

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

PRINTED: 07/03/2012
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 06/21/2012
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NAME OF PROVIDER OR SUPPLIER KENSINGTON MANOR CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 225 SAINT JOHN ROAD ELIZABETHTOWN, KY 42701
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(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
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<p>F 000 INITIAL COMMENTS</p> <p>A standard health survey was conducted 06/19/12 through 06/21/12 and deficiencies were cited with the highest scope and severity of an "F". The facility had the opportunity to correct the deficiencies before remedies would be recommended for imposition. A Life Safety Code survey was conducted on 06/19/12 and found the facility meeting minimum requirements for participation in Medicare and Medicaid.</p> <p>F 167 SS=C 483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE</p> <p>A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility.</p> <p>The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's resident handbook, it was determined the facility failed to ensure the results of state surveys were available for viewing by all individuals who reside in or visit the facility, without having to ask a staff person for access to the survey results in two (2) of the two (2) nursing units and the front desk by the main entrance.</p> <p>The findings include:</p>	<p>F 000 "This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Kensington Manor Care & Rehabilitation Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."</p> <p>F167 1. Binders labeled "Survey Results" were placed in the front lobby, long term care dayroom, and the sitting room on the Rehabilitation Recovery Unit on 6-21-12 by the Administrator. The receptionist and RN #2 Unit Manager were re-educated to the location of the survey binders within the facility and that they are to be accessible to residents and visitors on 6-21-12 by the Administrator. Resident #7 and #8 and the family of Resident #2 were notified of survey binder availability and their locations within the facility by the Social Services Director on July 6, 2012.</p>
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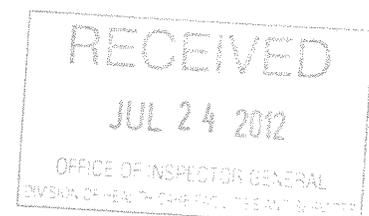
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Mary Ann Morony</i>	TITLE <i>X Adm</i>	(X6) DATE <i>X 7/24/12</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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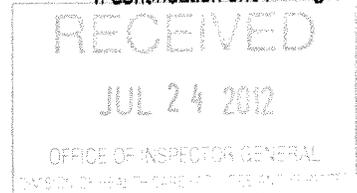
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F 167	<p>Continued From page 1</p> <p>Record review of the facility's admission packet revealed an insert titled Resident Rights and Information for Residents Living in Kentucky: Federal and State Resident Rights, Advance Directives, State Bed Hold, State Medicaid Eligibility, and an AIDS Fact Sheet. KY-OFC0509-153, Section G of the document stated the facility must make the state survey results available for examination in a place readily accessible to residents and post a notice of their availability.</p> <p>Observation, on 06/19/12 at 10:45 AM, revealed a sign on the wall at the main entrance receptionist's desk that stated survey results were available upon request, but the survey results were stored behind the desk in an unlabeled black binder.</p> <p>Observation, on 06/20/12 at 10:45 AM, revealed the state survey results book for the public was not found.</p> <p>Observation, on 06/21/12 at 9:30 AM, revealed the state survey results were stored in a white binder, labeled Public Data Binder, at the 200 and 300 hall nurses' station in a location where it was not visible to residents or visitors.</p> <p>Observation, on 06/21/12 at 10:20 AM, revealed the state survey results were stored on the Rehab Unit, on a shelf at the nurses' station, in a white binder labeled Public Data Binder.</p> <p>Interview, on 06/21/12, at 9:15 AM, with the Receptionist at the front desk revealed the state survey results were in a black binder behind the receptionist's desk in an area not visible to</p>	F 167	<p>2. Binders labeled "Survey Results" were placed in the front lobby, long term care dayroom, and the sitting room on the Rehabilitation Recovery Unit on 6-21-12 by the Administrator. Signage was posted in the main lobby by the Maintenance Director on July 6, 2012 indicating that survey results are available for review and the specific locations within the center where the binders can be located. A Resident Council meeting was held on 7-6-12 when residents were re-educated by Administrator on the availability of survey results and the locations within the facility where the survey binder are kept.</p> <p>3. The Regional Director of Clinical Operations re-educated the Administrator on 6-21-12 to the posting requirements of Survey Results. The Administrator re-educated Social Services, the Director of Nursing and Assistant Director of Nursing to survey result posting requirement and the locations they are kept within the facility on June 27, 2012.</p>	



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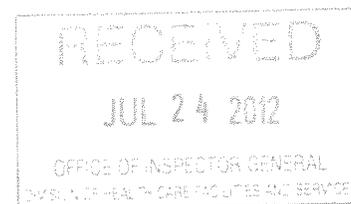
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F 167	<p>Continued From page 2</p> <p>residents and visitors. The receptionist stated no one had given her instructions to store the survey results behind the desk, but to her knowledge it had always been kept there.</p> <p>Interview with unsampled Resident C, on 06/21/12 at 11:30 AM, revealed the resident was the Resident Council president. The resident revealed he/she was not aware of the location of the survey results book. While holding up the binder labeled Public Data Binder, the resident asked what the book was and what the term, public data, meant.</p> <p>Interview, on 06/21/12 at 11:20 AM, with Resident #8 revealed he/she was unsure what type of information was in the white binder, labeled Public Data Binder, but he/she guessed it might be some type of health information.</p> <p>Interview, on 06/21/12 at 11:25 AM, with Resident #7 revealed he/she had not seen the Public Data Binder during his/her stay on the Rehab Unit, and did not know what type of information the binder contained.</p> <p>Interview, on 06/21/12 at 11:25 AM, with Resident # 2's family member by phone revealed she had not seen the facilities survey results book in any common areas and was not aware the facility even had a state survey book.</p> <p>Interview, on 06/21/12 at 11:45 AM, with RN #2 Unit Manager (UM) for the Rehab Unit, revealed she was not immediately aware of where the state survey results were on her unit. When she was shown the Public Data Binder, stored on a shelf at the nurses' station, she stated she would</p>	F 167	<p>Nursing, maintenance, social services, activities and administrative staff were re-educated by Social Services or the Assistant Director of Nursing to the requirement of posting survey results and the locations of the survey binders within the facility by June 27, 2012.</p> <p>4. The Administrator or Manager on Duty will check that the survey binders are maintained in the designated areas weekly x4 weeks and then monthly x2 months and at least quarterly. These findings will be submitted to the Performance Improvement Committee monthly x3 months and then at least quarterly for further review and recommendation.</p> <p>Completion Date 7-13-12</p>



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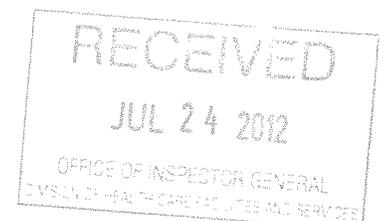
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F 167	Continued From page 3 not be able to identify its contents as state survey results based on how the binder was labeled. Interview, on 06/21/12 at 4:40 PM, with the Director of Nursing (DON) revealed she did not think the Public Data Binder label readily identified the contents as state survey results. Interview, on 06/21/12 at 4:45 PM, with the Facility's Administrator revealed she was ultimately responsible for updating the contents of the state survey results binder, for ensuring it was clearly labeled as the state survey results, and for placing the results in areas where all residents and visitors could view them without asking staff for assistance.	F 167		
F 364 SS=F	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation, Interview, and review of the facility's policy, it was determined the facility failed to ensure food and drinks were served at preferable temperatures for three (3) of sixteen (16) sampled Residents (#1, #9, and # 11, and three (3) of three (3) unsampled Residents (A, B, and C), covering four (4) of four (4) halls. Residents at the resident council meeting, as well as, residents on all four halls voiced concerns regarding the hot food not served hot and cold	F 364	F364 1. Open milk cartons were discarded by the Dietary Manager on 6-21-12. Resident #1, #9, and #11 were assessed with no changes in condition noted on 6-21-12 by a licensed nurse. 2. Open milk cartons were discarded by the Dietary Manager on 6-21-12. The Administrator re-educated the Dietary Manager to maintaining food and drinks at temperatures preferable to the residents including that milk will be stored on ice when outside of the refrigerator on 6-21-12, and this practice was implemented beginning with the supper meal on 6-21-12. A resident council meeting was held on 7-6-12	



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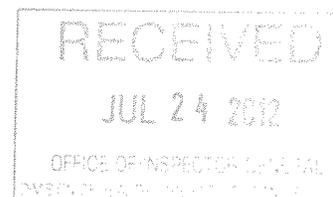
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F 364	<p>Continued From page 4 food and drinks were not cold.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Food, dated 07/08, revealed food is served palatable, attractive and at the proper temperature.</p> <p>Observation, on 06/19/12 during lunch meal service, revealed the 200 hall tray pass included four cups of milk were sitting on top of the meal cart on a tray. They were not on ice. On the 300 hall trays, the cart was not enclosed. It contained six trays and one tray contained one cup of milk not on ice.</p> <p>Observation, on 06/20/12 during lunch hall tray pass, revealed the Dietary Manager went to retrieve the Director of Nursing to help pass hall trays on the 300 hall.</p> <p>Observation, on 06/21/12 at 8:00 AM, revealed seven breakfast trays on an open cart on the 300 hallway, which included four trays with milk on the trays, not on ice.</p> <p>Review of the Resident Council Minutes, dated 05/24/12, revealed many residents said food was not always hot when the trays came out to the dining room.</p> <p>During the group interview conducted, on 06/19/12 at 2:30 PM, revealed three (3) unsampled Residents (A, B, and C), complained of the food not being hot enough.</p> <p>Interview with Resident #9, on 06/20/12 at 10:15 AM, revealed all meals are eaten in the room.</p>	F 364	<p>when no further concerns were voiced by residents regarding to food/drink temperatures. Interviews were completed with cognitively intact residents by the Dietary Manager, Activities Director and/or Social Services to determine resident preference and satisfaction with food and drink temperatures on July 11, 2012. Any identified concerns were immediately addressed.</p> <p>3. The Administrator, Director of Nursing, Assistant Director of Nursing and Dietary Manager re-educated nursing and dietary staff including Cook #1 and Dietary Aide #1 to the meal delivery process which included timely passing of meal trays, maintaining food and drink temperatures including keeping milk on ice when not refrigerated by July 12, 2012.</p> <p>4. A Food Committee Meeting will be held weekly x4 weeks and then monthly x2 months to determine resident satisfaction with food and drink temperatures by the Dietary Manager and Administrator. These findings will be submitted to the Performance Improvement Committee monthly x3 months and then at least quarterly for further review and recommendation.</p> <p>Completion Date</p>	7-13-12	



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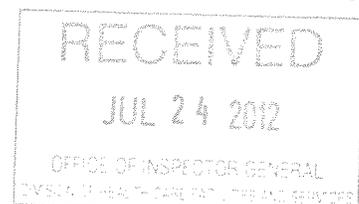
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F 364	<p>Continued From page 5</p> <p>The resident stated hot foods were sometimes cold and the cold food, including the milk, was sometimes warm. The resident stated he/she had reported this to the CNA who brought in the tray.</p> <p>Interview with Certified Nursing Assistant #2, on 06/21/12 at 9:10 AM, revealed two CNAs worked each hallway. She stated one CNA passed breakfast trays and the other passed lunch trays. She stated the milk was not usually put on ice.</p> <p>Interview with CNA #3, on 06/21/12 at 9:18 AM, revealed she usually worked the 200 hall and in regards to the milk it was off and on whether the milk was on ice.</p> <p>Interview with Dietary Cook #1, on 06/21/12 at 10:10 AM, revealed cold drinks go on top of the cart and should be on ice. She stated no one wants to drink warm milk. She stated they must have forgotten on Tuesday to put the milk on ice. She went on to say the Dietary Manager did audits on the passing of the hall trays and how long it took to deliver the trays to the residents. She stated she did not know how many staff passed hall trays at each meal. She stated she had not heard of any complaints in five to six months of problems or concerns with the food temperatures.</p> <p>Interview with Dietary Aide #1, on 06/21/12 at 10:30 AM, revealed she was responsible for the hall trays and the drink set up. She stated the hall trays with milk are poured in cups and placed on the trays but they should be on ice. In regards to the cups of milk on top of the cart on the 200 hallway not on ice, they just forgot. She stated</p>	F 364		



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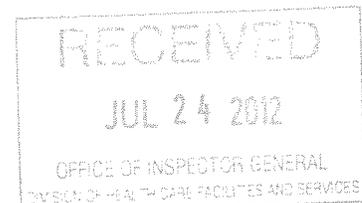
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F 364	<p>Continued From page 6</p> <p>she had not heard of any complaints in at least the past 2 months.</p> <p>Interview with the Social Worker, on 06/21/12 at 4:00 PM, revealed she had attended the last Resident Council Meeting on 05/24/12 and remembered the residents had complained about the food temperatures. She stated she verbally told the Dietary Manager but may not have indicated the complaints came from the Resident Council meeting.</p> <p>Interview with the Dietary Manager, on 06/21/12 at 4:30 PM, revealed she had not done any audits on the hall tray pass since hire in February, 2012, and was not aware of how long it took for staff to pass hall trays. She stated she did not have any control over how long it took for hall trays to be passed. She stated she was not aware there were that many complaints about the food temperature or a complaint from the Resident Council Meeting. She stated she thought it was one resident and they had addressed the concern with the one resident by hand delivering the tray. She acknowledged there was not a system in place for the timely delivery of hall trays. She stated the milk should not be left out and should be on ice for the hall trays.</p> <p>Observation of the meal service and tray line in the Rehabilitation Unit dining room, on 06/19/12 at 11:45 AM, revealed a gallon container of milk sitting on a table to the left of the steam table. Staff were observed pouring milk from the container, sitting it back on the table, and serving the glasses to the residents. Observation of the meal service in the Rehabilitation Unit dining room, on 06/19/12 at 1:00 PM, revealed the same</p>	F 364		



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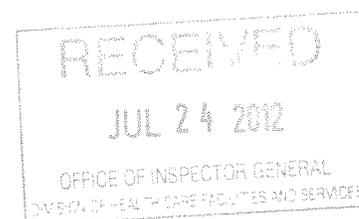
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F 364	<p>Continued From page 7</p> <p>milk carton sitting on the table and being used and distributed to the residents eating in their rooms after sitting out, not refrigerated for one (1) hour and fifteen (15) minutes .</p> <p>Interview with Resident #1, on 06/21/12 at 11:05 AM, revealed the milk was not served cold.</p> <p>Interview, on 06/21/12 at 11:10 AM, with Resident #11 revealed the milk served by the facility was warm when she received her breakfast trays in her room. She preferred cold milk to pour over her cereal.</p> <p>Interview with the Rehab Unit Manager, on 06/21/12 at 2:40 PM, revealed the milk was normally kept out of the refrigerator and on the table during meal service. The Unit Manager revealed she had never seen temperatures done on the dairy products served on the Rehabilitation Unit.</p> <p>Interview with the Dietary Manager, on 06/21/12 at 3:00 PM, revealed milk should not be sitting out for an extended period of time and an hour was too long to sit out during meal service. The Dietary Manager revealed the potential for residents to become sick from milk sitting out an extended period of time.</p>	F 364	
F 441 SS=E	<p>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>	F 441	<p>F441</p> <p>1. Licensed Practical Nurse #1 and Certified Nursing Assistant #1 were both re-educated to Infection Control Guidelines that included hand washing by the Assistant Director of Nursing on 6-20-12.</p>



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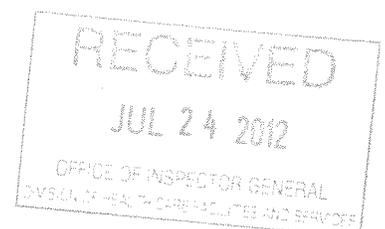
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NAME OF PROVIDER OR SUPPLIER KENSINGTON MANOR CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 225 SAINT JOHN ROAD ELIZABETHTOWN, KY 42701		
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F 441	<p>Continued From page 8</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it -</p> <ol style="list-style-type: none"> (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. <p>(b) Preventing Spread of Infection</p> <ol style="list-style-type: none"> (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. <p>(c) Linens 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, and review of the facility's policy, it was determined the facility failed to ensure staff washed/sanitized their hands to prevent the spread of infection to two (2)</p>	F 441	<p>Resident #1 and #4 were assessed by a licensed nurse on 6-20-12 with no signs of infection noted.</p> <p>2. Residents residing in the center benefit from proper hand washing procedures. Licensed Practical Nurse #1 and Certified Nursing Assistant #1 were both re-educated to Infection Control guidelines that included hand washing by the Assistant Director of Nursing by 6-27-12. Resident #1 and #4 were assessed by a licensed nurse on 6-20-12 with no signs of infection noted. The Assistant Director of Nursing, Unit Managers, Nursing Supervisors, and Dietary Manager completed observations of staff hand hygiene procedures during resident care and meal times at random June 28, 2012 thru July 10, 2012 to determine proper hand washing practices. Any concerns identified were addressed immediately.</p> <p>3. The Staff Development Coordinator and Director of Nursing re-educated licensed nurses, certified nursing assistants, dietary, therapy, housekeeping, activities, social services, maintenance, and administrative staff to Infection Control guidelines including hand washing by July 12, 2012.</p>		



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

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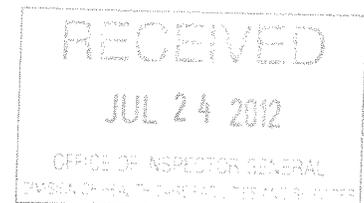
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185443	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/21/2012
NAME OF PROVIDER OR SUPPLIER KENSINGTON MANOR CARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, 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)
F 441	<p>Continued From page 9</p> <p>of the sixteen (16) sampled residents (Residents #4 and #7) during the skin assessments. In addition, proper hand hygiene was not performed during meal pass on the rehab unit.</p> <p>The findings include:</p> <p>Record review of the facility's policy regarding Standard Precaution Guidelines, Section 10, dated October 2009, revealed after hands were scrubbed, rinsed, and dried with a paper towel, the faucet on the hand sink should be turned off with the disposable paper towel. The policy stated hand hygiene was required before and after direct resident contact (for which hand hygiene was indicated by acceptable professional practice). Facility employees were to use standard precautions when providing care to all residents regardless of the diagnosis or suspected infection.</p> <p>Observation, on 06/20/12 at 10:15 AM, revealed Licensed Practical Nurse (LPN) #1 did not wash her hands upon entering Resident #4's room to begin his/her skin assessment. At the completion of the skin assessment, LPN #1 removed her gloves, washed her hands, and turned off the water faucets with her bare hands.</p> <p>Observation, on 06/20/12 at 10:40 AM, revealed LPN #1 did not wash her hands upon entering Resident # 7's room to begin his/her skin assessment. After the skin assessment, LPN #1 removed her gloves, washed her hands, and turned off the water faucets with her bare hands.</p> <p>Observation, on 06/20/12 at 12:20 PM, in the rehab dining room, revealed Certified Nursing</p>	F 441	<p>4. The Director of Nursing and or Staff Development Coordinator will complete observations of a minimum of 2 licensed nurses and 2 certified nursing assistants during meal times and resident care to determine that hand washing procedures are as per policy weekly x8 weeks and then monthly x1 month and then at least quarterly. These findings will be submitted to the Performance Improvement Committee monthly x3 months and then at least quarterly for further review and recommendation.</p> <p>Completed</p>
			(X5) COMPLETION DATE 7-13-12



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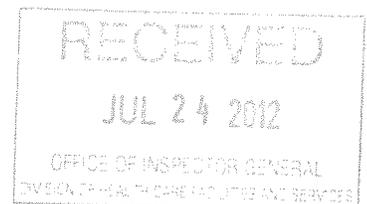
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185443	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/21/2012
NAME OF PROVIDER OR SUPPLIER KENSINGTON MANOR CARE AND REHABILITATION CENTER			STREET ADDRESS, 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>Assistant (CNA) #1 washed her hands on two separate occasions at the sink behind the serving table in the rehab dining room, rather than in the residents' rooms where she delivered the meal trays. After washing her hands, CNA #1 turned off the faucet handles with her bare hands.</p> <p>Interview, on 06/20/12 at 4:20 PM, with LPN # 1 revealed she should have washed her hands upon entering the residents' rooms and before performing direct care for Resident #4 and Resident #7, even though clean gloves were worn. LPN #1 stated proper hand washing procedures involved washing for five (5) seconds with soap and water, rinsing, drying, and using a paper towel to turn off the faucet handles. LPN # 1 stated the potential problem was recontamination of her clean hands with germs from the faucet handles, and the spread of infection to residents.</p> <p>Interview, on 06/21/12 at 2:00 PM, with CNA #1 revealed she should have used a paper towel to turn off the faucet handles each time she washed her hands during meal pass. CNA #1 stated the potential problem was the transfer of germs to her clean hands. CNA #1 stated she was supposed to wash her hands or use hand sanitizer after every third tray she passed, and she typically washed her hands at the sink behind the steam table, rather than in residents' rooms, because it was closest to the area where she picked up meal trays for delivery. CNA #1 stated her last hand hygiene in-service occurred about one year ago.</p> <p>Interview, on 06/21/12 at 9:15 AM, with</p>	F 441			



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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 06/21/2012	
NAME OF PROVIDER OR SUPPLIER KENSINGTON MANOR CARE AND REHABILITATION 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 11</p> <p>Registered Nurse (RN) # 2 Unit Manager, revealed staff members should wash their hands before giving direct care to residents. They should remove their gloves, and wash their hands before leaving residents' rooms. Proper hand washing procedure included scrubbing one's hands, wrists, and finger nails for approximately one minute, rinsing, drying hands with a paper towel, and turning off the faucet handles with a clean paper towel. The potential problem would be the transfer of pathogens to clean hands if paper towels were not used to turn off the faucet handles.</p> <p>Interview on 06/21/12 at 2:45 PM, with the Assistant Director of Nursing (ADON) revealed new employees were educated in proper hand washing technique during orientation, which emphasized the importance of washing one's hands even if gloves were worn while giving direct care to the residents. Employees were required to review a required hand washing tutorial annually.</p>	F 441		



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 06/19/2012
NAME OF PROVIDER OR SUPPLIER KENSINGTON MANOR CARE AND REHABILITATION 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	
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: Five (5) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic, dry sprinkler system; hydraulically designed.</p> <p>GENERATOR: Type II, 55KW generator, fuel source is natural gas.</p> <p>A standard Life Safety Code survey was conducted on 06/19/12. Kensington Manor Care and Rehabilitation Center 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

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.