Residents with a Brief Interview of Mental Status (BIMS) score of eight (8) or greater were interviewed and residents with a BIMS of less than eight (8) were physically assessed for any signs and symptoms of possible quality of life or resident rights violations. 4. Compliance audits of the admission process were completed by [DATE] of all admissions within the previous thirty (30) days. The audits were performed by the DON, ADON, Unit Managers or Nursing Supervisors of all resident's medical records to include notification of the Attending Physician, review of the Physician Admitting Orders with the Attending Physician and ensuring professional standards were followed.

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F 0490 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 13) 5. The DON, Unit Managers, Nursing Supervisors or Medical Records staff completed audits of all resident charts by [DATE]. The Audit included; resident's Advance Directive, physician's orders [REDACTED]. 6. On [DATE], all management staff was educated by the Regional Nurse Consultant. Education included: Advance Directive Policy and Procedure, Admission/physician's orders [REDACTED]. 7. Education for all nursing staff was initiated on [DATE] and completed by [DATE], with the exception of four (4) full-time status staff on leave and twenty-one (21) part-time staff. Certified letters were sent to the twenty-one (21) part-time staff to notify each of the mandatory education prior to returning to duty. Education was provided by the Staff Development Coordinator, Unit Mangers and Nursing Supervisors. Education included Advance Directive Policy and Procedure, Admission/Physician order [REDACTED]. The education related to the policies and procedures was added to the training agenda for New Employee Orientation. 8. Beginning [DATE] and concluding on [DATE], the Staff Development Coordinator, Unit Managers and Nursing Supervisors conducted education for all licensed staff (with the exception of the part-time staff who were notified by certified letter they could not work until receiving the required education) on the admission policy and procedure, to include: clarification of the process for Physician notification of new admissions, obtaining admission orders [REDACTED]. The above education was incorporated into the facility's New Employee Orientation. 9. On [DATE], all Physicians with privileges at the facility were educated by the DON in regards to the admission process and expectations with compliance to include: Discharge Summaries or Orders from a discharging facility would be faxed to the Physician's office and the Physician would be called for approval of the Orders with a Telephone Order written stating the Physician's review and approval of the Orders. 10. Human Resources and/or Staff Development performed audits of all personnel files for CPR certifications. Audits were completed by [DATE] and given to the Regional Nurse Consultant to review for non-compliance with CPR regulations. Seventeen (17) licensed nurses were noted to have on-line only CPR certifications. 11. Sixteen (16) of the seventeen (17) staff identified to have on-line CPR certifications received CPR instruction with hands on component by [DATE], provided by the DON, a certified American Heart CPR Instructor. One (1) employee would not be allowed to work until CPR certification with hands on component was obtained. 12. Beginning [DATE], the DON, ADON, Unit Manager, Nursing Supervisor or Medical Records staff will review all new admissions daily during the morning clinical meeting to ensure compliance with Physician notification, Physician Orders, Interim Care Plan, Advance Directive, and Resident Rights. Findings of the review will be reported in the Quality Assurance (QA) committee meeting. The committee consists of the Medical Director, Administrator, DON, Social Services Director and at least two (2) other department managers, different line staff as appropriate, and outside consultants as appropriate. The committee will meet weekly for four (4) weeks then monthly to determine the need for continued education or revision of the plan. Based on evaluation, the QA committee will determine at what frequency the ongoing review of new admissions will need to continue. Concerns identified will be corrected immediately by the DON, ADON, Unit Managers or Nursing Supervisor and reported to the Administrator to ensure any needed investigation initiated and reported guidelines were met. 13. The DON, ADON, Unit Managers, or Nursing Supervisor will monitor care delivery as outlined per the care plan on five (5) residents per unit per day until immediacy is removed, beginning [DATE], then five (5) residents daily for four (4) weeks, to ensure compliance with care delivery as outlined by the Care Plan along with compliance of Professional Standards requirements. Findings will be reported in the QA committee weekly to determine the further need of continued education or the revision of the plan. 14. Mock codes will be conducted by the DON, ADON, Unit Managers, Staff Development Coordinator or Nursing Supervisor twice weekly, on rotating shifts, for four (4) weeks beginning [DATE], to ensure understanding and compliance with Code Blue Policy and Procedure. The first two (2) mock codes were conducted by Clinical Managers for education on how to conduct a code; the Mock codes will be conducted by the nurses. Findings will be reported to the QA committee weekly to determine compliance and any further need of continued education or revision of the plan. 15. The DON, Staff Development Coordinator or Human Resources will track all licensed nurses CPR certification monthly beginning [DATE], to ensure compliance with CPR policy, procedure and governing regulations. Findings and compliance will be reported monthly to the QA committee to determine any need for education or revision of the process. 16. A Regional Nurse or corporate office staff was on site since [DATE] and will remain on site daily until immediacy is removed, then will be on site three (3) times weekly for four (4) weeks. Regional/Corporate staff will review compliance with the plan and will review compliance with policy and procedure of any code blue that occurs and review compliance with new or re-admissions. During weekly follow-up, guidance and recommendations will be provided with compliance validated. 17. Administrative oversight of the facility will be completed by the Vice President of Operations, Nurse Consultant, or Special Projects Administrator daily until removal of the immediacy beginning [DATE], then weekly for four (4) weeks, then monthly. 18. A Quality Assurance meeting will be held weekly until immediacy is removed beginning on [DATE], the for four (4) weeks, then monthly for recommendations and further follow up regarding the stated plan. Based on evaluation, the QA committee will determine at what frequency any ongoing audits will need to continue. The Administrator has the oversight to ensure an effective plan is in place to meet resident well-being and ensure resident rights as well as an effective plan to identify facility concerns and implement a plan of correction to involve all staff of the facility. Corporate Administrative oversight of the Quality Assurance meeting will be completed by the Special projects Administrator, the Regional Vice President of Operations, or a member of regional staff three (3) times a week until immediacy is removed beginning [DATE], then weekly for four (4) weeks, then monthly. The State Survey Agency validated the implementation of the facility's AOC as follows: 1. Review of the facility's investigation of the incident revealed an audit of Resident #1's medical record with areas concern noted. Interview with the DON, on [DATE] at 5:20 PM, revealed she audited Resident #1's medical record and identified areas of concern with immediate implementation of education provided to staff. 2. Review of the facility's audit of all resident's Advance Directive, Care Plans and physician's orders [REDACTED]. Interview with the DON, on [DATE] at 5:20 PM, revealed she had participated with other management staff to audit all resident records to verify accuracy of the resident's Advance Directive, Care Plans and Physician's code status order. 3. Review of the audit tool utilized to interview and assess all residents for possible resident rights violations revealed management staff interviewed all resident's with a Brief Interview for Mental Status (BIMS) score of eight (8) or greater and a physical assessment was completed for resident's whose BIMS was less than eight (8). Interview with the DON, on [DATE] at 5:20 PM, revealed management staff interviewed or assessed each of the facility's residents for any signs or symptoms of resident rights violations. Interview with interviewable residents revealed staff did talk with them regarding their resident rights. 4. The audit tool, dated [DATE], utilized to audit previous thirty (30) days facility new admissions was reviewed. New admissions were audited for compliance with admission process including: Physician notification, review of New Admission physician's orders [REDACTED]. Areas of concern identified with the audit were documentation in relation to missing dates and times on the Nursing Admission Assessment on four (4) residents. Review of the education provided to staff revealed policy and procedures related to accuracy of the admission process and documentation was provided. Review of the staff sign in sheets revealed instruction was provided beginning [DATE] with review of policy and procedure. On [DATE], a more comprehensive education was provided to staff related to the policy and procedure. Interview with the DON, on [DATE] at 5:20 PM, revealed she initiated education to the nursing staff immediately on [DATE]. Per the DON, the Regional Nurse provided comprehensive education to the management staff on [DATE]. Further interview revealed, after receiving the comprehensive education, the management staff were responsible for providing the comprehensive education to the facility's nursing staff. 5. Review of the audit of each resident's medical record to include: Advance Directive, physician's orders [REDACTED]. Interview with the DON, on [DATE] at 5:20 PM, revealed she and other management staff audited each resident's medical record to ensure compliance with quality of care delivery. 6. Review of education provided by the Regional Nurse to all management staff with the sign in sheet dated [DATE] and signed by the Regional Nurse revealed the education provided included: Cardiopulmonary Resuscitation, Advance Directives, Physician Visits and Medical Orders, Admission Criteria, Care Planning - Interdisciplinary Team, Resident Rights, Quality

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	185146	A. BUILDING _____ B. WING _____	09/03/2015

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FOUNTAIN CIRCLE CARE & REHABILITATION CENTER	200 GLENWAY ROAD WINCHESTER, KY 40391

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0490 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 14) of Care, Professional Standards, and QA. Interview with the Regional Nurse Consultant, on [DATE] at 5:20 PM, revealed he provided comprehensive education to management staff related to the facility's policies and procedures stated above. Continued interview revealed the facility revised the CPR policy to include mandatory hands on skills certification for staff. 7. Review of education provided to all nursing staff to include: Cardiopulmonary Resuscitation, Advance Directives, Physician Visits and Medical Orders, Admission Criteria, Care Planning - Interdisciplinary Team, Resident Rights, Quality of Care, Professional Standards, and QA. Review of sign in sheets revealed the education was initiated on [DATE] and concluded on [DATE]. Review of certified letters sent to twenty-one (21) part-time clinical staff related to mandatory education prior to working. Continued review of sign-in sheets revealed education for part-time clinical staff, non-licensed staff and non-nursing staff continued per AOC. Review of New Orientation Agenda for clinical staff, revealed education would be provided with orientation process. Review of audit tool utilized for validation of CPR certification with hands on skills component revealed staff had obtained education with hands on skill component. Interview, on [DATE] at 10:20 AM with SRNA #8; at 10:30 AM with SRNA #7; at 10:40 AM with SRNA #4; at 10:50 AM with SRNA #2; and, at 11:00 AM with SRNA #6 revealed they had all been provided education related to Cardiopulmonary Resuscitation, Resident Rights, Quality of Care and Professional Standards between [DATE] and [DATE] in a verbal lecture setting allowing for question and answers. Interview, on [DATE] at 5:50 PM with RN #1 and at 6:12 PM with LPN #1; on [DATE] at 11:15 AM with LPN #12; at 11:25 AM with LPN #3; at 4:16 PM with LPN #11; at 4:30 PM with LPN #2; at 4:45 PM with RN #4; at 5:00 PM with RN #2; at 5:17 PM with RN #3; and, Unit Manager #1 at 4:29 PM, revealed they had all been provided education related to Cardiopulmonary Resuscitation, Advance Directives, Physician Visits and Medical Orders, Admission Criteria, Care Planning, Resident Rights, Professional Standards, and Quality of Care in a verbal lecture setting allowing for question and answers. 8. Review of the education provided to all licensed staff related to the admission policy and procedure revealed the education was initiated on [DATE] and completed on [DATE] after additional education was provided by the Regional Nurse Consultant. Interview with the DON, on [DATE] at 5:20 PM, revealed she had initiated staff education on [DATE]. After receiving comprehensive education provided by the Regional Nurse Consultant on [DATE], the management team re-educated staff with the completion date for full-time clinical staff to be [DATE]. 9. Review of the education provided to all Physicians with privileges to included; clarification of the process for notifying the Physician of new admits and obtaining orders, and the Interim Care Plan and Professional Standards. Further review, revealed there was follow up letters sent to each Physician related to the educations provided. 10. Review of the Audit of personnel files for CPR certification revealed the Audit was completed on [DATE] with the Regional Nurse Consultant review on [DATE]. Data from the audit revealed seventeen (17) staff without the hands on skill component for CPR certification. 11. Review of the Audit of personnel files for CPR certifications revealed sixteen (16) of the seventeen (17) identified staff without hands on skill component CPR certifications had obtained certifications with the hands on skills component. Interview with the DON, on [DATE] at 5:20 PM, revealed she was a Certified American Heart CPR Instructor. Further interview revealed, she had conducted four (4) CPR classes for staff that included the hands on skills component. Per interview, one staff still remained out of compliance with the CPR certification hands on component and would not be allowed to work until appropriate certification was obtained. 12. Review of the Daily New Admission Log, revealed new admissions were reviewed daily for compliance with Physician Notification, Physician Orders, Interim Care Plan, Advance Directive, and Resident Rights beginning [DATE]. Interview with the DON on [DATE] at 5:20 PM, revealed areas of concern were identified when the audits were initiated on [DATE]; however, after staff received education, data collected had improved. Further interview revealed any issues identified would be immediately corrected with data reviewed with the QA committee weekly for four (4) weeks, then monthly with the results of the collected data to determine the need for additional education or the revision of the plan. 13. Review of documentation monitoring care delivery as outlined per the resident's care plan, revealed five (5) resident care plans per day per unit were reviewed by management staff beginning [DATE]. Interview with the DON, on [DATE] at 5:20 PM, revealed management staff had audited resident care plans daily. Further interview revealed five (5) care plans were audited on each unit daily since [DATE]. 14. Review of documentation of the Mock codes revealed they were conducted twice weekly on rotating shifts beginning [DATE]. Interview, on [DATE] at 5:50 PM with RN #1 and at 6:12 PM with LPN #1; on [DATE] at 11:15 AM with LPN #12; at 11:25 AM with LPN #3; at 4:16 PM with LPN #11; at 4:30 PM with LPN #2; at 4:45 PM with RN #4; at 5:00 PM with RN #2; at 5:17 PM with RN #3; and, Unit Manager #1 at 4:29 PM, revealed they had all been provided education related to Cardiopulmonary Resuscitation and Advance Directives with Mock Codes conducted on different shifts. 15. Review of documentation of CPR certification tracking revealed the date the certification was obtained and verification the certification contained a hands on skills component. Interview with the DON, on [DATE] at 5:20 PM, revealed the facility had previously been tracking CPR expiration dates; however, the facility added verification of a hands on skills component to their tracking data to ensure compliance. 16. Review of the documentation of a calendar, signed by the Regional Nurse and Regional Vice President of Operations revealed the Regional Vice President of Operations was on site [DATE] and [DATE]. Further review revealed, the Regional Nurse was on site daily from [DATE] to [DATE] with the exception of [DATE]. Interview with the Regional Nurse, on [DATE] at 5:20 PM, revealed he had been in the facility each day with the exception of [DATE]. Interview with the Administrator on [DATE] at 5:20 PM, revealed the Regional Nurse had been on site daily since [DATE] with the exception of [DATE]. Interview with Unit Manager #1, on [DATE] at 4:29 PM, revealed the Regional Nurse had been on site seemed like daily for over two (2) weeks. 17. Review of documentation of a calendar, signed by the Regional Nurse and Regional Vice President of Operations revealed on site Administrative oversight was performed by the Regional Vice President of Operations on [DATE] and [DATE]. Further review revealed, on site Administrative oversight was performed by the Regional Nurse on each day from [DATE] to [DATE], with the exception of [DATE]. Interview with the Regional Nurse, on [DATE] at 5:20 PM, revealed he had been on site at the facility daily since [DATE] with the exception of [DATE]. Interview with the Administrator on [DATE] at 5:20 PM, revealed the Regional Nurse had been on site daily since [DATE] with the exception of [DATE]. Interview with Unit Manager #1, on [DATE] at 4:29 PM, revealed the Regional Nurse had been on site seemed like daily for over two (2) weeks. 18. Review of the QA sign in sheets revealed, meetings were conducted on [DATE], [DATE], and [DATE] with the areas of concern discussed. The Medical Director was in attendance on [DATE]. Interview with the Administrator, on [DATE] at 11:15 AM, revealed the data obtained from the audits performed, revealed areas of concern related to the Mock codes which were initially performed. Continued interview revealed, the data was analyzed and it was determined additional education was needed. Further interview revealed the additional education was provided with positive data resulting from ongoing Mock codes and audits.
F 0514 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Keep accurate, complete and organized clinical records on each resident that meet professional standards** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based interview, record review and review of facility policy, it was determined the facility failed to have an effective system to ensure clinical records were maintained in accordance with accepted professional standards and practices which were complete and accurately documented, for one (1) of twelve (12) sampled residents (Resident #1). On [DATE], Resident #1 was found to be unresponsive, and without a pulse or respirations. Staff notified the on-call Physician of Resident #1's death; however, staff failed to inform the Physician the resident was a Full Code status and CPR was not performed. In addition a Telephone Order dated [DATE] was documented to withhold CPR (cardiopulmonary

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0514 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 15) resuscitation) related to resident already deceased when found, no heart rate, no respirations, and cool to touch as received by the on-call Physician. However, interview with Licensed Practical Nurse (LPN) #2 who wrote the order, and interview with the on-call Physician revealed there was no order instructing staff to withhold CPR. Also, the Nurse's Note dated [DATE] written by LPN #1 was not complete and accurately documented as there was no time noted for the entry. The facility's failure to maintain clinical records which were complete and accurately documented has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on [DATE], and was determined to exist on [DATE]. The facility was notified of the Immediate jeopardy on [DATE]. The facility provided an acceptable credible Allegation of Compliance (AOC) on [DATE] with the facility alleging removal of the Immediate Jeopardy on [DATE]. The State Survey Agency validated removal of the Immediate Jeopardy as alleged on [DATE], prior to exit on [DATE], with remaining non-compliance in the area of 42 CFR 483.75 Administration, F-514 Clinical Records at a Scope and Severity of a D while the facility develops and implements a Plan of Correction and the facility's Quality Assurance (QA) monitors to ensure compliance with systemic changes. The findings include: Review of the facility's policy titled Telephone Orders, undated, revealed each entry should contain the instructions from the Physician, and should include the date, time, and signature and title of the person transcribing the information. Review of Resident #1's clinical record, revealed the facility admitted the resident on [DATE], with [DIAGNOSES REDACTED]. Review of the Nursing Admission Information form, dated [DATE], revealed the facility admitted Resident #1 under the care of the Attending Physician, on [DATE] at 6:40 PM. Review of the Advance Directives/Informed Consent, signed by Resident #1's Responsible Party (RP) on [DATE], revealed the RP had requested/consented in the event of death for staff to use cardiac compressions or artificial ventilation to resuscitate Resident #1. Review of the physician's orders [REDACTED].>Review of the Nurse's Note, dated [DATE], not timed, completed by LPN #1, revealed LPN #1 found the resident sitting on the floor next to the bed with blood on the pillow and ear, with no pulse found. However, there was no documented evidence LPN #1 immediately initiated CPR for Resident #1's as per physician's orders [REDACTED]. Review of the physician's orders [REDACTED].#2, revealed a Telephone Order was received from Resident #1's on-call Physician to withhold CPR (cardiopulmonary resuscitation). Continued review revealed the order was given related to resident already deceased when found, no heart rate, no respirations, and cool to touch. Interview with LPN #2, on [DATE] at 4:31 PM, revealed she contacted the on-call Physician to notify him of Resident #1's death. Continued interview revealed she informed the Physician the Registered Nurse (RN) had decided the resident was too far gone for CPR. She stated she thought she had advised him the resident was a Full Code status. Continued interview revealed the Physician responded, Oh, no .OK, but did not say to withhold CPR. Interview with the on-call Physician, on [DATE] at 12:07 PM, revealed he was notified on [DATE] around 7:30 AM by the facility of Resident #1's death. Continued interview revealed staff did not inform him Resident #1 was a Full Code, and he did not give an order to withhold CPR. Interview with the Director of Nursing (DON), on [DATE] at 3:09 PM, revealed staff should completely inform the Physician of a resident's status and document exactly what the physician orders, and all documentation should be dated and timed. Interview with the Administrator, on [DATE] at 4:50 PM, revealed staff should write orders as stated by the Physician as well as ensure documentation was complete and accurate. The facility provided an acceptable credible Allegation of Compliance (AOC) on [DATE], which alleged removal of the IJ effective [DATE]. Review of the AOC revealed the facility implemented the following: 1. On [DATE], the Director of Nursing (DON) reviewed Resident #1's medical record and care plan with the following areas of concern identified: a. The date and time were missing regarding the Physician notification on the Nursing Admission Assessment b. the Advance Directive of Full Code status was not care planned on the Interim Care Plan. c. CPR was not immediately initiated per Resident #1's/Power of Attorney's (POA's) request as indicated on the Advance Directive. 2. Beginning [DATE] and concluding on [DATE], the DON, Unit Managers, Nursing Supervisors or Medical Records staff audited all resident Advance Directive/Code Status/physician's orders [REDACTED]. 3. Beginning [DATE] and concluding on [DATE], the DON, Assistant Director of Nursing (ADON), Unit Managers and Nursing Supervisors assessed all residents for any possible resident rights violations. Residents with a Brief Interview of Mental Status (BIMS) score of eight (8) or greater were interviewed and residents with a BIMS of less than eight (8) were physically assessed for any signs and symptoms of possible quality of life or resident rights violations. 4. Compliance audits of the admission process were completed by [DATE] of all admissions within the previous thirty (30) days. The audits were performed by the DON, ADON, Unit Managers or Nursing Supervisors of all resident's medical records to include notification of the Attending Physician, review of the Physician Admitting Orders with the Attending Physician and ensuring professional standards were followed. 5. The DON, Unit Managers, Nursing Supervisors or Medical Records staff completed audits of all resident charts by [DATE]. The Audit included; resident's Advance Directive, physician's orders [REDACTED]. 6. On [DATE], all management staff was educated by the Regional Nurse Consultant. Education included: Advance Directive Policy and Procedure, Admission/physician's orders [REDACTED]. 7. Education for all nursing staff was initiated on [DATE] and completed by [DATE], with the exception of four (4) full-time status staff on leave and twenty-one (21) part-time staff. Certified letters were sent to the twenty-one (21) part-time staff to notify each of the mandatory education prior to returning to duty. Education was provided by the Staff Development Coordinator, Unit Mangers and Nursing Supervisors. Education included Advance Directive Policy and Procedure, Admission/Physician order [REDACTED]. The education related to the policies and procedures was added to the training agenda for New Employee Orientation. 8. Beginning [DATE] and concluding on [DATE], the Staff Development Coordinator, Unit Managers and Nursing Supervisors conducted education for all licensed staff (with the exception of the part-time staff who were notified by certified letter they could not work until receiving the required education) on the admission policy and procedure, to include: clarification of the process for Physician notification of new admissions, obtaining admission orders [REDACTED]. The above education was incorporated into the facility's New Employee Orientation. 9. On [DATE], all Physicians with privileges at the facility were educated by the DON in regards to the admission process and expectations with compliance to include: Discharge Summaries or Orders from a discharging facility would be faxed to the Physician's office and the Physician would be called for approval of the Orders with a Telephone Order written stating the Physician's review and approval of the Orders. 10. Human Resources and/or Staff Development performed audits of all personnel files for CPR certifications. Audits were completed by [DATE] and given to the Regional Nurse Consultant to review for non-compliance with CPR regulations. Seventeen (17) licensed nurses were noted to have on-line only CPR certifications. 11. Sixteen (16) of the seventeen (17) staff identified to have on-line CPR certifications received CPR instruction with hands on component by [DATE], provided by the DON, a certified American Heart CPR Instructor. One (1) employee would not be allowed to work until CPR certification with hands on component was obtained. 12. Beginning [DATE], the DON, ADON, Unit Manager, Nursing Supervisor or Medical Records staff will review all new admissions daily during the morning clinical meeting to ensure compliance with Physician notification, Physician Orders, Interim Care Plan, Advance Directive, and Resident Rights. Findings of the review will be reported in the Quality Assurance (QA) committee meeting. The committee consists of the Medical Director, Administrator, DON, Social Services Director and at least two (2) other department managers, different line staff as appropriate, and outside consultants as appropriate. The committee will meet weekly for four (4) weeks then monthly to determine the need for continued education or revision of the plan. Based on evaluation, the QA committee will determine at what frequency the ongoing review of new admissions will need to continue. Concerns identified will be corrected immediately by the DON, ADON, Unit Managers or Nursing Supervisor and reported to the Administrator to ensure any needed investigation initiated and reported guidelines were met. 13. The DON, ADON, Unit Managers, or Nursing Supervisor will monitor care delivery as outlined per the care plan on five (5) residents per unit per day until immediacy is removed, beginning [DATE], then five (5) residents daily for four (4) weeks, to ensure compliance with care delivery as outlined by the Care Plan along with compliance of Professional Standards requirements. Findings will be reported in the QA committee weekly to determine the further need of continued education or the revision of the plan. 14. Mock codes will be conducted by the DON, ADON, Unit Managers, Staff Development Coordinator or Nursing Supervisor twice

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F 0514 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 16) weekly, on rotating shifts, for four (4) weeks beginning [DATE], to ensure understanding and compliance with Code Blue Policy and Procedure. The first two (2) mock codes were conducted by Clinical Managers for education on how to conduct a code; the Mock codes will be conducted by the nurses. Findings will be reported to the QA committee weekly to determine compliance and any further need of continued education or revision of the plan. 15. The DON, Staff Development Coordinator or Human Resources will track all licensed nurses CPR certification monthly beginning [DATE], to ensure compliance with CPR policy, procedure and governing regulations. Findings and compliance will be reported monthly to the QA committee to determine any need for education or revision of the process. 16. A Regional Nurse or corporate office staff was on site since [DATE] and will remain on site daily until immediacy is removed, then will be on site three (3) times weekly for four (4) weeks. Regional/Corporate staff will review compliance with the plan and will review compliance with policy and procedure of any code blue that occurs and review compliance with new or re-admissions. During weekly follow-up, guidance and recommendations will be provided with compliance validated. 17. Administrative oversight of the facility will be completed by the Vice President of Operations, Nurse Consultant, or Special Projects Administrator daily until removal of the immediacy beginning [DATE], then weekly for four (4) weeks, then monthly. 18. A Quality Assurance meeting will be held weekly until immediacy is removed beginning on [DATE], the for four (4) weeks, then monthly for recommendations and further follow up regarding the stated plan. Based on evaluation, the QA committee will determine at what frequency any ongoing audits will need to continue. The Administrator has the oversight to ensure an effective plan is in place to meet resident well-being and ensure resident rights as well as an effective plan to identify facility concerns and implement a plan of correction to involve all staff of the facility. Corporate Administrative oversight of the Quality Assurance meeting will be completed by the Special projects Administrator, the Regional Vice President of Operations, or a member of regional staff three (3) times a week until immediacy is removed beginning [DATE], then weekly for four (4) weeks, then monthly. The State Survey Agency validated the implementation of the facility's AOC as follows: 1. Review of the facility's investigation of the incident revealed an audit of Resident #1's medical record with areas concern noted. Interview with the DON, on [DATE] at 5:20 PM, revealed she audited Resident #1's medical record and identified areas of concern with immediate implementation of education provided to staff. 2. Review of the facility's audit of all resident's Advance Directive, Care Plans and physician's orders [REDACTED]. Interview with the DON, on [DATE] at 5:20 PM, revealed she had participated with other management staff to audit all resident records to verify accuracy of the resident's Advance Directive, Care Plans and Physician's code status order. 3. Review of the audit tool utilized to interview and assess all residents for possible resident rights violations revealed management staff interviewed all resident's with a Brief Interview for Mental Status (BIMS) score of eight (8) or greater and a physical assessment was completed for resident's whose BIMS was less than eight (8). Interview with the DON, on [DATE] at 5:20 PM, revealed management staff interviewed or assessed each of the facility's residents for any signs or symptoms of resident rights violations. Interview with interviewable residents revealed staff did talk with them regarding their resident rights. 4. The audit tool, dated [DATE], utilized to audit previous thirty (30) days facility new admissions was reviewed. New admissions were audited for compliance with admission process including: Physician notification, review of New Admission physician's orders [REDACTED]. Areas of concern identified with the audit were documentation in relation to missing dates and times on the Nursing Admission Assessment on four (4) residents. Review of the education provided to staff revealed policy and procedures related to accuracy of the admission process and documentation was provided. Review of the staff sign in sheets revealed instruction was provided beginning [DATE] with review of policy and procedure. On [DATE], a more comprehensive education was provided to staff related to the policy and procedure. Interview with the DON, on [DATE] at 5:20 PM, revealed she initiated education to the nursing staff immediately on [DATE]. Per the DON, the Regional Nurse provided comprehensive education to the management staff on [DATE]. Further interview revealed, after receiving the comprehensive education, the management staff were responsible for providing the comprehensive education to the facility's nursing staff. 5. Review of the audit of each resident's medical record to include: Advance Directive, physician's orders [REDACTED]. Interview with the DON, on [DATE] at 5:20 PM, revealed she and other management staff audited each resident's medical record to ensure compliance with quality of care delivery. 6. Review of education provided by the Regional Nurse to all management staff with the sign in sheet dated [DATE] and signed by the Regional Nurse revealed the education provided included: Cardiopulmonary Resuscitation, Advance Directives, Physician Visits and Medical Orders, Admission Criteria, Care Planning - Interdisciplinary Team, Resident Rights, Quality of Care, Professional Standards, and QA. Interview with the Regional Nurse Consultant, on [DATE] at 5:20 PM, revealed he provided comprehensive education to management staff related to the facility's policies and procedures stated above. Continued interview revealed the facility revised the CPR policy to include mandatory hands on skills certification for staff. 7. Review of education provided to all nursing staff to include: Cardiopulmonary Resuscitation, Advance Directives, Physician Visits and Medical Orders, Admission Criteria, Care Planning - Interdisciplinary Team, Resident Rights, Quality of Care, Professional Standards, and QA. Review of sign in sheets revealed the education was initiated on [DATE] and concluded on [DATE]. Review of certified letters sent to twenty-one (21) part-time clinical staff related to mandatory education prior to working. Continued review of sign-in sheets revealed education for part-time clinical staff, non-licensed staff and non-nursing staff continued per AOC. Review of New Orientation Agenda for clinical staff, revealed education would be provided with orientation process. Review of audit tool utilized for validation of CPR certification with hands on skills component revealed staff had obtained education with hands on skill component. Interview, on [DATE] at 10:20 AM with SRNA #8; at 10:30 AM with SRNA #7; at 10:40 AM with SRNA #4; at 10:50 AM with SRNA #2; and, at 11:00 AM with SRNA #6 revealed they had all been provided education related to Cardiopulmonary Resuscitation, Resident Rights, Quality of Care and Professional Standards between [DATE] and [DATE] in a verbal lecture setting allowing for question and answers. Interview, on [DATE] at 5:50 PM with RN #1 and at 6:12 PM with LPN #1; on [DATE] at 11:15 AM with LPN #12; at 11:25 AM with LPN #3; at 4:16 PM with LPN #11; at 4:30 PM with LPN #2; at 4:45 PM with RN #4; at 5:00 PM with RN #2; at 5:17 PM with RN #3; and, Unit Manager #1 at 4:29 PM, revealed they had all been provided education related to Cardiopulmonary Resuscitation, Advance Directives, Physician Visits and Medical Orders, Admission Criteria, Care Planning, Resident Rights, Professional Standards, and Quality of Care in a verbal lecture setting allowing for question and answers. 8. Review of the education provided to all licensed staff related to the admission policy and procedure revealed the education was initiated on [DATE] and completed on [DATE] after additional education was provided by the Regional Nurse Consultant. Interview with the DON, on [DATE] at 5:20 PM, revealed she had initiated staff education on [DATE]. After receiving comprehensive education provided by the Regional Nurse Consultant on [DATE], the management team re-educated staff with the completion date for full-time clinical staff to be [DATE]. 9. Review of the education provided to all Physicians with privileges to included; clarification of the process for notifying the Physician of new admits and obtaining orders, and the Interim Care Plan and Professional Standards. Further review, revealed there was follow up letters sent to each Physician related to the educations provided. 10. Review of the Audit of personnel files for CPR certification revealed the Audit was completed on [DATE] with the Regional Nurse Consultant review on [DATE]. Data from the audit revealed seventeen (17) staff without the hands on skill component for CPR certification. 11. Review of the Audit of personnel files for CPR certifications revealed sixteen (16) of the seventeen (17) identified staff without hands on skill component CPR certifications had obtained certifications with the hands on skills component. Interview with the DON, on [DATE] at 5:20 PM, revealed she was a Certified American Heart CPR Instructor. Further interview revealed, she had conducted four (4) CPR classes for staff that included the hands on skills component. Per interview, one staff still remained out of compliance with the CPR certification hands on component and would not be allowed to work until appropriate certification was obtained. 12. Review of the Daily New Admission Log, revealed new admissions were reviewed daily for compliance with Physician

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185146	A. BUILDING _____ B. WING _____	**09/03/2015**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FOUNTAIN CIRCLE CARE & REHABILITATION CENTER	**200 GLENWAY ROAD WINCHESTER, KY 40391**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0514 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 17) Notification, Physician Orders, Interim Care Plan, Advance Directive, and Resident Rights beginning [DATE]. Interview with the DON on [DATE] at 5:20 PM, revealed areas of concern were identified when the audits were initiated on [DATE]; however, after staff received education, data collected had improved. Further interview revealed any issues identified would be immediately corrected with data reviewed with the QA committee weekly for four (4) weeks, then monthly with the results of the collected data to determine the need for additional education or the revision of the plan. 13. Review of documentation monitoring care delivery as outlined per the resident's care plan, revealed five (5) resident care plans per day per unit were reviewed by management staff beginning [DATE]. Interview with the DON, on [DATE] at 5:20 PM, revealed management staff had audited resident care plans daily. Further interview revealed five (5) care plans were audited on each unit daily since [DATE]. 14. Review of documentation of the Mock codes revealed they were conducted twice weekly on rotating shifts beginning [DATE]. Interview, on [DATE] at 5:50 PM with RN #1 and at 6:12 PM with LPN #1; on [DATE] at 11:15 AM with LPN #12; at 11:25 AM with LPN #3; at 4:16 PM with LPN #11; at 4:30 PM with LPN #2; at 4:45 PM with RN #4; at 5:00 PM with RN #2; at 5:17 PM with RN #3; and, Unit Manager #1 at 4:29 PM, revealed they had all been provided education related to Cardiopulmonary Resuscitation and Advance Directives with Mock Codes conducted on different shifts. 15. Review of documentation of CPR certification tracking revealed the date the certification was obtained and verification the certification contained a hands on skills component. Interview with the DON, on [DATE] at 5:20 PM, revealed the facility had previously been tracking CPR expiration dates; however, the facility added verification of a hands on skills component to their tracking data to ensure compliance. 16. Review of the documentation of a calendar, signed by the Regional Nurse and Regional Vice President of Operations revealed the Regional Vice President of Operations was on site [DATE] and [DATE]. Further review revealed, the Regional Nurse was on site daily from [DATE] to [DATE] with the exception of [DATE]. Interview with the Regional Nurse, on [DATE] at 5:20 PM, revealed he had been in the facility each day with the exception of [DATE]. Interview with the Administrator on [DATE] at 5:20 PM, revealed the Regional Nurse had been on site daily since [DATE] with the exception of [DATE]. Interview with Unit Manager #1, on [DATE] at 4:29 PM, revealed the Regional Nurse had been on site seemed like daily for over two (2) weeks. 17. Review of documentation of a calendar, signed by the Regional Nurse and Regional Vice President of Operations revealed on site Administrative oversight was performed by the Regional Vice President of Operations on [DATE] and [DATE]. Further review revealed, on site Administrative oversight was performed by the Regional Nurse on each day from [DATE] to [DATE], with the exception of [DATE]. Interview with the Regional Nurse, on [DATE] at 5:20 PM, revealed he had been on site at the facility daily since [DATE] with the exception of [DATE]. Interview with the Administrator on [DATE] at 5:20 PM, revealed the Regional Nurse had been on site daily since [DATE] with the exception of [DATE]. Interview with Unit Manager #1, on [DATE] at 4:29 PM, revealed the Regional Nurse had been on site seemed like daily for over two (2) weeks. 18. Review of the QA sign in sheets revealed, meetings were conducted on [DATE], [DATE], and [DATE] with the areas of concern discussed. The Medical Director was in attendance on [DATE]. Interview with the Administrator, on [DATE] at 11:15 AM, revealed the data obtained from the audits performed, revealed areas of concern related to the Mock codes which were initially performed. Continued interview revealed, the data was analyzed and it was determined additional education was needed. Further interview revealed the additional education was provided with positive data resulting from ongoing Mock codes and audits.