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

PRINTED: 09/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185061		08/23/2012
NAME OF PROVIDER OR SUPPLIER: KENWOOD HEALTH AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 130 MEADOWLARK DRIVE RICHMOND, KY 40475	

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SEP 18 2012
Division of Health Care
Southern Enforcement Branch

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
	A standard health survey was conducted on 08/21-23/12. Deficient practice was identified with the highest scope and severity at 'E' level.			
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES	F 246		
	A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.		**F246** 1. Resident #9 received chicken noodle soup per preference after the evening meal on 8/21/2012. Medical Director was made aware by the Administrator that Resident #9 food preferences were not followed on 8/21/2012 .No new orders noted.	
	This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure services were provided based on individual needs and preferences for one of eighteen sampled residents (Resident #9). The Food Preference Record identified Resident #9 preferred chicken noodle soup to be provided with meals; however, the soup was not provided for the resident during the evening meal on 08/21/12.		2.Dietary Manager (DM) and Registered Dietician (RD) will complete a one time audit by 9/20/2012 of all current residents to identify any resident that does not have food preferences up to date. Any issues noted will be immediately corrected. RD to monitor tray line at least 3 times by 9/23/2012 to identify if food preferences are followed at meal time. Any issue will be immediately corrected.	
	The findings include:			
	Interview with the Registered Dietitian (RD) on 08/22/12, at 10:45 AM, revealed the facility did not have a policy/procedure to ensure food tray accuracy and food preferences were honored.		3. Education Training Director and /or Dietary Manager to re educate dietary and nursing staff by 9/21/2012 regarding policy to obtain food preferences and to ensure food preferences are followed when meal is served. DM to audit at least 10 trays daily 5 x weekly x 4 weeks beginning week of 9/24/2012.	
	Review of the medical record revealed the facility admitted Resident #9 on 04/30/08, with diagnoses to include Psychosis, Esophageal			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Christy King, TITLE: Administrator, (X6) DATE: 9/18/12

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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NAME OF PROVIDER OR SUPPLIER: KENWOOD HEALTH AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE: 130 MEADOWLARK DRIVE, RICHMOND, KY 40475

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F 246	Continued From page 1 Reflux, Failure to Thrive, and Senile Dementia. Review of the quarterly MDS assessment with a reference date of 06/10/12, revealed the resident was assessed to have a BIMS (Brief Interview for Mental Status) score of "0" and was not interviewable. Resident #9 was observed on 08/21/12, at 6:20 PM, to be served the evening meal. The resident's meal consisted of pureed meat with gravy, mashed potatoes, pureed vegetable, applesauce, and whole milk. Facility staff was observed to spoon feed the resident. A review of the resident's tray card revealed Resident #9's food preferences were identified for the dinner meal as gravy and chicken noodle soup; however, no soup was observed to be provided on the resident's tray. In addition, a review of the Food Preference Record maintained by the Dietary Department dated 04/04/11, revealed Resident #9 was identified on the record to prefer chicken noodle soup and cabbage. Interview with Certified Nurse Aide (CNA) #2 on 08/21/12, at 6:30 PM, revealed the CNA was responsible to check the resident's tray card to verify the correct diet was provided and to verify the food preferences were on the resident's tray. The CNA stated she had overlooked the soup item on Resident #9's tray card. Interview with the Dietary Manager (DM) on 08/22/12, at 1:20 PM, revealed the cook was responsible to ensure residents received the correct diet and food preferences. The DM also	F 246	UM/Administrator to audit at least 5 trays monthly to ensure food preferences are followed and recorded beginning week of 9/24/2012. RD/DM to audit all admissions with 72 hours to ensure food preferences are recorded x 2 months beginning week of 9/24/2012. IDT to audit 5 records weekly x 4 weeks beginning week of 9/24/2012 to ensure food preferences obtained per policy. 4.QA committee consisting of at least Administrator , Director of Nursing, Social Services, Dietary, Life Enrichment Director and MDS department to review audit findings weekly x 2 weeks beginning week of 9/26/2012 and then monthly until committee makes recommendation to resolve issue. 5. Date of Compliance 9/28/2012	

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NAME OF PROVIDER OR SUPPLIER: KENWOOD HEALTH AND REHABILITATION CENTER

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F 246	Continued From page 2 stated she did not know why the resident did not receive the soup on 08/21/12. Interview with the dietary cook on 08/22/12, at 1:10 PM, revealed Resident #1 should have received chicken soup on the evening meal tray. The dietary cook stated she did not know why the resident did not receive the soup during the evening meal on 08/21/12.	F 246		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to provide effective housekeeping/maintenance services to ensure a sanitary, comfortable interior. The shower rooms were observed to have broken tiles, soiled tile/grout, and areas of mold. Two doors were observed to have sharp, splintered edges and the baseboard in one resident room was separated from the wall. In addition, there was a buildup of soil in the hallway next to the baseboards on the A-B Wings. The findings include: An interview with the Regional Clinical Coordinator on 08/23/12, at 2:30 PM, revealed there was no maintenance policy for the facility. Observations of the facility on 08/21/12 and	F 253	**F253** 1. Resident room doors B-6 and E-6 were immediately repaired. The baseboard in resident room E-7 was immediately repaired. A/B Wing and C Wing shower rooms were deep cleaned and mold/built up was removed. C Wing shower room broken tile was replaced. 2. Director of Maintenance (DOM) inspected all doors for splintered edges. DOM inspected all baseboards in resident rooms. Environmental Service Manager coordinated for all shower rooms to be deep cleaned and any mold/built up was removed.	

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F 253	Continued From page 3 08/23/12, revealed the following areas in need of maintenance/housekeeping services: 1. The A/B Wing shower room was observed to have mold on the tiles in the shower. The C Wing shower contained broken tiles and soiled tiles/grout. The shower room on the E Wing was observed to have a sharp, splintered edge on the entrance door. 2. The doors in resident rooms B-6 and E-6 were observed to have splintered door edges. 3. The baseboard in resident room B-7 was observed to have separated from the wall. 4. A buildup of soil was observed in the A/B hallway next to the baseboards and in the corners. An interview with the Environmental Services Supervisor at 11:00 AM on 08/23/12, revealed the shower rooms were to be "deep cleaned" on a weekly basis. The Environmental Services Supervisor stated he was planning to clean the corners/edges but had not "gotten to them yet." An interview with the Maintenance Supervisor (MS) on 08/23/12, at 11:00 AM, revealed he made rounds throughout the building frequently but had not noticed the rough door edges. According to the MS, staff was to complete a work order for maintenance needs and place it in a receptacle at the nurses' station. The MS stated he checked the work order box several times daily and no one had reported the rough edges on the doors or the separated baseboard to him.	F 253	3. Director of Maintenance and Environmental Services Supervisor will tour center weekly beginning, 09/28/2012 x 4 weeks then monthly, to ensure doors, baseboard and shower rooms are in good repair. Any issues identified will be immediately corrected. 4.QA committee consisting of at least Administrator , Director of Nursing, Social Services, Dietary, Life Enrichment Director and MDS department to review audit findings weekly x 2 weeks beginning week of 9/24/2012 and then monthly until committee makes recommendation to resolve issue. 5. Date of Compliance 9/28/2012	

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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, record review, interview, and a review of facility policy, it was determined the facility failed to provide appropriate treatment and services to maintain/restore as much bladder function as possible for one of eighteen sampled residents (Resident #8). Resident #8 was assessed as occasionally incontinent of bladder on 05/14/12. A quarterly assessment on 08/04/12, revealed the resident was assessed to always be incontinent. However, there was no evidence the facility had assessed Resident #8 to identify causative factors of the decline in the resident's bladder function in an attempt to restore as much bladder function as possible. The findings include: A review of the facility's Management of Urinary Incontinence policy, no date given, revealed the facility should identify pattern and frequency for a resident with suspected or known urinary incontinence. The policy directed staff to	F 315	**F315** 1. A 3-day bowel and bladder assessment was immediately initiated on Resident #8 on 08/23/2012. Physician was notified on 08/23/2012 with no new orders. 2. Director Of Nursing and Unit Managers to complete a 100% audit of all bowel and bladder assessments and complete a 3 day bowel and bladder pattern to identify any change in continence level by 9/26/2012. Any issue identified will be corrected immediately. Director of Nursing and MDS nurse(s) to complete a 100% audit and compare updated bowel and bladder assessment to the last MDS completed to identify any resident with a decline in toileting by 9/26/2012. Any issue identified will be immediately corrected.	

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F 315	Continued From page 5 complete a three-day elimination tracking to determine a pattern and to complete a comprehensive bladder assessment using the Bladder Collection and Assessment tool. There were no specific staff members indicated by the policy who would be responsible to complete the procedures. A review of the medical record for Resident #8 revealed the facility admitted the resident on 05/07/12, with diagnoses that included Congestive Heart Failure, Hypertension, Depression, End Stage Renal Disease, and Anxiety. The comprehensive admission Minimum Data Set (MDS) assessment with an Assessment Reference Date of 05/14/12, revealed Resident #8 was occasionally incontinent of bladder with no toileting program or trial in progress. A quarterly MDS assessment with an Assessment Reference Date of 08/04/12, revealed Resident #8 was assessed to always be incontinent. There was no evidence a urinary toileting program/trial was in place for Resident #8 in an attempt to restore the resident's bladder function as much as possible. Further review of the medical record revealed there was no evidence a reassessment was completed when a change in continence was assessed. Observations of Resident #8 on 08/21/12, at 11:53 AM, revealed the resident to be in bed with an empty urinal on the overbed table and a strong odor of urine in the room. An interview with State Registered Nurse Aide (SRNA) #1 on 08/21/12, at 3:00 PM, revealed the direct care staff was to check on residents at least every two hours and to either offer toileting	F 315	3. Education Training Director will re educate nursing staff by 9/28/2012 regarding policy and procedure for bowel and bladder assessments, continence assessments, 3 day bowel and bladder pattern and monitoring for continence change by utilizing the MDS. IDT to audit all new admissions beginning 9/26/2012 x 2 months to ensure bowel and bladder assessment completed, 3 day pattern completed, and MDS is accurate and looks at any change to continence level. DON/Unit Manager to randomly audit 3 bowel and bladder assessments weekly x 4 weeks beginning week of 9/26/2012 to ensure assessment is accurate and any decline from last MDS assessment is addressed. 4.QA committee consisting of at least Administrator , Director of Nursing, Social Services, Dietary, Life Enrichment Director and MDS department to review audit findings weekly x 2 weeks beginning week of 9/26/2012 and then monthly until committee makes recommendation to resolve issue. 5. Date of Compliance 9/28/2012	

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F 315	Continued From page 6 assistance or to perform incontinence care if the resident was incontinent. SRNA #1 stated Resident #8 was incontinent most of the time. SRNA #1 further stated the direct care staff used the "Care Tracker" to document care delivery. An interview with the Minimum Data Set Registered Nurse (MDS RN) on 08/23/12, at 3:55 PM, revealed the MDS RN reviewed the Care Tracker documentation for Resident #8 when she was assessing the resident's bladder function. The MDS RN stated the resident had a decline in continence when the quarterly assessment was completed on 08/04/12, but she did not "catch" it. According to the MDS RN, the facility had converted to a new computer program and the previous assessment was not included on the newer program. The MDS RN stated she was unaware there had been a decline in Resident #8's continence status because she did not compare the quarterly MDS assessment with the previous MDS assessment. An interview with the Director of Nursing (DON) on 08/22/12, at 2:10 PM, revealed the facility's procedure was for the admitting nurse or unit manager to complete a bladder assessment upon admission to the facility. The DON further stated residents were to be reassessed quarterly or if/when a change in continence occurred. The DON stated the facility also conducts a "Daily Clinical Review" to ensure assessed care needs have been addressed, but somehow nobody "caught" the decline in continence for Resident #8.	F 315		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		

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F 441	Continued From page 7 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. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced	F 441	F441 1. Resident #1 no longer resides at center. Upon notification hand washing did not occur during wound care for Resident #1 as per policy the Administrator notified the Medical Director on 8/22/2012, no new orders were noted. 2. A one time audit will be completed by the Education Training Director to monitor at least six (6) Licensed Personnel by 09/26/2012 performing a wound dressing change to identify any Licensed Personnel not washing hands during a wound dressing change. Any issue identified will be immediately corrected. A one time audit of at least 10 C.N.A. (Certified Nurse Aide) performing hand washing during routine care will be completed by the Education Training Director by 9/26/2012 to identify any staff not washing hands during care. Any issue identified will be immediately corrected.	

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F 441	Continued From page 8 by: Based on observation, interview, record review, and facility policy review, the facility failed to maintain an Infection Control Program designed to help prevent the development and transmission of disease and infection for one of eighteen sampled residents (Resident #1). Facility staff failed to perform appropriate handwashing procedures when providing wound care for Resident #1. The findings include: A review of the Handwashing/Hand Hygiene policy/procedure (dated April 2012) revealed handwashing was considered the primary means to prevent the spread of infections. The policy noted handwashing should be performed under the following conditions: before and after changing a dressing, upon and after coming in contact with a resident's intact skin, and after contact with a resident's mucous membranes and body fluids or excretions. A review of the medical record revealed the facility readmitted Resident #1 on 07/01/12, with an unstageable wound to the coccyx. A skin assessment conducted on 08/22/12, at 10:00 AM, revealed Resident #9's coccyx area was red/excoriated with a small open area noted. Observation conducted during wound care for Resident #1 on 08/22/12, at 10:05 AM, revealed Registered Nurse (RN) #1 performed handwashing and put on gloves prior to initiating the wound care. RN #1 was observed to pour normal saline (N/S) over dry 4 x 4 gauze and clean the resident's wound with the gauze. The	F 441	3. Education Training Director to re educate nursing staff regarding infection control policy specifically focusing on hand washing by 09/28/2012. Director of Nursing to monitor at least two (2) Licensed Personnel per week x 4 weeks beginning week of 10/1/2012 performing wound dressing change to ensure infection control policy is being followed. Education Training Director to ensure hand washing competency during wound dressing change for all Licensed Personnel by 09/28/2012. 4.QA committee consisting of at least Administrator , Director of Nursing, Social Services, Dietary, Life Enrichment Director and MDS department to review audit findings weekly x 2 weeks beginning week of 9/24/2012 and then monthly until committee makes recommendation to resolve issue. 5. Date of Compliance 9/28/2012	

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F 441	Continued From page 9 RN then dried the wound with different 4 x 4 gauze. RN #1 proceeded to apply Skin Barrier ointment to the open wound with the same gloved finger. The RN failed to perform handwashing or change gloves after cleaning the wound and before applying ointment to the resident's open wound. Interview conducted with RN #1 on 08/22/12, at 10:50 AM, revealed she was the treatment nurse for the facility. RN #1 stated she had been trained to perform handwashing and to change gloves when moving from a "dirty" area to a "clean" area during wound care. The RN stated the gloves were considered "dirty" after the wound had been cleaned and she should have washed her hands and changed gloves before applying the ointment to the wound.	F 441		

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STREET ADDRESS, CITY, STATE, ZIP CODE: 138 MEADOWLARK DRIVE, RICHMOND, KY 40475

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K 000	INITIAL COMMENTS CFR: 42 CFR §483.70 (a) BUILDING: 01 PLAN APPROVAL: 1985 SURVEY UNDER: 2000 Existing FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: One story, Type III (000) SMOKE COMPARTMENTS: 6 COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM FULLY SPRINKLERED, SUPERVISED (WET & DRY SYSTEM) EMERGENCY POWER: Type II diesel generator A life safety code survey was initiated and concluded on 08/22/12. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility was found not in substantial compliance with the Requirements for Participation for Medicare and Medicaid. Deficiencies were cited with the highest deficiency identified at "F" level.	K 000		
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or	K 018		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Christy Ling | TITLE: Administrator | (X6) DATE: 9/18/12

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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185061	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 08/22/2012
NAME OF PROVIDER OR SUPPLIER KENWOOD HEALTH AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 130 MEADOWLARK DRIVE RICHMOND, KY 40475	

(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 018	Continued From page 1 hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure corridor doors were able to resist the passage of smoke. This deficient practice affected one of six smoke compartments, staff, and approximately twenty-five residents. The facility has the capacity for 93 beds with a census of 89 on the day of the survey. The findings include: During the Life Safety Code tour on 08/22/12, at 10:50 AM, with the Director of Maintenance (DOM), three resident room doors on the C Wing were observed to have an excessive gap at the top of the doors. Corridor doors must be able to	K 018	**K018** 1. All three doors on C wing were repaired on 09/14/2012. 2. Director of Maintenance (DOM) will complete a one time audit on all doors by 09/28/2012. Any issues will be fixed immediately 3. Director of Maintenance (DOM) will audit all door monthly beginning October 2012. Any issues will be fixed immediately. 4. Director of Maintenance (DOM) will present findings to QA committee at monthly meetings beginning November 2012. 5. Date of Compliance: 09/28/2012.	

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	185061	A. BUILDING 01 - MAIN BUILDING 01 B. WING	08/22/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENWOOD HEALTH AND REHABILITATION CENTER	130 MEADOWLARK DRIVE RICHMOND, KY 40475

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K 018	Continued From page 2 resist the passage of smoke in a fire situation. An interview with the DOM on 08/22/12, at 10:50 AM, revealed repairs were ongoing on corridor doors but it was hard to keep up with the door repairs.	K 018		
K 047 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure doors that could be mistaken for exits had signage stating that these doors were not exits. This deficient practice affected one of six smoke compartments, staff, and approximately twenty-five residents. The facility has the capacity for 93 beds with a census of 89 on the day of the survey. The findings include: During the Life Safety Code survey conducted on 08/22/12, at 10:40 AM, with the Director of Maintenance (DOM), a door leading to an outside courtyard was observed not to have signage stating that this was not an exit. No Exit signage is required on doors that are likely to be mistaken for an exit. An interview with the DOM on 08/22/12, at 10:40 AM, revealed he was not aware of this	K 047	**K047** 1. The door leading to the outside courtyard was labeled with a No Exit sign on 9/14/2012. 2. Director of Maintenance (DOM) will complete a one time audit on all door signs by 09/28/2012. Any issues will be fixed immediately 3. Director of Maintenance (DOM) will audit all door signs monthly beginning October 2012. Any issues will be fixed immediately 4. Director of Maintenance (DOM) will present all findings to QA committee at monthly meetings beginning November 2012. 5. Date of Compliance: 09/28/2012	

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K 047	Continued From page 3 requirement. An exterior door next to resident room C-8 was also observed not to have the proper signage. Reference: NFPA 101 (2000 Edition). 7.10.8.1* No Exit. Any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO EXIT Such sign shall have the word NO in letters 2 in. (5 cm) high with a stroke width of 3/8 in. (1 cm) and the word EXIT in letters 1 in. (2.5 cm) high, with the word EXIT below the word NO. Exception: This requirement shall not apply to approved existing signs. A.7.10.8.1 The likelihood of occupants mistaking passageways or stairways that lead to dead-end spaces for exit doors and becoming trapped governs the need for exit signs. Thus, such areas should be marked with a sign that reads as follows: NO EXIT Supplementary identification indicating the character of the area, such as TO BASEMENT, STOREROOM, LINEN CLOSET, or the like, is permitted to be provided. (See A.7.10.2.)	K 047		
K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested	K 062		

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NAME OF PROVIDER OR SUPPLIER KENWOOD HEALTH AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 130 MEADOWLARK DRIVE RICHMOND, KY 40475	

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K 062	Continued From page 4 periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure that sprinkler heads were maintained as required. This deficient practice affected four of six smoke compartments, staff, and approximately seventy-five residents. The facility has the capacity for 93 beds with a census of 89 on the day of the survey. The findings include: During the Life Safety Code survey on 08/22/12, at 10:15 AM, with the Director of Maintenance (DOM), paint was observed on a sprinkler head in the activities room. Foreign matter on sprinkler heads decreases their ability to react as intended in a fire situation. Paint was also observed on sprinkler heads in the B and E corridors and in the kitchen. A missing sprinkler head was observed in the attic area near the A-B nursing station. An interview with the DOM on 08/22/12, at 10:15 AM, revealed he was aware foreign matter should not be on sprinkler heads. Reference: NFPA 25 (1998 Edition). 2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper	K 062	**K062** 1. Sprinkler heads in the activities room, kitchen and B and E corridors were cleaned and all foreign matter removed on 09/15/2012. Brown Sprinkler Corporation was contacted to add two sprinkler heads to A/B unit on 09/14/2012. 2. Director of Maintenance (DOM) will complete a one time audit on all sprinkler heads by 09/28/2012. All issues will be fixed immediately. Brown Sprinkler Corporation faxed invoice on 09/18/2012. 3. Director of Maintenance (DOM) will audit all sprinkler heads monthly beginning October 2012. All issues will be fixed immediately. Director of Maintenance (DOM) will confirm with Brown Sprinkler Corporation to add two sprinkler heads to A/B unit.	

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	185061	A. BUILDING 01 - MAIN BUILDING 01 B. WING	08/22/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENWOOD HEALTH AND REHABILITATION CENTER	130 MEADOWLARK DRIVE RICHMOND, KY 40475

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K062	Continued From page 5 orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation. Reference: NFPA 13 (1999 Edition). 5-5.1 General. Sprinklers shall be located, spaced, and positioned in accordance with the requirements of this section. Sprinklers shall be positioned to provide protection of the area consistent with the overall objectives of this standard by controlling the positioning and allowable area of coverage for each sprinkler. The requirements of 5-5.2 through 5-5.6 shall apply to all sprinkler types unless modified by more restrictive rules in Sections 5-6 through 5-11.	K062	4. Director of Maintenance (DOM) will present all findings to QA committee at monthly meetings beginning November 2012. 5. Date of Compliance: 09/28/2012	
K066 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.	K066	**K066** 1. Metal self-closing containers to dispose of cigarette ashes were ordered on 08/24/2012. 2. Director of Maintenance (DOM) completed a one time audit to ensure metal self-closing containers to dispose of cigarette ashes is used in all approved smoking areas by 09/14/2012.	

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K 066	Continued From page 6 (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that smoking areas were maintained as required. The findings include: During the Life Safety Code survey conducted on 08/22/12, at 10:20 AM, with the Director of Maintenance (DOM), an outside smoking area in the courtyard was observed not to have a metal self-closing container to dispose of cigarette ashes as required. Smoking areas in the front entrance and the employee area outside the kitchen were also observed not to have self-closing metal containers to dispose of cigarette ashes. An interview with the DOM on 08/22/12, at 10:20 AM, revealed he was responsible for Life Safety Code requirements but was not aware of this requirement.	K 066	3. Director of Maintenance (DOM) will audit all approved smoking areas monthly beginning October 2012 to ensure metal self-closing containers to dispose of cigarette ashes are being used. Any issues will be corrected immediately. 4. Director of Maintenance (DOM) will present all findings to QA committee at monthly meetings beginning November 2012. 5. Date of Compliance: 09/28/2012.	
K 072 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct	K 072		

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K 072	Continued From page 7 exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that corridors and access to exits remained free from obstructions to full instant use in case of fire or other emergency. This deficient practice affected one of six smoke compartments, staff, and approximately twenty-five residents. The facility has the capacity for 93 beds with a census of 89 on the day of the survey. The findings include: During the Life Safety Code tour on 08/22/12, at 09:30 AM, a table and chairs were observed in the path to an exit of the facility. The initial tour of the facility on 08/21/12 during the health survey also revealed a table and chairs in this same location. Items in exit access corridors are permitted as long as they are in use. An interview with the Director of Maintenance (DOM) on 08/22/12, at 10:00 AM, revealed he was aware this exit is required to be maintained. The DOM stated he tries to keep this area clear but staff members leave the table and chairs there when they are no longer in use.	K 072	**K072** 1. The table and chairs blocking the egress was removed on 08/24/2012. 2. Director of Maintenance (DOM) completed one time audit to ensure all corridors and access to exits remained free from obstructions on 08/24/2012. 3. Director of Maintenance (DOM) and/or Maintenance Assistant will audit all corridors and exits to ensure they are free from obstructions at least 3x a week beginning 09/24/2012. All issues will be corrected immediately. 4. Director of Maintenance (DOM) will present all findings to QA committee at monthly meetings beginning November 2012. 5. Date of Compliance: 09/28/2012.	
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144		

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K 144	Continued From page 8 This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to maintain the generator set by NFPA standards. This deficient practice affected six of six smoke compartments, staff, and all the residents. The facility has the capacity for 93 beds with a census of 89 on the day of the survey. The findings include: During the Life Safety Code survey on 08/22/12, at 1:10 PM, an interview with the Director of Maintenance (DOM) during a record review revealed the DOM was not aware the generator transfer switch should be exercised and logged once a month. This test helps ensure the generator transfer switch is operating properly. Reference: NFPA 110 (1999 Edition). 6-4.5 Level 1 and Level 2 transfer switches shall be operated monthly. The monthly test of a transfer switch shall consist of electrically operating the transfer switch from the standard position to the alternate position and then a return to the standard position.	K 144	K144 1. The generator transfer switch was exercised and logged on 08/22/2012. 2. Director of Maintenance (DOM) exercised and logged the generator transfer switch on 09/07/2012. 3. Director of Maintenance (DOM) will exercise and log the generator transfer switch monthly beginning October 2012. Any issues will be corrected immediately. 4. Director of Maintenance (DOM) will present all findings to QA committee at monthly meetings beginning November 2012. 5. Date of Compliance: 09/28/2012.	

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