

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

PRINTED: 06/07/2011  
FORM APPROVED  
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                                    |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>185443 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____   | (X3) DATE SURVEY COMPLETED<br><br>05/26/2011 |
| NAME OF PROVIDER OR SUPPLIER<br><br>KENSINGTON MANOR CARE AND REHABILITATION CENTER |   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>225 SAINT JOHN ROAD<br>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<br><br>A standard health survey for recertification was conducted 05/24/11 through 05/26/11 and found the facility was not meeting the minimum requirements. Deficiencies were cited with the highest scope and severity of a "D" with the facility having the opportunity to correct the deficiencies before remedies would be recommended for imposition.  | F 000  | "This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, <b>Kensington Manor Care &amp; Rehabilitation Center</b> 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."<br><br>F 248<br><br>1. Resident #9 was re-assessed by the Interdisciplinary Team ( IDT) which consists of the Director of Nursing Services, MDS Coordinator, Activity Director and Social Services Director on 6/7/11. The Activity Director completed an activity assessment for resident #9 on 6/7/2011. |  |
| F 248<br>SS=D   | 483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES<br><br>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, review of the resident record and facility activity log it was determined the facility failed to provide an ongoing activity program to meet the needs, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of one (1) Resident (#9) of the seventeen (17) sampled residents.<br><br>The findings include:<br><br>The facility did not have an activities program policy.<br><br>Resident #9 was admitted to the facility on 10/16/09 with diagnoses of Senile Dementia, Congestive Heart Failure, Unspecified Essential | F 248  |  |  |

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

TITLE

(X6) DATE

*[Signature]*

*x administrator*

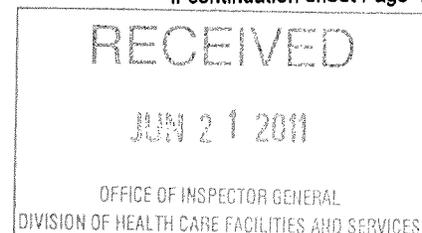
*6/17/11*

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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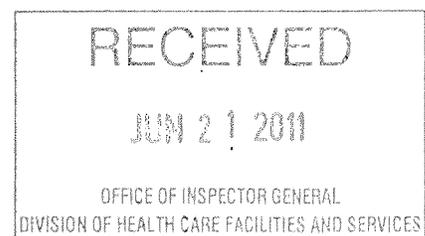
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| F 248   | <p>Continued From page 1<br/>Hypertension and Depressive Type Psychosis.</p> <p>Review of the clinical record revealed the most recent activity assessment was completed on 10/19/09 and the facility assessed Resident #9's interest to be country music, fishing, spiritual/religious activities, watching television, and talking/conversation.</p> <p>The facility assessed Resident #9 on the Quarterly Resident Assessment Instrument Version 3.0 (RAI) dated 03/18/11, as having trouble concentrating on things, such as watching television. The facility further assessed Resident #9 to have unclear speech, rarely or never understood, rarely or never understands and highly impaired vision. The facility noted Resident #9 was unable to complete the Brief Interview for Mental Status.</p> <p>Review of the activity care plan for Resident #9 initiated on 01/22/10, revised on 07/01/10 and 09/25/10, with a target date of 06/20/11 revealed a "Focus" of "Resident self initiates activities and enjoys watching TV and socializing. Per family resident will come out of room for snacks and social time to dayroom as tolerated."</p> <p>Observation, on 05/24/11 at 11:40am, of Resident #9 revealed the resident was sitting in a geriatric chair with a tray attached to the chair. At 2:00pm, the resident was observed in the geriatric chair with his/her hands on the side of the tray, pushing the tray back and forth. The resident stopped moving the tray when addressed, and continued to pull the tray back and forth once the surveyor stopped talking. The television was on at an elevated volume in the room; however, the</p> | F 248  | <p>2. Current residents will be re-assessed by the IDT team by 6/24/2011 to determine the current interests of the resident. Identified residents plan of care will be updated as indicated by the activity assessment by the IDT team by 6/24/2011 to reflect.</p> <p>3. Re-education was completed by the Administrator to the Activity Director on 6/7/2011 regarding a program of activities designed to meet the interests of each resident.</p> <p>4. The Activity Director and Administrator will review 5 resident's activity assessments and observe participation of activities weekly for 4 weeks then monthly times 2 months to ensure interests and needs of the resident. Findings will be reported by the Administrator to Performance Improvement Committee for review and recommendations.</p> <p>5. Date of compliance: 6/25/2011</p> |                      |  |



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| F 248   | <p>Continued From page 2 resident was not watching.</p> <p>On, 05/25/11 at 8:14am, the resident was observed in the geriatric chair in the hallway, outside the resident's room. The resident was again moving the attached tray back and forward.</p> <p>Observation, on 05/26/11 at 8:10am, revealed Resident #9 was sitting in a geriatric chair in his/her room. The television was on; however, the resident was not watching the television. At 10:50am, Resident #9 was lying in bed, with his/her eyes closed. The television remained on.</p> <p>Interview, on 05/26/11 at 11:08am, with Certified Nursing Assistant (CNA) #1 (who was responsible for the resident) revealed the resident could not self-initiate activities. CNA #1 stated the only activities she had seen Resident #9 participate in was in the day room when movies were being shown.</p> <p>Review of the scheduled activity calendar for May 24-26, 2011 (during the survey) revealed music with Gloria and volunteer visits were provided on 05/24/11. On 05/25/11 sensory stimuli (room visits) was provided; however, there was no evidence Resident #9 was in attendance at any of these activities. The only activities Resident #9 was passively involved in was television in the resident's room and sitting in the hallway.</p> <p>Interview, on 05/26/11 at 1:05pm, with the Activities Director revealed she considered Resident #9 to self initiate activities because they (staff) turn on the television for him/her. She stated to meet the goal of "A" for active, on the Activities Program Participation Record, staff</p> | F 248  |   |  |



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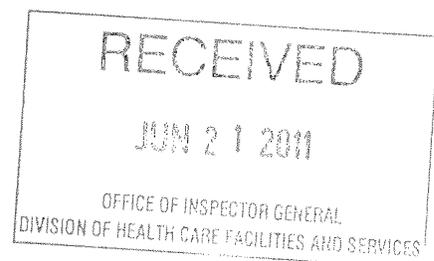
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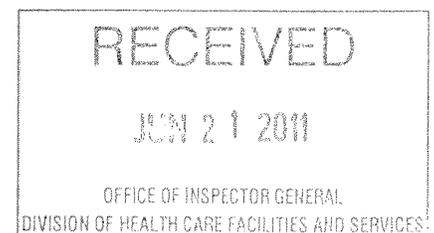
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| F 248         | Continued From page 3<br>would have to turn the television on. She indicated the role of the Activity Director is to provide activities for the residents that would comfort and ease; programs such as music. However, review of the activity program participation record for the dates of May 1, 2011 through May 24, 2011, revealed Resident #9 only attended two (2) musical activities and was sitting at the nursing station eight (8) times. The participation log revealed the resident actively watched the television; however, observation during the survey revealed the television was on but the resident was not watching. There was only one (1) entry for participation of a "Sensory" activity for the month of April and May 2011. Additionally, Resident #9's son had just started to allow the facility to take the resident out of his/her room. The resident could have been taken to the musical activities. She revealed Resident #9 did not receive 1:1 room visits and she felt the resident could benefit from that program. | F 248 |  |  |
| F 253<br>SS=D | 483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES<br><br>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview it was determined the facility failed to have effective housekeeping and maintenance services for two (2) residents (#7 and #17) of the 17 sampled residents. Resident #17 geriatric chair had torn  | F 253 | F 253<br><br>1. The privacy curtain for resident #7 was changed on 5/26/11 by the Environmental Services Supervisor. Resident #17's geriatric chair arm rests were repaired on 5/31/2011 by an independent contractor. |  |



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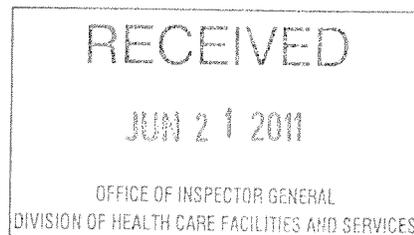
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| F 253   | <p>Continued From page 4</p> <p>arm rests and several spots of a brown substance were noted on Resident #7's privacy curtain for three days.</p> <p>The findings include:</p> <p>During the initial Environmental tour, on 05/24/11 at 9:41am, the following observations were noted:</p> <p>The geriatric chair for Resident #17 had multiple frayed tears in the arm rests on both sides of the chair even though the facility had previously identified the need for repair.</p> <p>The privacy curtain for Resident #7 had several areas of a brown substance on the curtain and remained there through 05/26/11.</p> <p>Interview with the Director of Maintenance, on 05/26/11 at 10:15am, revealed maintenance is responsible for the repair of geriatric chairs and wheelchairs. He stated he was aware of the torn arm rests on the geriatric chair for Resident #17, however, had not gotten around to getting it repaired. He stated geriatric chairs and wheelchairs are checked monthly, and if a problem is noted it is repaired. He stated no records are kept of completed repairs.</p> <p>Interview with the Office Manager, on 05/26/11 at 1:00pm, revealed arrangements were made for the repair of the arm rests for Resident #17's geriatric chair on 05/19/11. She stated it was the responsibility of maintenance to remove the arm rests and take them to an outside source to be repaired.</p> <p>Interview with the Director of Housekeeping, on</p> | F 253  | <p>2. Rounds of the facility were completed by the maintenance director and environmental services director on 5/16/2011 on current resident's privacy curtains and equipment. Any identified issues were corrected as of what 6/07/2011.</p> <p>3. Re-education was provided on 6/7/11 to the Environmental Services Supervisor and the Maintenance Director by the Administrator regarding services necessary to maintain sanitary, orderly and comfortable interior to include cleanliness of privacy curtains and maintenance of geriatric chairs.</p> <p>4. The Maintenance Director and Environmental Services Supervisor will conduct rounds of the facility 3 times a week for 4 weeks, then weekly times 2 months to assess privacy curtains and resident equipment for maintained repair. The results will be presented to the Performance Improvement Committee by the Administrator for review and further recommendations.</p> |  |



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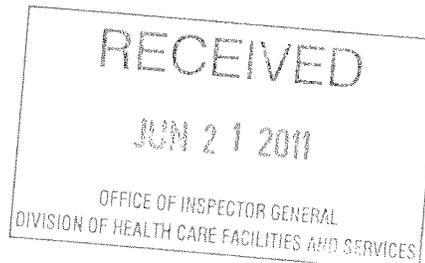
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| F 253   | Continued From page 5<br>05/26/11 at 1:15pm, revealed the privacy curtains in all rooms are taken down once a month and washed or washed as needed. She instructs all housekeepers to pull the privacy curtain and check them as part of the daily cleaning routine. She related that she does not keep a log of when privacy curtains are cleaned. She was not aware of the soiled privacy curtain in the room of Resident #7.<br><br>Interview with the Administrator, on 05/26/11 at 1:20pm, revealed the facility did not have a policy regarding the cleaning of privacy curtains. The Administrator stated privacy curtains are cleaned on an as needed bases.  | F 253  | 5. Date of Compliance: 6/25/2011   |  |
| F 280<br>SS=D   | 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP<br><br>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.<br><br>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. | F 280  | 1. Resident #9's activity care plan was reviewed and updated to reflect current needs by the Interdisciplinary Team (IDT), which consists of the Director of Nursing Services, MDS Coordinator, Activity Director and Social Services Director on 6/7/11.<br><br>2. Current residents care plans will be reviewed by the IDT team by 6/24/2011 to ensure current status of resident is reflected. Identified residents care plans will be revised to reflect current needs/interventions by the IDT team by 6/24/2011. |  |



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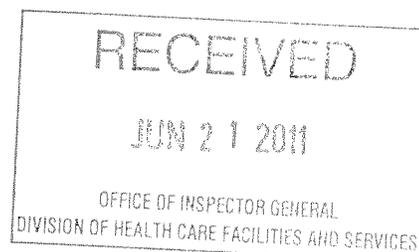
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| F 280   | Continued From page 6<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on resident record review and interview, it was determined the facility failed to review and revise the care plan to reflect the current Activity status of one (1) resident (#9) of the seventeen (17) sampled residents.<br><br>The findings include:<br><br>Resident #9 was admitted to the facility on 10/16/09 with diagnoses of Senile Dementia, Congestive Heart Failure, Unspecified Essential Hypertension and Depressive Type Psychosis.<br><br>An activity assessment dated 10/19/09 was the last activity assessment the facility completed for Resident #9.<br><br>Review of the Quarterly MDS (minimum data set) assessment completed on 03/18/11 revealed Resident #9 had trouble concentrating on things, such as watching television. Resident #9 was further assessed to have unclear speech, rarely or never understood, rarely or never understands and highly impaired vision.<br><br>Review of the activity care plan, initiated on 01/22/10, revised on 09/25/10 with a targeted goal date of 06/20/11, revealed Resident #9 would self initiate activities and enjoyed watching TV and socializing.<br>"Per family resident will come out of room for snacks and social time to dayroom as tolerated."<br><br>The care plan listed the following interventions: 1) | F 280  | 3. Re-education was provided to the Activity Director on 6/7/2011 by the Administrator regarding updating and revising activity care plans with current activity status of residents. The nursing staff will be re-educated by the Administrator on or before 6/24/2011 regarding revision of care plans to reflect current status of resident.<br><br>4. The Activity Director and Administrator will monitor 5 residents activity care plans per week times 4 weeks, then weekly times 3 months to ensure activity care plans are updated to reflect resident's current status and needs. The Director of Nursing will review 5 residents care plans monthly for 3 months to ensure revision of care plans to reflect current status and needs. The findings will be reported to Performance Improvement Committee by the Administrator and Director of Nursing for review and recommendations.<br><br>5. Date of compliance: 6/25/2011 |  |



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| F 280   | Continued From page 7<br>Interact with the resident four times per month to review needs for self initiated activities; 2) introduce to other residents with similar interests; 3) remind resident about group outings; 4) bring resident out of room for snacks; and 5) arrange/invite for resident to attend senior citizen group daily.<br><br>Interview, on 05/26/11 at 11:08am, with Certified Nursing Assistant (CNA) #1 revealed Resident #9 would not be able to self initiate activities. CNA #1 stated the only activity, in which she had seen Resident #9 attend, were movies shown in the day room.<br><br>Interview, on 05/26/11 at 1:05pm, with the Activities Director revealed the care plan for Resident #9 should have been updated "a while back". The care plan should not be the same care plan developed when the resident was admitted to the facility. She stated she was responsible for the activities program and the care plan should have been revised to reflect the activities the resident was attending. Refer to F248. | F 280  |   |  |





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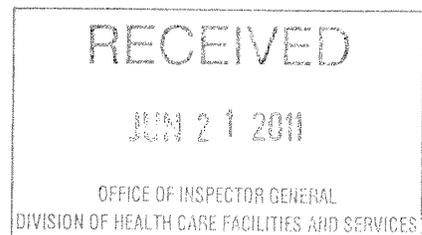
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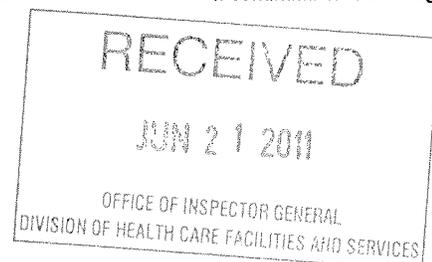
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| K 018 | <p>Continued From page 1</p> <p>to affect one (1) smoke compartment, residents, staff, and visitors. The facility is licensed for eighty two (82) beds with a census of seventy six (76) the day of the survey.</p> <p>The findings include:</p> <p>Observation on 05/24/11 at 10:30am with the Maintenance Supervisor revealed resident room door number 204 would not latch when closed.</p> <p>Interview, on 05/24/11 at 10:30am, with the Maintenance Supervisor revealed the door needed to be worked on to ensure the door would latch and keep smoke/fire from entering the resident room in the event of a fire.</p> <p>Reference: NFPA 101 (2000 edition)<br/>19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors.<br/>Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or</p> | K 018 |  |  |
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                                    |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>185443 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 01 - MAIN BUILDING 01<br>B. WING _____   | (X3) DATE SURVEY COMPLETED<br><br>05/24/2011 |
|---|---|--|--|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>KENSINGTON MANOR CARE AND REHABILITATION CENTER |   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>225 SAINT JOHN ROAD<br>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 018   | Continued From page 2<br>combustible materials.<br>Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke.<br>19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with 19.3.5.2.<br>Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials.<br>Exception No. 2: Existing roller latches demonstrated to keep the door closed against a force of 5 lbf (22 N) shall be permitted to be kept in service. | K 018  |  |  |
| K 047<br>SS=E   | NFPA 101 LIFE SAFETY CODE STANDARD<br>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<br><br>This STANDARD is not met as evidenced by:  | K 047  | K047<br><br>1. No Exit signage was placed on doors leading to the exterior that did not lead to a public way on 5/24/2011 by the Maintenance Director.<br><br>2. The Maintenance Director conducted a facility audit on 5/24/2011 and no other issues were identified. |  |



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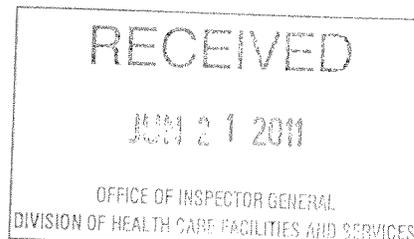
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| K 047 | <p>Continued From page 3</p> <p>Based on observation and interview, it was determined the facility failed to identify non-emergency exit doors as NO EXIT, according to NFPA standards, so residents could avoid confusion in an emergency and exit the building at the most accessible exit. The deficient practice has the potential to affect three (3) smoke compartments, including residents, staff, and visitors. The facility is licensed for eighty two (82) beds with a census of seventy six (76) the day of the survey.</p> <p>The findings include:</p> <p>Observation on 05/24/11 at 9:47am revealed doors leading to the exterior, that did not lead to a public way, were marked on the facility evacuation layout as EXITS. During the tour the doors appeared to be exits but were not marked EXIT or NO EXIT.</p> <p>Interview, on 05/24/11 at 9:47am, with the Maintenance Supervisor revealed he was unaware the doors needed NO EXIT signage.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>7.10.8.1* No Exit.<br/>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</p> <p>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,</p> | K 047 | <p>3. Re -education was provided by the Administrator to the Maintenance Director on 5/24/2011 regarding exit and directional signs being displayed per life safety code standard.</p> <p>4. The Maintenance Director will conduct monthly facility audits on display of exit and directional signage. The results of the audits will be presented by the Maintenance Director to the Performance Improvement Committee for review and further recommendations.</p> <p>5. Date of compliance: 6/25/2011</p> |  |
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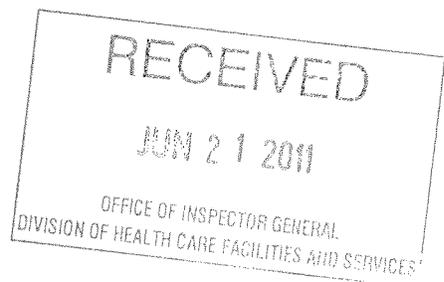
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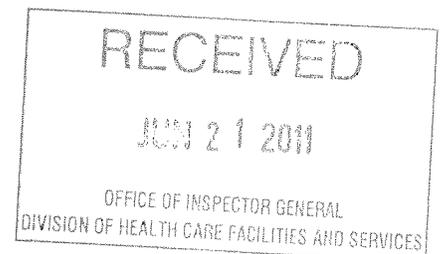
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| K 047         | Continued From page 4 with the word EXIT below the word NO.   | K 047 |  |  |
| K 050<br>SS=F | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2<br><br>This STANDARD is not met as evidenced by:<br>Based on interview and record review it was determined the facility failed to ensure fire drills were conducted at random times on each shift. The deficient practice has the potential to affect all smoke compartments, staff and residents. The facility is licensed for eighty two (82) beds with a census of seventy six (76) the day of the survey.<br><br>The findings include:<br><br>Record review on 05/24/11 at 2:30pm with the Maintenance Supervisor, revealed the fire drills were not being conducted at varied times as required.<br><br>During the interview with the Maintenance Supervisor, on 05/24/11 at 2:30pm, the Maintenance Supervisor indicated he was not aware that the times of the drill should be under varied conditions. | K 050 | K050<br><br>1. Fire drills will be conducted at random times on each shift on or by 6/24/2011.<br><br>2. No residents found to be affected by the cited deficiency.<br><br>3. Re -education was provided to the Maintenance Director by the Administrator on 5/24/2011 regarding conducting fire drills at random times on each shift at least quarterly.<br><br>4. Dates and times of fire drills conducted will be monitored monthly by the Administrator. The findings will be reported by the Administrator to the Performance Improvement Committee for review and further recommendations.<br><br>5. Date of compliance: 6/25/2011 |  |



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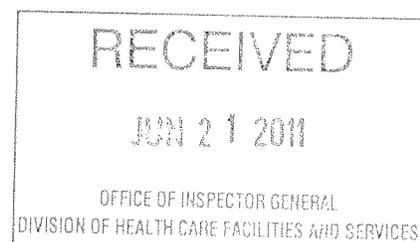
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| K 050   | Continued From page 5  | K 050  |  |  |
| K 051<br>SS=F   | <p>Reference: NFPA Standard NFPA 101 19.7.1.2. Fire drills shall be conducted at least quarterly on each shift and at unexpected times under varied conditions on all shifts.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6</p> <p>This STANDARD is not met as evidenced by:</p> | K 051  | <p>K051</p> <ol style="list-style-type: none"> <li>1. A fire alarm control panel and the generator panel/annunciator will be installed at the main nursing station so they can be visually monitored. Contract with Vanguard Alarm Company to complete the installation on the fire alarm control panel was received on 6/16/2011. Contract with Vanguard Alarm Company to complete the installation on the generator panel/annunciator was received on 6/16/2011.</li> <li>2. Maintenance Director conducted a facility review on 5/24/11 and no other issues were identified.</li> </ol> |  |



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| K 051   | <p>Continued From page 6</p> <p>Based on observation and interview it was determined the facility failed to ensure the building fire alarm system was installed as required by NFPA standards. The deficient practice has the potential to affect all smoke compartments, staff, and the residents. The facility is licensed for eighty two (82) beds with a census of seventy six (76) on the day of the survey.</p> <p>The findings include:</p> <p>Observation on 05/24/11 at 10:22am with the Maintenance Supervisor revealed the Fire Alarm Control Panel (FACP) and the Generator Panel/Annunciator were located in a locked mechanical closet in the 200 Wing. The nurses at the nursing station could not visually see any annunciation panels. There was a (FACP) annunciator panel located in the front office area, but that location is not staffed on all three (3) shifts.</p> <p>Interview, on 05/24/11 at 10:22am, with the Maintenance Supervisor revealed the nurses' station had a key to unlock the room if they heard the annunciation of a signal.</p> <p>Reference: NFPA 72 (1999 Edition).</p> <p>1-5.4.4 Distinctive Signals.<br/>Fire alarms, supervisory signals, and trouble signals shall be distinctively and descriptively annunciated.</p> <p>1-5.4.6 Trouble Signals.<br/>Trouble signals and their restoration to normal shall be indicated within 200 seconds at the</p> | K 051  | <p>3. Re -education was provided to the Maintenance Director by the Administrator on 5/24/2011 regarding visually accessible fire alarm control panel and generator panel/annunciator.</p> <p>4. The fire alarm control panel and the generator panel/annunciator will be monitored on a monthly basis by the Maintenance Director. The findings will be reported by the Maintenance Director to Performance Improvement Committee for review and further recommendations.</p> <p>Will be installed 6-29-11 (RW)</p> <p>5. Date of Compliance: 6/25/2011 (RW)</p> |  |



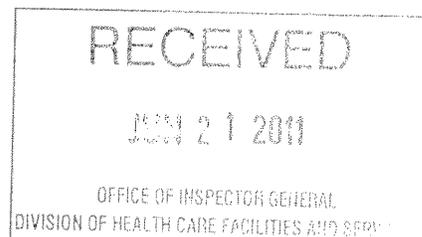
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| K 051              | <p>Continued From page 7</p> <p>locations identified in 1-5.4.6.1 or 1-5.4.6.2. Trouble signals required to indicate at the protected premises shall be indicated by distinctive audible signals. These audible trouble signals shall be distinctive from alarm signals. If an intermittent signal is used, it shall sound at least once every 10 seconds, with a minimum duration of 1/2 second. An audible trouble signal shall be permitted to be common to several supervised circuits. The trouble signal(s) shall be located in an area where it is likely to be heard.</p> <p>5-2.6.1.4<br/>Upon receipt of trouble signals or other signals pertaining solely to matters of equipment maintenance of the fire alarm systems, the central station shall perform the following actions:<br/>(1) *Communicate immediately with persons designated by the subscriber</p> <p>A-5-2.6.1.4(1)<br/>The term immediately in this context is intended to mean "without unreasonable delay." Routine handling should take a maximum of 4 minutes from receipt of a trouble signal by the central station until initiation of the investigation by telephone.</p> <p>5-5.3.2.1.6.2<br/>The following requirements shall apply to all combinations in 5-5.3.2.1.6.1:<br/>(1) Both channels shall be supervised in a manner approved for the means of transmission employed.<br/>(3) The failure of either channel shall send a trouble signal on the other channel within 4 minutes.<br/>(8) Failure of telephone lines (numbers) or cellular service shall be annunciated locally.</p> | K 051         |   |                      |



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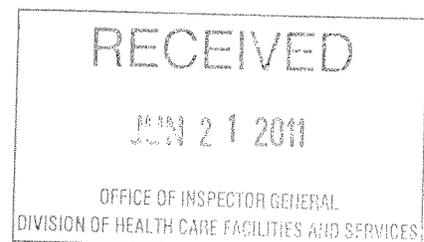
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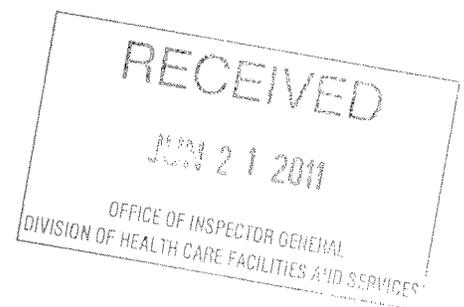
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| K 051         | Continued From page 8<br>3-8.1* Fire Alarm Control Units.<br>Fire alarm systems shall be permitted to be either integrated systems combining all detection, notification, and auxiliary functions in a single system or a combination of component subsystems. Fire alarm system components shall be permitted to share control equipment or shall be able to operate as standalone subsystems, but, in any case, they shall be arranged to function as a single system. All component subsystems shall be capable of simultaneous, full load operation without degradation of the required, overall system performance.   | K 051 |  |  |
| K 056<br>SS=F | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5<br><br>This STANDARD is not met as evidenced by:<br>Based on observation and interview it was determined the facility failed to ensure the building had a complete sprinkler system, according to NFPA standards. The deficient | K 056 | KO56<br><br>1. Sprinklers will be placed at the overhang on the new wing next to room number 1, the 200 wing next to room number 213 and the 300 wing next to the physical therapy room. Contract with Century Sprinkler Company to complete the sprinkler installation was received on 6/14/2011. |  |



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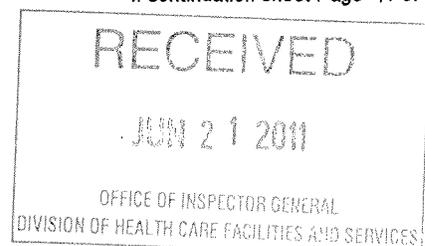
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| K 056   | Continued From page 9<br>practice has the potential to affect all residents, staff and visitors. The facility is licensed for eighty two (82) beds with a census of seventy six (76) the day of the survey.<br><br>The findings include:<br><br>Observation on 5/24/11 at 10:05am with the Maintenance Supervisor, revealed two overhangs with no sprinklers. The overhangs are located at the front of the new wing next to room number 1, the 200 Wing next to room number 213, and the 300 Wing next to the Physical Therapy room. All three overhangs are over four (4) foot in width.<br><br>Interview, on 05/24/11 at 10:05am, with the Maintenance Supervisor revealed he was not aware the overhangs needed to be sprinkled.<br><br>Reference: NFPA 13 (1999 Edition) 5-13 8.1 Sprinklers shall be installed under exterior roofs or canopies exceeding 4 Ft. (1.2 m) in width. Exception: Sprinklers are permitted to be omitted where the canopy or roof is of noncombustible or limited combustible construction. | K 056  | 2. The Maintenance Director conducted a facility audit on 5/24/11 and no other issues were identified.<br><br>3. Re-education was provided to the Maintenance Director by the Administrator regarding sprinklers being installed under exterior roofs or canopies exceeding 4ft. in width.<br><br>4. The facility will be audited by the Maintenance Director monthly to ensure installation of sprinklers. The findings will be reported by the Maintenance Director to the Performance Improvement Committee for review and further recommendations. |  |
| K 072<br>SS=F   | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>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 exits, access to, egress from, or visibility of exits.<br>7.1.10  | K 072  | 5. Date of Compliance: <del>6/25/2011</del><br><br>K072<br><br>1. The trash carts on 100, 200 and 300 corridors were moved by the Director of Nursing Services on 5/24/11. The bed and lounge  | <u>RW</u><br>7-8-11                          |



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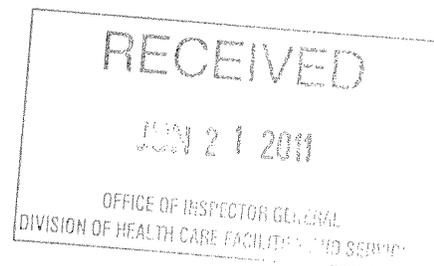
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                                    |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>185443 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 01 - MAIN BUILDING 01<br>B. WING _____   |                      | (X3) DATE SURVEY COMPLETED<br><br>05/24/2011 |
| NAME OF PROVIDER OR SUPPLIER<br><br>KENSINGTON MANOR CARE AND REHABILITATION CENTER |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>225 SAINT JOHN ROAD<br>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 072   | <p>Continued From page 10</p> <p>This STANDARD is not met as evidenced by:<br/>Based on observation and interview, it was determined the facility failed to maintain exit access according to NFPA standards. The deficient practice has the potential to affect all residents, staff, and visitors. The facility is licensed for eighty two beds (82) with a census of seventy six (76) the day of the survey.</p> <p>The findings include:</p> <p>Observations on 05/24/11 at 12:40am with the Maintenance Supervisor revealed that trash carts were being stored in the 100, 200, and 300 corridors for longer than thirty (30) minutes.</p> <p>Interview, on 05/24/11 at 10:40am, with the Maintenance Supervisor revealed each trash cart stayed in each corridor.</p> <p>Observation on 05/24/11 at 11:00am with the Maintenance Supervisor revealed a bed and a lounge chair stored in the corridor next to the kitchen.</p> <p>Interview, on 05/24/11 at 11:00am, with the Maintenance Supervisor revealed he thought if the items were pushed to one side of the corridor it would be acceptable to store items in this location.</p> <p>Reference: NFPA 101 (2000 Edition)<br/>Means of Egress Reliability 7.1.10.1<br/>Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.</p> | K 072  | <p>chair in the corridor next to the kitchen was moved by the Environmental Services Director on 5/24/2011.</p> <ol style="list-style-type: none"> <li>The Administrator audited the facility on 5/24/2011 to ensure that no storage of items in corridor for longer than 30 minutes. No issues were identified.</li> <li>Re-education was provided to the Maintenance Director and Environment Services Director by the Administrator on no storage of items in corridor for longer than 30 minutes on 5/24/2011. The nursing staff will be re-educated by Director of Nursing Services on or before 6/24/2011 regarding no storage of items in corridor for longer than 30 minutes.</li> <li>The facility corridors will be monitored 3 times a week for 4 weeks, and then weekly times 2 months by the Administrator to ensure no items are stored longer than 30 minutes. The results will be reported by the Administrator to the Performance Improvement Committee for review and further recommendations.</li> <li>Date of compliance: 6/25/2011</li> </ol> |                      |  |



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|---|--|--|---|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>KENSINGTON MANOR CARE AND REHABILITATION CENTER |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>225 SAINT JOHN ROAD<br>ELIZABETHTOWN, KY 42701   |  |
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| K 147<br>SS=D   | <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>This STANDARD is not met as evidenced by:<br/>Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained according to NFPA standards. The deficient practice has the potential to affect two (2) smoke compartments, including residents, staff, and visitors. The facility is licensed for eighty two beds with a census of seventy six (76) the day of the survey.</p> <p>The findings include:</p> <p>Observation on 05/24/11 at 9:55am revealed an air conditioning unit stored in an electrical mechanical room in front of electrical panels.</p> <p>Interview with the Maintenance Supervisor, on 05/24/11 at 9:55am, revealed he was aware of the storage regulation and moved the unit upon discovery.</p> <p>Observation on 05/24/11 at 10:55am revealed a multi plug power strip was being used in the Physical Therapy room to power a microwave oven, coffee pot, and a radio.</p> <p>Interview, on 05/24/11 at 10:55am, revealed he was unaware the power strip was in use.</p> | K 147  | <p>K147</p> <ol style="list-style-type: none"> <li>The air conditioning unit was removed from the electrical mechanical room by the Maintenance Director on 5/24/11. The multi plug power strip was removed from the Physical Therapy room on 5/24/2011 by the Maintenance Director.</li> <li>Facility rounds were conducted by the Maintenance Director on 5/24/2011. No issues were identified.</li> <li>Re-education was provided to the Maintenance Director by the Administrator on 5/24/2011 regarding storage and the use of multi plug power strips. The facility staff, including therapy staff, will be educated by the Administrator on or before 6/24/2011 regarding the use of multi plug power strips.</li> </ol> |  |



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| K 147   | Continued From page 12<br>Reference: NFPA 99 (1999 edition)<br><br>3-3.2.1.2 D<br><br>Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.<br><br>Reference: NFPA 70 (1999 edition)<br><br>110-26. Spaces<br><br>About Electrical Equipment. Sufficient access and working space shall be provided and maintained around all electric equipment to permit ready and safe operation and maintenance of such equipment. Enclosures housing electrical apparatus that are controlled by lock and key shall be considered accessible to qualified persons. | K 147  | 4. The Maintenance Director will conduct facility rounds weekly times 4 weeks, then monthly times 2 months to identify storage of items and use of multi plug power strips. The findings will be reported by the Maintenance Director to the Performance Improvement Committee for review and further recommendations.<br><br>5. Date of compliance: 6/25/2011 |                      |  |

