

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

PRINTED: 07/01/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185443	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/17/2015
NAME OF PROVIDER OR SUPPLIER KENSINGTON CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 225 SAINT JOHN ROAD ELIZABETHTOWN, KY 42701	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A Recertification Survey was initiated on 06/14/15 and concluded on 06/17/15 with deficiencies cited at the highest scope and severity of an "E".	F 000	Kensington Center provides this plan of correction without admitting or denying the validity or existence of the allege deficiencies. The Plan of Correction is prepared and executed solely because it is required by federal and state law.	
F 151 SS=E	483.10(a)(1)&(2) RIGHT TO EXERCISE RIGHTS - FREE OF REPRISAL The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights. This REQUIREMENT is not met as evidenced by: Based on interview, record review and policy review, it was determined the facility failed to ensure five (5) of five (5) unsampled residents, (Unsampled Residents A, B, C, D and E) were afforded the opportunity to vote in the recent primary election. The findings include: Review of the Voting Policy, revised 09/01/13, revealed facility residents had the right to exercise their rights as a citizen of the United States and to participate in national, state, county and local elections, free from interference, coercion, and reprisal. The Director of Recreation or designee would assure that all patients who were able and desired to do so were supported in exercising their right to vote in their local community and were responsible for coordinating patient's voting in national, state, county, and	F 151	1. The Social Service Director interviewed Unsampled residents A, B, C, D and E to determine changes in residents mood as a result of not voting on 07/08/15 with no areas of concern identified. 2. All residents have the potential to be affected. The Social Service Director and the Administrator conducted resident interviews to determine if other residents' rights had been respected and wishes honored to include the right to vote No concerns were identified. 3. Re-education to all Activities personnel by Social Services Director on 07/09/15 regarding: Residents Rights to include the right to vote. A post-test to validate understanding was given after completion of re-education. The Activities Director Social Service Director and or the Administrator will ensure upcoming elections on posted on activities calendar and present information of the upcoming election to the Resident Council. Cont. on page 2	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

[Signature] *[Title]* 7/24/15

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

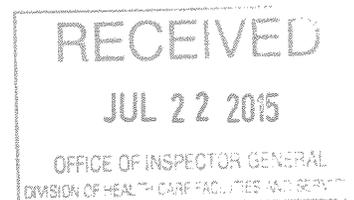
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If continuation sheet Page 1 of 11
JUL 22 2015
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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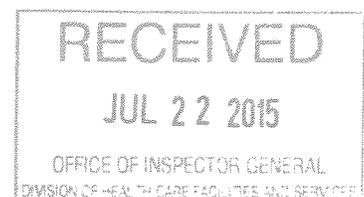
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F 151	Continued From page 1 local elections, in accordance with local jurisdiction requirements. Interview with Unsampled Residents A, B, C, D and E, during the group meeting, on 06/15/15 at 11:00 AM, revealed all five (5) residents were not aware of the election last month (May 2015) and would have liked to vote in the primary elections. Interview with Activity Assistant, on 06/16/15 at 3:14 PM, revealed the Activity Director instructed her around the end of April 2015 to ask all the residents if they wanted to vote. The Activity Assistant stated she did not ask all of the residents. She just focused on all of the Rehab residents. The Activity Assistant stated she had asked some of the residents on the long term units, but they said no. The Activity Assistant stated in all only two (2) residents (licensed for eighty-two (82) beds) voted from the facility. The Activity Assistant stated she did not document who all she asked about voting, but was aware each resident had the right to vote. Interview with the Activity Director, on 06/16/15 at 2:38 PM, revealed she sent her Activity Assistant to ask the residents about voting. She stated there was only two (2) residents who voted from the facility, because she placed ballots in the mail for them. The Activity Director stated she did not follow up with the Activity Assistant about which residents were asked about voting and should have followed up. The Activity Director stated she was usually responsible for ensuring residents were made aware of the voting every year, but had obtained a new job as Social Services and delegated the task to the Activity Assistant. The Activity Director stated the residents had the right to vote.	F 151	Cont. from page 1 4. The Activities Director, Social Service Director and or Administer will audit calendar for upcoming elections and present information monthly of upcoming elections to the resident council meeting regarding voting notification for 1 year. 5 residents will be interviewed monthly to determine their rights are respected to include the right to vote by the Activities director and or Social Services director. Results of the audits will be submitted monthly for 12 twelve months to the Quality Improvement Committee by the Activities Director and or Social Service Director for further review and recommendation. The Quality Improvement committee consist of: Administrator, Director of Nursing, Assistant Director of Nursing, Social Services, Medical Director, Activities Director, Business Office Manager, Pharmacy Consultant, Maintenance Director, Dietary Manager and Housekeeping Supervisor.	07/23/15	



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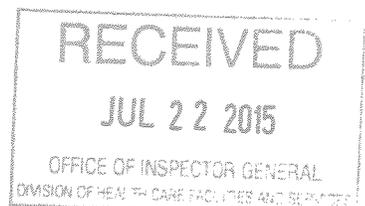
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F 151	Continued From page 2	F 151			
F 281 SS=D	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to assure that services being provided according to acceptable standards of clinical practice for one (1) of sixteen (16) sampled residents (Resident # 1) urinary drainage bag was not maintained at a level lower than the bladder.</p> <p>The findings include:</p> <p>Review of the Lippincott Manual of Nursing Practice, Eighth Edition, page 757, Maintaining a closed drainage system, revealed the urinary drainage bag should be maintained with unobstructed urine flow. Further review revealed the drainage bag should be maintained in a dependent position below the level of the bladder and urine should not be allowed to collect in the tubing because a free flow of urine was required</p>	F 281	<p>1. Resident #1 was assessed for signs or symptoms of urinary tract infection on 6/15/15 by LPN#2. No change in status was identified. Urinary bedside drainage bag was placed at the level below the bladder for resident #1. On 6/15/2015 the Assistant Director of Nursing replaced the urinary leg bag with a bedside drainage bag. Re-education was provided by Assistant Director of Nursing with LPN #2 and LPN#3 regarding care of Foley catheter on 6/15/15 and a post-test was given to ensure understanding.</p> <p>Cont. on page 4</p>		



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F 281	<p>Continued From page 3 to prevent infection.</p> <p>Review of the facility's procedure titled "Care of Indwelling Urinary Catheter", revised on 01/02/14, revealed the urinary catheter tubing was to be secured to keep the drainage bag below the level of the resident's bladder and should be positioned for straight drainage.</p> <p>Record review revealed the facility readmitted Resident #1, on 05/21/14, with diagnoses of Alzheimer's Disease, Chronic Airway Obstruction, Hypertension, and Urinary Retention. Review of the June 2015 Physician's Orders revealed an order for an indwelling urinary catheter.</p> <p>Observation of Resident #1, on 06/15/15 at 10:05 AM, during a skin assessment revealed Resident #1 was laying in bed, with an indwelling urinary catheter attached to a leg bag at the level of the bladder.</p> <p>Observation and interview, on 06/16/15 at 8:35 AM, revealed Resident #1 was abed eating breakfast. Interview with Resident #1 revealed the urinary drainage bag remained intact to his/her leg.</p> <p>Interview with Licensed Practical Nurse (LPN) #2, on 06/16/15 at 2:30 PM, revealed Resident #1 should not have a leg bag while in bed. She stated the urinary drainage bag should be below the level of the bladder at all times to prevent urine from refluxing into the bladder.</p> <p>Interview with the Charge Nurse, LPN #3, on 06/16/15 at 2:35 PM, revealed Resident #1 should not have a leg bag while in bed. She stated that it was important to have the urinary</p>	F 281	<p>Cont from page 3</p> <p>2. All residents have the potential to be affected including residents who utilize Foley catheters. An audit was conducted on 06/15/15 by the Assistance Director of Nurses (ADON) to determine that residents with Foley catheters urinary drainage bags are maintained at a level lower than the bladder to prevent reflux of urine into the bladder and leg bags not utilized on residents when in bed. No areas of concern were identified.</p> <p>3. Re-education to licensed nursing staff was completed by ADON on 07/09/15 on professional standards of care to include Care of Indwelling urinary catheter regarding maintaining urinary drainage bags level lower than the bladder and leg bags not utilized on residents when in bed. A post-test to validate understanding was given after completion of re-education. Staff not available during this time frame will be provide re-education including post-test upon return to work.</p> <p>Cont. on page 5</p>		



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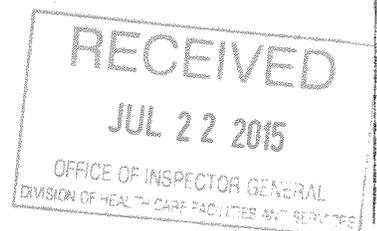
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F 281	Continued From page 4 drainage bag below the level of the bladder to prevent reflux of urine into the bladder and to decrease the risk of a urinary tract infection. LPN #3 stated that most nurses know that, and it was just overlooked. Interview with the Assistant Director of Nursing (ADON), on 06/06/15 at 2:50 PM, revealed residents should not be in bed with a leg bag due to the risk of infection. She stated she did spot checks on all urinary catheters; however, did not document the results. Interview with the Medical Director revealed his expectation was for all urinary drainage bags to be maintained below the level of the bladder to decrease the risk of infections.	F 281	cont. from page 4 4. Infection control audits to include visual observation of urinary catheter drainage bags are at a level lower than the bladder and leg bags not utilized when a resident is in bed will be complete by DON, ADON, and or Unit Manager daily x2 weeks across all shifts including weekends, then 3x's week x 2 weeks then weekly for 2 months, then monthly for 3 months. Areas of concern will be corrected upon discovery. The Director of Nursing and or Assistant Director of Nursing will submit a summary of the audit results to the monthly Quality Improvement (QIC) committee for six (6) months for further review and recommendations. The Quality Improvement committee consist of: Administrator, Director of Nursing, Assistant Director of Nursing, Social Services, Medical Director, Activities Director, Business Office Manager, Pharmacy Consultant, Maintenance Director, Dietary Manager and Housekeeping Supervisor.		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure one (1) of sixteen (16) sampled residents (Resident # 1) urinary drainage bag was	F 315		07/23/15	
			F 315 Cont. on page 6		

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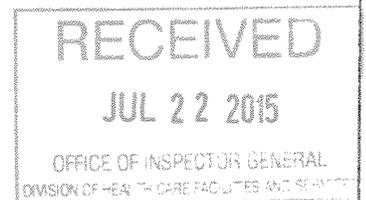
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F 315	<p>Continued From page 5</p> <p>maintained at a level lower than the bladder to prevent urinary tract infections.</p> <p>The findings include:</p> <p>Review of the facility's procedure regarding Care of the Indwelling Urinary Catheter, revised on 01/02/14, revealed the urinary catheter tubing was to be secured to keep the drainage bag below the level of the resident's bladder and should be positioned for straight drainage.</p> <p>Record review revealed the facility readmitted Resident #1, on 05/21/14, with diagnoses of Alzheimer's Disease, Chronic Airway Obstruction, Hypertension, and Urinary Retention. Review of the June 2015 Physician's Orders revealed an order for an indwelling urinary catheter.</p> <p>Review of a Quarterly Minimum Data Set (MDS) assessment, dated 04/09/15, revealed the facility had assessed Resident #1's cognition as severely impaired with a Brief Interview Mental Status (BIMS) score of three (3) which meant the resident was not interviewable.</p> <p>Observation of Resident #1, on 06/15/15 at 10:05 AM, during a skin assessment revealed Resident #1 was laying in bed, with an indwelling urinary catheter attached to a leg bag at the level of the bladder.</p> <p>Observation and interview on 06/16/15 at 8:35 AM, revealed Resident #1 was abed eating breakfast. Interview with Resident #1 revealed the urinary drainage bag remained intact to his/her leg.</p> <p>Interview with Licensed Practical Nurse (LPN) #2,</p>	F 315	<p>Cont. from page 5</p> <p>1. Resident #1 was assessed for signs or symptoms of urinary tract infection on 6/15/15 by LPN#2. No change in status was identified. Urinary bedside drainage bag was placed at the level below the bladder for resident #1. On 6/15/2015 the Assistant Director of Nursing replaced the urinary leg bag with a bedside drainage bag. Re-education was provided by Assistant Director of Nursing with LPN #2 and LPN#3 regarding care of Foley catheter on 6/15/15 and a post-test was given to ensure understanding.</p> <p>2. All residents have the potential to be affected including residents who utilize Foley catheters. An audit was conducted on 06/15/15 by the Assistance Director of Nurses (ADON) to determine that residents with Foley catheters urinary drainage bags are maintained at a level lower than the bladder to prevent reflux of urine into the bladder and leg bags not utilized on residents when in bed. No areas of concern were identified.</p> <p>Cont on page 7</p>		



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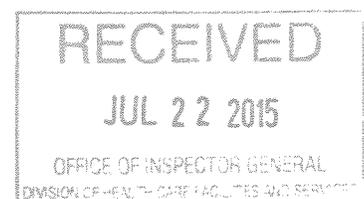
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F 315	<p>Continued From page 6</p> <p>on 06/16/15 at 2:30 PM, revealed Resident #1 should not have a leg bag while in bed. She stated the urinary drainage bag should be below the level of the bladder at all times to prevent urine from refluxing into the bladder.</p> <p>Interview with the Charge Nurse, Licensed Practical Nurse (LPN) #3, on 06/16/15 at 2:35 PM, revealed Resident #1 should not have a leg bag while in bed. She stated that it was important to have the urinary drainage bag below the level of the bladder to prevent reflux of urine into the bladder and to decrease the risk of a urinary tract infection. LPN #3 stated that most nurses know that, and it was just overlooked.</p> <p>Interview with the Assistant Director of Nursing (ADON), on 06/06/15 at 2:50 PM, revealed residents should not be in bed with a leg bag due to the risk of infection. She stated she did spot checks on all urinary catheters; however, did not document the results.</p> <p>Interview with the Medical Director revealed his expectation was for all urinary drainage bags to be maintained below the level of the bladder to decrease the risk of infections.</p> <p>F 441 SS=D 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control</p>	F 315	<p>Cont. from page 6</p> <p>3. Re-education to licensed nursing staff was completed by ADON on 07/09/15 on professional standards of care to include Care of Indwelling urinary catheter regarding maintaining urinary drainage bags level lower than the bladder and leg bags not utilized on residents when in bed. A post-test to validate understanding was given after completion of re-education. Staff not available during this time frame will be provide re-education including post-test upon return to work.</p> <p>4. Infection control audits to include visual observation of urinary catheter drainage bags are at a level lower than the bladder and leg bags not utilized when a resident is in bed will be completed by DON, ADON, and or Unit Manager daily x2 weeks across all shifts including weekends, then 3x's week x 2 weeks, then twice a month for 2 months, then monthly for 3 months, areas of concern will be corrected upon discovery.</p> <p>F 315 continued on next page</p> <p>Cont. on page 8</p>	



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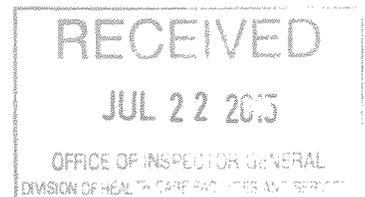
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F 441	<p>Continued From page 7</p> <p>Program under which it -</p> <p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens</p> <p>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and policy review, it was determined the facility failed to ensure an infection control program was followed for one (1) of sixteen (16) sampled residents, (Resident #9) and two (2) of seven (7) unsampled residents, (Unsampled Resident F</p>	<p>F 441</p> <p>F 441</p> <p>F 441</p>	<p>Cont. from page 7</p> <p>F 315</p> <p>The Director of Nursing and or Assistant Director of Nursing will submit a summary of the audit results to the monthly Quality Improvement Committee (QIC) for six (6) months for further review and recommendations.</p> <p>The Quality Improvement committee consist of Administrator, Director of Nursing, Assistant Director of Nursing, Social Services, Medical Director, Activities Director, Business Office Manager, Pharmacy Consultant, Maintenance Director, Dietary Manager and Housekeeping Supervisor.</p> <p>F 441</p> <p>1. CNA #3 providing care for resident #9 on 6/15/15 was re-educated to the facility policy on droplet precautions including need to don personal protective equipment prior to entering the resident room and appropriate handwashing and glove usage by the Assistant Director of Nursing 06/15/15. A post test was given at that time to determine understanding. Resident #9 did not experience any negative outcome. The linens were removed from the linen cart and replaced with clean linen after the linen cart was disinfected by housekeeping on 6/15/15.</p>	<p>07/23/15</p>



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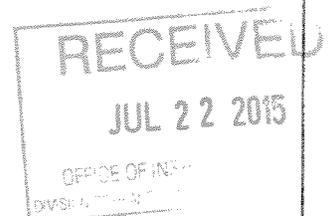
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F 441	<p>Continued From page 8</p> <p>and G). CNA #3 failed to don personal protective equipment when entering Resident #9's isolation room. LPN #5 failed to follow infection control procedures by not sanitizing the accucheck machine after use on Unsampld Residents F and G.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Review of the Infection Control Policies and Procedures, revised 10/01/13, revealed Droplet Precautions would be followed in addition to Standard Precautions when caring for a patient who had known or suspected infection by microorganisms that were transmitted by droplets; for example, influenza. The staff would put on a mask upon entering the room of an infected individual. <p>Review of Resident #9's clinical record revealed the facility admitted the resident on 05/27/15 with diagnoses of Crones Disease, Methicillin Resistant Staphylococcus Aureus (MRSA) of the Sputum, Comfort Measures and Depression.</p> <p>Observation of Certified Nursing Assistant (CNA) #3, on 06/15/15 at 10:02 AM, revealed CNA #3 entered Resident #9's room with out donning personal protective equipment (PPE). CNA #3 then reached above Resident #9's head, above his/her bed to turn off the call light. CNA #3 then exited Resident #9's room without sanitizing or washing her hands. CNA #3 obtained clean linen and re-entered Resident #9's room without donning PPE and placed the linen in Resident #9's room. CNA #3 then came out of Resident #9's room and donned PPE (mask, gloves and gown) entered Resident #9's room and closed the door for privacy.</p>	F 441	<p>Cont. from page 8</p> <p>The blood glucose meter and the Medication cart was sanitized on 6/15/15 by LPN #5. LPN #5 was re-educated to the policy, of Glucose Meter cleaning and disinfecting by ADON on 6/15/15. A post-test was given at the time of re-education to determine understanding. Unsampld residents #F and #G were assessed for signs and symptoms of infection by Assistant Director of Nursing and unit manager on 6/15/15 No change was identified.</p> <ol style="list-style-type: none"> 2. All resident have the potential to be affected including residents who require droplet precautions and accuchecks. Facility rounds were completed by Assistant Director of Nursing (ADON) on 06/16/15 to determine staff were disinfecting blood glucose meter prior to leaving residents room and PPE was donned prior to entering a resident room who required precautions including appropriate handwashing and glove usage. No areas of concern identified. <p>Cont. on page 10</p>	



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

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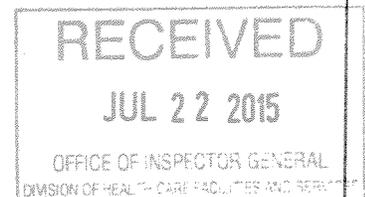
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185443	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/17/2015
NAME OF PROVIDER OR SUPPLIER KENSINGTON CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 225 SAINT JOHN ROAD ELIZABETHTOWN, KY 42701	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE
F 441	<p>Continued From page 9</p> <p>Interview with CNA #3, on 06/17/15 at 1:20 PM, revealed when she started her shift, she would obtain report from the previous CNA. CNA #3 stated she could not remember what Resident #9 was on precautions for. CNA #3 did remember seeing the isolation signage on Resident #9's door to come see the nurse, as well as the PPE bin located outside of Resident #9's door. CNA #3 stated when a resident had MRSA of the sputum, she had to make sure she donned a facial mask to prevent the spread of the infection. CNA #3 stated she could have inhaled the infection or carried it on her clothes and spread the infection to others.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 06/17/15 at 1:55 PM, revealed Resident #9 had a diagnosis of MRSA of the sputum. LPN #1 stated staff should put on a mask, gloves and a gown to protect themselves from infections and preventing the spread of infection to staff and residents. LPN #1 stated if the CNA's were not sure of what PPE to don or precautions to follow, the CNA's should come to see the nurse. LPN #1 stated she had not witnessed any CNA entering rooms without donning PPE.</p> <p>Interview with the Assistant Director of Nursing (ADON), on 06/17/15 at 2:00 PM, revealed if a resident was diagnosed with MRSA of the sputum she expected the staff to don gloves, a mask and a gown before entering the room. She stated Resident #9's type of infection would be a droplet isolation. The ADON stated if the droplets were not contained, the droplets could land on staff skin and other areas. The ADON stated she was the Infection Control Nurse and she monitored the staff to ensure they were following isolation</p>	F 441	<p>Cont. from page 9</p> <p>3. Re-education to nursing personnel completed by ADON on 07/09/15 regarding: Infection control policy and procedure for droplet precautions including need to don PPE prior to entering the resident room and appropriate handwashing and glove usage; Use of personal protective equipment and signage; hand washing; and proper cleaning of blood glucose meter. A post-test to validate understanding was given after completion of re-education. Staff not available during this time frame will be provide re-education including post-test upon return to work.</p> <p>4. Infection control rounds to include visual observation of disinfecting blood glucose meters and donning personal protective equipment if indicated including handwashing and glove usage will be completed by DON, ADON and or Unit Manager daily x 2 weeks across all shifts including weekends, then 3x's week x 2 weeks, weekly for 2 months, then monthly for 3 months. Areas of concern will be corrected upon discovery.</p> <p>Cont. on page 11.</p>



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185443	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/17/2015
NAME OF PROVIDER OR SUPPLIER KENSINGTON CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 225 SAINT JOHN ROAD ELIZABETHTOWN, KY 42701		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	<p>Continued From page 10</p> <p>precautions; however, she could not provide any evidence of this. The ADON stated she had not identified any concerns with infection control.</p> <p>2. Review of the facility's policy and procedure regarding Glucose Meters, revised on 06/01/15, revealed it's purpose was to maintain the equipment at the optimal level of functioning, prolong the life of the meter, and maintain infection control standards. Further review revealed staff were to disinfect the meter after each patient use.</p> <p>Observation during a blood glucose monitoring procedure, on 06/15/15 at 11:43 AM and 11:48 AM, and 06/16/15 at 4:40 PM and 5:05 PM, revealed LPN #5 placed the blood glucose meter on the medication cart after use on Unsampled Residents F and G.</p> <p>Interview with LPN #5, on 06/16/15 at 5:15 PM, revealed she should have placed the used blood glucose meter on a barrier and not directly on the medication cart. She stated this was important to prevent the spread of infection.</p> <p>Interview with the Director of Nursing (DON), on 06/16/15 at 5:50 PM, revealed it was her expectation for staff to follow the policy and procedure related to the blood glucose meter. She further stated staff should hold the used blood glucose meter in their hand until it was appropriately sanitized.</p>	F 441	<p>Cont. from page 9</p> <p>Results of the audits will be submitted to the monthly Quality Improvement committee (QIC) by the Director of Nursing and or the Assistant Director of Nursing monthly for 6 months for further review and recommendations. The Quality Improvement committee consist of: Administrator, Director of Nursing, Assistant Director of Nursing, Social Services, Medical Director, Activities Director, Business Office Manager, Pharmacy Consultant, Maintenance Director, Dietary Manager and Housekeeping Supervisor.</p>	07/23/15	



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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185443	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 06/16/2015
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NAME OF PROVIDER OR SUPPLIER KENSINGTON CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 225 SAINT JOHN ROAD ELIZABETHTOWN, KY 42701
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 2000, Original building; 2010, Physical Therapy and Rehabilitation addition.</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type III Unprotected.</p> <p>SMOKE COMPARTMENTS: Six (6) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic, dry sprinkler system.</p> <p>GENERATOR: Type II, 55KW generator, fuel source is natural gas.</p> <p>A Recertification Life Safety Code Survey was conducted on 06/16/15. The facility was found to be in compliance with the Requirements for Participation in Medicare and Medicaid in accordance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire).</p>	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.