

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

PRINTED: 10/12/2012
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 C 10/10/2012
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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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F 000	INITIAL COMMENTS	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."	
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 develop an initial care plan to address the use of an indwelling catheter for one (1) of five (5) sampled residents. Resident # 2.</p> <p>The findings include:</p> <p>The facility utilizes the Resident Assessment Instrument (RAI) and Federal Regulations as guidelines to develop care plans.</p> <p>Observation of Resident #2, on 10/10/12 at 11:25 AM, revealed the resident laying in bed with an indwelling catheter drainage bag anchored to the bed frame. Observation revealed yellow urine was in the catheter tubing and drainage bag.</p>	F 281	<p>1. The care Plan for resident #2 was updated to include Foley Catheter on 10/11/2012 by licensed nurse.</p> <p>2. A review of the care plans for all current residents admitted within the last 30 days was completed as of 10-25-12 by the Director of Nursing, Assistant Director of Nursing and Unit Manager to determine that the care plan reflects the residents needs. Any concerns identified were corrected by a licensed nurse when identified.</p> <p>3. Licensed nurses will be re-educated by the Director of Nurses and Assistant Director of Nurses as of 10-25-12 on completing the initial care plan process to meet the needs of the resident.</p>	

REGISTRAR/DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Maureen Morris</i>	TITLE <i>x Adm</i>	(X6) DATE <i>x 10/25/12</i>
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A 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.

OCT 25 2012
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F 281	Continued From page 1 Record review revealed the facility admitted Resident #2 on 09/26/12 with diagnoses of Failure to Thrive, Dehydration, Osteoporosis, Depression, Anemia, Generalized Weakness, Dysphagia, and Aspiration Pneumonia. Review of the admission nursing assessment, dated 09/26/12, revealed the resident had an indwelling catheter. However, review of the initial care plan, dated 09/26/12, revealed no care plan had been developed to address the use of a catheter. There were no interventions developed to instruct staff when to clean or change the catheter or monitor for infections. Interview with RN #2 and RN #3, on 10/10/12 at 5:30 PM, revealed the staff nurse who completed the admission paperwork should have developed the initial care plan. They stated there were four areas that were always addressed on a residents' initial care plan: falls, skin, advance directives, and pain. RN #2 stated the comprehensive care plan was developed by the minimum data set (MDS) nurse. RN #3 revealed there was no evidence in the record an initial care plan had been developed to address the indwelling catheter. She stated there should have been. She indicated it had been an oversight on the staff nurse's part. Interview with the MDS nurse and the Director of Nursing (DON), on 10/10/12 at 5:45 PM, revealed the admission MDS assessment had been completed on 10/09/12 and the comprehensive assessment was not due until 10/16/12. The MDS nurse stated she was not responsible for the initial care plan, the staff nurses do those. However, she stated the indwelling catheter should have been addressed. The DON agreed	F 281	4. The Director of Nursing and/or Assistant Director of Nursing will review the initial care plan of each newly admitted resident weekly x8 weeks and then monthly x1 and then she/he will review 10 resident care plans quarterly x3 quarters to determine that the care plan reflects the residents needs. Any issues identified will be corrected upon identification. A summary of findings will be submitted to the Performance Improvement Committee monthly x3 months and then quarterly x3 for further review and recommendation. 5. Date of compliance:	10/25/12 10-26-12 per Sue Thompson by PB 10-26-12

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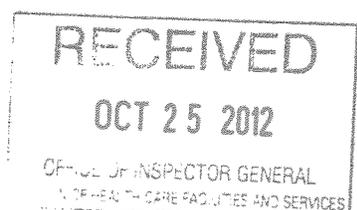
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<p>F 281</p> <p>F 327 SS=D</p>	<p>Continued From page 2 with the MDS nurse. She validated there was no care plan to address the use of an indwelling catheter and she said there should have been.</p> <p>483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION</p> <p>The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, and review of the facility's policy, it was determined the facility failed to ensure each resident had sufficient fluid intake to maintain adequate hydration for one (1) of five (5) sampled residents. The facility identified Resident #1 at risk for dehydration and the Registered Dietitian (RD) recommended 1500 ml-2000 ml daily for hydration. However, the facility failed to monitor the resident's fluid intake. On 10/09/12, the resident was admitted to an acute hospital for dehydration and Leukocytosis.</p> <p>The findings include: Review of the facility's policy regarding hydration, revised May 2009, revealed the definition of sufficient fluid means the amount of fluids needed to prevent dehydration. The RD determines the resident's daily fluid needs. The average fluid intake for an adult is 1500 ml. Resident who do not meet their estimated fluid need for three (3) consecutive days are monitored by IDT (interdiscipline team).</p>	<p>F 281</p> <p>F 327</p>	<p>F 327</p> <p>1. Resident #1 was discharged on 10/9/2012.</p> <p>2 The Director of Nursing, Assistant Director of Nursing and Unit Manager completed an audit of the current residents to identify risk of dehydration as of 10-25-12 to determine adequate intake. Any concerns identified were reviewed by the Interdisciplinary Team for further intervention</p> <p>3. The nursing assistants have been re-educated to the Hydration policy and to report refusals or on changes in the residents intake to the nurse as of 10-25-12 by the Assistant Director of Nursing and the Director of Nursing. The licensed nurses will be re-educated by the Director of Nursing and the Assistant Director of Nursing as of 10-25-12 to the Hydration policy including to review meal consumptions records and resident status each shift to determine the resident is provided with sufficient fluid intake.</p> <p>4. The Director of Nursing, Assistant Director of Nursing and/or the Unit Manager will audit current residents to identify risk of dehydration weekly times 3 months and then quarterly x3 to determine that resident are receiving sufficient fluid intake. Any concerns identified will be addressed upon identification.</p>	
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F 327	<p>Continued From page 3</p> <p>Review of the closed clinical record for Resident #1 revealed the facility admitted the resident on 09/17/12 with diagnoses of Malaise, Fatigue, Diabetes, Parkinson's Disease and Alzheimer's Disease. The admission assessment, dated 09/24/12, revealed the facility had assessed the resident with a cognition impairment based on the Brief Interview Mental Status score of five (5). Continued review of the admission assessment revealed the facility provided extensive to total assist with most activities of daily living (ADLs). Review of the labwork collected on 09/25/12 revealed results of a normal BUN (19).</p> <p>Review of a medical nutrition therapy assessment, completed on 09/24/12, revealed the RD assessed Resident #1's fluid needs to be 1500-2000 ml daily. On 09/26/12, the dietitian documented the resident's meal intake to be 25-100% and recommended fluid intake and weights be monitored. Review of the care plan revealed interventions to monitor meal intake and fluids. However, the care plan did not state how this was to be done.</p> <p>Review of the meal intake records for October 2012 revealed the resident's daily fluid intake was not totaled with fluid intake below the recommended 1500-2000 ml/per day.</p> <p>10/01/12 the resident's daily fluid intake=600 ml. 10/02/12 = 600 ml. 10/03/12 = 125 ml. 10/04/12 = 480 ml. 10/05/12 = 480 ml. 10/06/12 = 480 ml. 10/07/12 = 360 ml, Resident started to refuse meals (breakfast and lunch). Review of the nurses notes for 10/07/12, revealed</p>	F 327	<p>A summary of findings will be submitted to the monthly Performance Improvement Committee monthly x3 months then quarterly x3 for further review and recommendations.</p> <p>5. Date of compliance: 10/25/12 <i>10-26-12 per SanThompson</i> <i>by PB 10-26-12</i></p>	

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F 327	Continued From page 4 the resident experienced episodes of vomiting. The physician ordered Zofran 4 mg/2 ml IM every four (4) hours as needed. 10/08/12 = 480 ml, resident eating 25% of meals. 10/09/12 = refused all food and fluids. Review of the closed clinical record revealed Resident #1 was admitted to the hospital, on 10/09/12 at 3:52 PM, with diagnoses of dehydration and leukocytosis. Review of the hospital labwork upon admission revealed an elevated blood urea nitrogen (BUN, a test that measures kidney function) of 41 (normal range 5-25) and BUN/Creatine of 37 (normal range 6-20). The resident's white blood count was 17.00 (normal range 4.80-10.80). A urinalysis was completed with findings positive for a Urinary Tract Infection (UTI) with Enterococcus bacteria. Interview with the Director of Nursing (DON), Administrator, and Assistant Director of Nursing (ADON), on 10/10/12 at 5:45 PM, revealed the resident was not eating well prior to admission and experienced nausea and vomiting the day of admittance to the hospital. The DON and administrator revealed the resident was not on Intake & Output but rather monitored by meal intake records. The DON said the direct care staff are suppose to record how much a resident eats and drinks at each meal. The administrator stated there was no particular person assigned to review those records. She indicated the RD would review the intake records upon her visits if the RD was completing an assessment for that particular resident. However, the RD had not reviewed Resident #1's fluid intake for October 2012. The Administrator acknowledged nobody was calculating the residents' daily fluid intake and	F 327			

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F 327	Continued From page 5 monitoring the meal intake log to ensure residents were receiving adequate hydration.	F 327		
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