

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

PRINTED: 09/15/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/20/2015
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)	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 **Amended-- An abbreviated survey (KY23734) was initiated on 08/18/15 and concluded on 08/20/15. This was a Minimum Data Set (MDS) 3.0 Staffing Focus Survey. Deficient practice was identified with the highest scope and severity at "E" level.	F 000	Disclaimer: Preparation and/or execution of the Plan of Correction does not constitute admission or agreement by the Provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared and/or executed solely because the provisions of federal and state law require it. The Provider maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor is it of such character as to limit the facilities capability to render adequate care.	
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment. Clinical disagreement does not constitute a material and false statement.	F 278	F 278 1. Resident #7: The MDS was corrected to reflect the resident's hearing deficits by the MDS Coordinator on 08/20/15. 2. A one time audit of each resident's hearing was initiated by the Social Services Director on 08/21/15 and will be completed by 09/30/15. If any discrepancies are noted, the MDS will be modified accordingly. 3. The new Social Services Director will be educated in regard to appropriate assessment and coding of section B0200/B0300 of the MDS related to hearing by the MDS Coordinator by 09/14/15. The MDS Coordinator will accompany the Social Services	

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

Alison Cox

TITLE

Administrator

(X6) DATE

09/17/15

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

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F 278	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to assure the accuracy of the Minimum Data Set (MDS) assessment for one (1) of ten (10) sampled residents (Resident #7). On the MDS, the facility coded/assessed Resident #7's ability to hear as adequate (no difficulty in normal conversation, social interactions, listening to television). However, observation and interview revealed Resident #7 was hard of hearing and used hearing aids. The findings include: Review of the Resident Assessment Instrument (RAI) Guidance, undated, revealed, "The RAI process, which includes the federally mandated MDS, is the basis for an accurate assessment of nursing home residents. The MDS information and the Care Area Assessment (CAA) process provide the foundation upon which the care plan is formulated." Record review revealed the facility readmitted Resident #7 on 05/18/15, with diagnoses which included Alzheimer's Disease, Chronic Respiratory Failure, Depression, and Anxiety. Review of the Quarterly MDS with an Assessment Reference Date (ARD) of 05/25/15, revealed in Section C0500 a Brief Interview for Mental Status (BIMS) score of 10, which indicated the resident was moderately impaired but was interviewable. Further review of the Quarterly MDS dated 05/25/15, revealed under Section B0200 ability to	F 278	Director on two (2) resident interviews per week for four (4) weeks to verify accurate assessment and coding related to hearing. The Interdisciplinary Care Plan Team consisting of at least the Director of Nursing, Social Services Director, Dietary Manager, and Activities Director will perform ongoing weekly audits related to hearing in section B0200/B0300 on the resident's current MDS prior to submission of the MDS. 4. The Quality Assurance Team consisting of at least the Administrator, Medical Director, Director of Nursing, Social Services Director, Dietary Manager and Maintenance Supervisor will review all audit findings and revise current plan at least monthly beginning 09/16/15 and ongoing until issue is resolved or satisfactory. 5. Date of Compliance: 09/30/15		

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F 278	<p>Continued From page 2</p> <p>hear was coded as adequate (no difficulty in normal conversation, social interactions, listening to television). Review of the MDS Section B0300 revealed hearing aid or other hearing appliances used was coded "No."</p> <p>Review of Physician's Orders dated 05/18/15, revealed an order to apply bilateral hearing aids every morning and remove the hearing aids and place them in the medication cart every evening.</p> <p>Observation of Resident #7 on 08/19/15 at 3:08 PM revealed the resident had hearing aids in both ears and was having a difficult time understanding conversation. Interview on 08/19/15 at 3:15 PM with Resident #7 revealed he/she could not hear very well with the hearing aids and could not hear at all without them. Continued interview revealed he/she needed people to come closer and speak louder for him/her to understand the conversation.</p> <p>Interview on 08/20/15 at 9:00 AM with State Registered Nursing Assistant (SRNA) #1 revealed Resident #7 was hard of hearing with his/her hearing aids. SRNA #1 stated she had to stand directly in front of the resident in order to be heard. Continued interview revealed Resident #7 would look at your lips when you spoke to him/her to help understand the conversation.</p> <p>Interview on 08/20/15 at 9:10 AM with Licensed Practical Nurse (LPN) #2 revealed she placed the hearing aids in the resident's ears, and was responsible for changing out the batteries. LPN #2 stated Resident #7 had difficulty hearing even when his/her hearing aids were placed in his/her ears.</p>	F 278			

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F 278	Continued From page 3 Interview on 08/20/15 at 9:40 AM, with the MDS Coordinator revealed it was the responsibility of the Social Services Director (SSD) to complete section B of the MDS and it should have been coded as moderate difficulty (speaker has to increase volume and speak distinctly). Continued interview revealed the SSD was no longer employed at the facility. Further interview with the MDS Coordinator revealed the resident refused to wear the hearing aids during the May reference period because the aide hurt his/her ears.	F 278			
F 279 SS=D	Interview on 08/20/15 at 11:50 AM, with the Director of Nursing (DON) revealed the SSD should have coded the MDS correctly and by not coding correctly, this could have interfered with Resident #7's plan of care. Continued interview with the DON revealed the MDS Coordinator was responsible for training staff on the MDS and was responsible to ensure the MDS was accurate. 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under	F 279	1. Resident #7: A communication care plan to address the resident's communication was initiated on 08/20/15 by the new Social Services Director. It was noted that the ADL care plan did address the need for hearing aides. 2. A one time audit of each resident's communication needs was initiated by the Social Services Director on 08/21/15 and will be completed by 09/30/15. If the need for corrections is noted, the care plan will be initiated or updated accordingly. 3. The new Social Services Director will be educated on how to develop a		

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F 279	<p>Continued From page 4</p> <p>§483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy, it was determined the facility failed to develop a comprehensive care plan with goals and approaches to address communication for one (1) of ten (10) sampled residents (Resident #7). The facility staff failed to initiate a care plan for Resident #7 to ensure his/her hearing difficulties were documented and interventions were in place to provide a means for the resident to communicate effectively.</p> <p>The findings include:</p> <p>Review of the facility's policy, "Care Plan Guidance," undated, revealed it was the practice of the facility and their affiliates to initiate, complete, and revise resident care plans in accordance with all Federal and State regulations and the Resident Assessment Instrument (RAI) guidance.</p> <p>Record review revealed the facility readmitted Resident #7 on 05/18/15, with diagnoses that included Alzheimer's disease, Chronic Respiratory Failure, Depression, and Anxiety. Review of the Quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 05/25/15, revealed in Section C0500, a Brief Interview for Mental Status (BIMS) score of 10, which indicated the</p>	F 279	<p>communication care plan by the MDS Coordinator by 09/14/15. The MDS Coordinator will accompany the Social Services Director on two (2) resident interviews per week for four (4) weeks to verify accurate assessment and coding related to hearing. The Interdisciplinary Care Plan Team consisting of at least the Director of Nursing, Social Services Director, Dietary Manager, and Activities Director will perform ongoing weekly audits of the communication care plans quarterly or as needed.</p> <p>4. The Quality Assurance Team consisting of at least the Administrator, Medical Director, Director of Nursing, Social Services Director, Dietary Manager and Maintenance Supervisor will review all audit findings and revise current plan at least monthly beginning 09/16/15 and ongoing until issue is resolved or satisfactory.</p> <p>5. Date of Compliance: 09/30/15</p>		

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F 279	<p>Continued From page 5</p> <p>resident was moderately impaired but interviewable.</p> <p>Review of Physician's Orders dated 05/18/15, revealed an order to apply bilateral hearing aids every morning and remove the hearing aids and place in the medication cart every evening.</p> <p>Review of a Physician's Order dated 05/19/15, revealed Resident #7 had an order for speech to evaluate and treat as indicated for four (4) weeks to increase communication.</p> <p>Review of the comprehensive care plan dated 02/27/15 revealed no evidence of a care plan to address Resident #7's communication needs.</p> <p>Interview on 08/20/15 at 9:00 AM, with State Registered Nursing Assistant (SRNA) #1 revealed Resident #7 was hard of hearing even when he/she was wearing hearing aids. SRNA #1 stated when speaking to the resident, she had to stand directly in front of the resident so the resident could hear her. Continued interview revealed Resident #7 would look at your lips when you spoke to him/her to help him/her to understand the conversation.</p> <p>Interview on 08/20/15 at 9:40 AM, with the MDS Coordinator revealed it was the responsibility of the Social Services Director (SSD) to complete a communication care plan, and Resident #7's Plan of Care should have included a communication care plan. Continued interview revealed it was crucial that staff involved in the communication process use good communication strategies and the care plan should have reflected goals and interventions to address Resident #7's communication needs. Further interview</p>	F 279			

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F 279	Continued From page 6 revealed the MDS Coordinator was the final observer to ensure the care plan was complete. Interview on 08/20/15 at 11:50 AM with the Director of Nursing (DON) revealed she expected Resident #7's MDS to be coded to trigger a communication care plan, and the care plan to reflect the individual needs of the resident. Further interview with the DON revealed the resident's full care needs were not adequately met with the current care plan.	F 279		
F 356 SS=E	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community	F 356	1. No specific resident was identified. The daily nurse staffing sheet was posted by the Staffing/Education Coordinator beginning on 08/18/15. 2. A daily check was completed by the Administrator 08/18/15-08/21/15, 08/24/15-08/28/15, 08/31/15-09/04/15, and 09/08/15-09/11/15 to identify that the daily nurse staffing information was posted. A daily check was completed on 08/22/15-08/23/15, 08/29/15-08/30/15, and 09/5/15-09/6/15 to identify that the daily nurse staffing information was posted on weekends. No issues were identified. 3. The Administrator reviewed the requirements and re-educated the management team regarding posting the nurse staffing information daily including weekends and maintaining the posted staffing data for 18 months on 08/24/15. The data will be kept in a binder. The Staffing/Education	

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F 356	<p>Continued From page 7 standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to post the nurse staffing data daily as required. Observations on 08/18/15 revealed the nurse staffing data that was posted was not current and did not correlate with the number of staff persons that were actually working in the facility. The staffing data that was posted was dated 08/14/15.</p> <p>The findings include:</p> <p>Interview on 08/20/15 at 11:50 AM, with the Director of Nursing (DON) revealed although there was not a policy related to daily posting of the nurse staffing data, her expectations were that the Staffing Coordinator would follow protocol and accurately post the 24-Hour Staffing Sheet. The DON stated this should include the facility's name, date, and correct number of Registered Nurses (RNs), Licensed Practical Nurses (LPNs), and State Registered Nursing Assistants (SRNAs) on duty.</p> <p>Observation on 08/18/15 at 8:49 AM revealed the nurse staffing data that was posted, upon entering the building, was dated 08/14/15 and did not accurately reflect the nursing staff on duty for the current day. Review of eighteen (18) months of daily staffing sheets revealed several staffing</p>	F 356	<p>Coordinator or Nursing designee or weekend manager will post the nurse staffing information daily. The Administrator and/or Director of Nursing and/or management team member as appointed by the Administrator or Director of Nursing will complete ongoing audits 5 times per week including weekends to identify that the daily nurse staffing information is current. Any issue will be addressed immediately.</p> <p>4. The Quality Assurance Team consisting of at least the Administrator, Medical Director, Director of Nursing, Social Services Director, Dietary Manager and Maintenance Supervisor will review all audit findings and revise current plan at least monthly beginning 09/16/15 and ongoing until issue is resolved or satisfactory.</p> <p>5. Date of Compliance: 09/30/15</p>		

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F 356	<p>Continued From page 8 sheets were missing for the weekends.</p> <p>Interview on 08/18/15 at 8:50 AM with LPN #1 revealed the posted staffing was incorrect and did not reflect the current staff in the building. Continued interview revealed the staffing information should be accurate in order for everyone to know who was caring for the residents.</p> <p>Interview on 08/18/15 at 8:55 AM, with the Staffing/Education Director revealed she was responsible for making sure staffing was posted daily with the correct date and accurate number of staffing for the current day. Continued interview on 08/20/15 at 11:30 AM, revealed the facility did not have a delegated person to post staffing for the weekends.</p> <p>Continued interview on 08/20/15 at 11:50 AM with the DON revealed it was important to have current staffing information posted to ensure adequate staffing to meet the needs of the residents.</p>	F 356			