

RECEIVED

013/022

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

OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES ADMINISTRATION
PRINTED: 08/02/2011
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 07/20/2011
--	--	--	---

NAME OF PROVIDER OR SUPPLIER KENSINGTON MANOR CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 225 SAINT JOHN ROAD ELIZABETHTOWN, KY 42701
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 000	INITIAL COMMENTS An abbreviated survey was initiated and concluded on 07/20/11 to investigate KY16742. The Division of Health Care substantiated KY16742 with deficiencies cited at the S/3 of a "G", actual harm.	F 000	Kensington Manor Plan of Correction Abbreviated Survey July 20th, 2011 <u>Plan of Correction</u>	
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on staff interview, review of the closed clinical record and the Pressure Ulcer Management policy, it was determined the facility failed to ensure preventative measures were implemented for identified risk of pressure sore development for one (1) of five (5) sampled residents (Resident #4). The facility assessed Resident #4 at risk for pressure sore development upon admission; however, failed to implement preventive measures that were consistent with the resident's identified needs until after the development of a pressure ulcer to the resident's back. The facility failed to perform weekly skin assessments according to their policy and failed to provide wound care treatment as ordered by the physician. The resident's wound	F 314	"This plan of correction is prepared and submitted as required by law. By submitting this Plan of Correction, Kensington Manor Care & Rehabilitation 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 314 1. Resident #4 was discharged on June 20, 2011, from the facility. 2. Current residents had a skin assessment completed by a licensed nurse, as of August 3, 2011. The Plan of care, notification and investigation was updated to reflect current status of residents by a licensed nurse as of August 3, 2011.	

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

TITLE

(X6) DATE

[Signature]

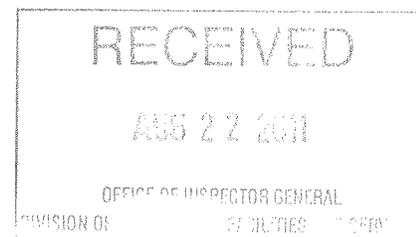
Administrator X 8/22/11

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.

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

PRINTED: 08/02/2011
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 07/20/2011
NAME OF PROVIDER OR SUPPLIER KENSINGTON MANOR CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 225 SAINT JOHN ROAD ELIZABETHTOWN, KY 42701	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 1 Increased in size, became infected, and the resident required hospitalization for several weeks. The resident experienced increased pain and received multiple treatments (IV, blood transfusion, wound vac, and chemical debridement). The findings include: Review of the facility's skin care and pressure ulcer management program policy (revised January 2008) revealed guidelines were utilized by the facility to prevent pressure ulcer development, promote healing, and prevent infection when skin breakdown occurs. The facility skin program used the 'APIE' approach to care giving: Assess, Plan, Implement, and Evaluate. Section (1) Assessment stated: upon admission, the facility would assess each resident's risk for development of pressure ulcers utilizing the nursing assessment and the Norton plus Pressure Ulcer Scale. Section (2) stated: planning; implementation; evaluation; and care planning, were to be based on the resident's assessment. A care plan would be developed with individualized interventions to prevent skin breakdown. The interventions would be specific to the risk factors identified through the assessment process, such as mobility, activity, moisture, nutrition, sensation, and friction. Once the care plan was written, the facility staff was responsible to ensure that all planned interventions and treatments were "carried out as written in the care plan." The policy stated a licensed nurse would perform a weekly head-to-toe skin check of the resident and document the findings on the treatment administration record (TAR) by using the	F 314	3. The Registered Nurses, Licensed Practical Nurses and Certified Nursing Assistants, have been re educated to the Pressure Ulcer Management Program by the Staff Development Coordinator as of August 5, 2011. The education included completion of weekly skin assessments, implementation of preventative measures for high risk residents, and providing wound care treatments. The certified nursing assistants use the Daily Skin Documentation Pad/Book to note and skin developments and a copy is given to the licensed nurse as well as the Director of Nursing or Assistant Director of Nursing to ensure interventions are implemented. 4. The Director of Nursing or the Assistant Director of Nursing will review treatment records to ensure skin assessments and treatments are completed as scheduled on 3 residents weekly times 3 months and complete a skin assessment on 3 residents weekly times 3 months. A summary of findings will be submitted to the Performance Improvement Committee by the Director of Nursing, monthly times 3 months for review and further recommendations. 5. Date of compliance:	10 August 2011.



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

PRINTED: 08/02/2011
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 07/20/2011	
NAME OF PROVIDER OR SUPPLIER KENSINGTON MANOR CARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 226 SAINT JOHN ROAD ELIZABETHTOWN, KY 42701		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	<p>Continued From page 2</p> <p>notations of "Y" = skin intact and "N" = not intact. The policy revealed any new skin issue was to be considered an "incident." Every incident required investigation to determine the root cause. Through the investigation, information was to be gathered, to determine why the resident may have developed a pressure ulcer.</p> <p>Review of the closed clinical record for Resident #4 revealed the nursing facility had admitted the resident on 05/05/11 with the following diagnoses: Muscle Weakness, Urinary tract Infection, Severe Back Pain with possibility of compression fractures of the spine, Osteoarthritis, Alzheimer's Disease, and unspecific Atherosclerosis. The nursing assessment dated 05/05/11 revealed Resident #4 did not have any pressure ulcers upon admission. The skin was assessed as warm, dry, and intact. Interview with Resident #4's daughter, on 07/20/11 at 11:00 AM, revealed the resident had no skin breakdown upon admission to the facility. The facility completed the Norton plus pressure ulcer scale assessment, on 05/05/11 which revealed the resident was at high risk for skin breakdown.</p> <p>Continued review of the closed clinical record revealed Physical (PT) and Occupational (OT) therapy initiated treatment on 05/12/11. Review of the weekly PT progress note dated 05/12/11 revealed the therapist had discussed the need to use a positioning device to support the resident's upper and lower back related to Kyphosis (forward curvature of the spine). The progress note identified increased risk for skin breakdown. The OT weekly progress note dated 05/12/11 revealed the resident's wheelchair had been modified to recline by raising the front wheels.</p>	F 314		

RECEIVED
AUG 22 2011
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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

PRINTED: 08/02/2011
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 07/20/2011
NAME OF PROVIDER OR SUPPLIER KENSINGTON MANOR CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 225 SAINT JOHN ROAD ELIZABETHTOWN, KY 42701	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
F 314	<p>Continued From page 3</p> <p>Bilateral bolsters and a pommel cushion were added to achieve functional upright position. The therapist assessed the resident to have severe Kyphotic posture with the resident's chin pressed "snugly against breast bone." There was no documented evidence any type of pressure relief device for the back was placed in the resident's wheelchair. The weekly skin assessment for May 2011 revealed the facility performed the first skin assessment for Resident #4 on 05/12/11 and found no skin issues.</p> <p>Review of the admission MDS (minimum data set) assessment completed on 05/17/11 revealed the facility assessed the resident as at risk for pressure sore development related to urinary incontinence, decreased mobility, Norton Plus assessment, and cognition impairment. The MDS assessment identified the resident had no skin breakdown at the time of the assessment. In addition, the facility assessed the resident to require extensive assistance from staff for bed mobility, transfers, ambulation, eating, dressing, toilet use, locomotion on the unit, and bathing.</p> <p>Review of the care plan dated 05/17/11 revealed Resident #4 had a potential risk for skin breakdown related to decreased mobility urinary incontinence, friction, and cognition impairment. The goal was for the resident to have no skin breakdown daily with the following interventions: (1) assist the resident to turn and reposition every 2 hours and as needed, (2) provide pressure reducing/relieving devices as ordered, (3) toilet the resident frequently, and (4) perform weekly skin assessments. Review of the May 2011 Nursing Assistant Care card revealed under the section "skin", there were instructions to turn and</p>	F 314		

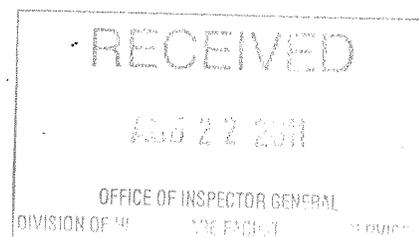
If continuation sheet Page 4 of 10

12/22/11

OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 08/02/2011
FORM APPROVED
OMB NO. 0938-0391

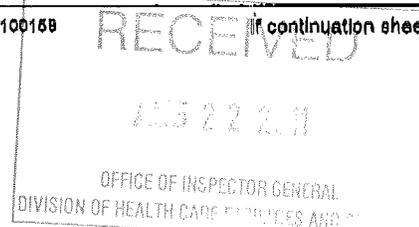
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185443	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/20/2011
NAME OF PROVIDER OR SUPPLIER KENSINGTON MANOR CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 225 SAINT JOHN ROAD ELIZABETHTOWN, KY 42701	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	<p>Continued From page 4</p> <p>reposition every two (2) hours and as needed. Pressure relief was only marked under the bed section, not the chair.</p> <p>Continued Interview with Resident #4's daughter, on 07/20/11 at 11:00 AM, revealed the resident developed a red area to the middle of the back on 05/19/11 and she had informed the nursing staff of the redness. She had reported the red area to a staff nurse (could not recall name) on 05/19/11. However, review of the weekly skin assessment revealed no documented evidence the facility assessed the resident's skin on this date despite being informed by the daughter of the red area. Interview with the Director of Nursing (DON), on 07/20/11 at 7:50 PM, revealed she did speak with the daughter on 05/19/11 and did not recall her reporting a red area on the resident's spine. She reviewed the skin assessment log and stated she could not provide evidence the skin assessment was conducted on 05/19/11 as scheduled and revealed there was no monitoring of the skin assessment forms to ensure they had been completed as scheduled.</p> <p>Review of the Interdisciplinary progress notes, dated 05/25/11 at 2:00pm, revealed the facility documented a new stage II pressure area on Resident #4's medial spine. " Resident has curvature of the spine." " Kyphotic area appears to rub" when the resident is sitting in the wheelchair or lying down. The physician was notified and ordered a wound treatment to cleanse with normal saline, cover with optifoam dressing and change every third day. On 05/25/11 the nursing facility called the daughter and reported an open area to the spine.</p>	F 314		



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

PRINTED: 08/02/2011
FORM APPROVED
OMB NO. 0938-0391

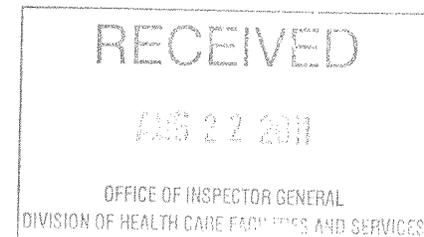
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185443	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/20/2011
NAME OF PROVIDER OR SUPPLIER KENSINGTON MANOR CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 226 SAINT JOHN ROAD ELIZABETHTOWN, KY 42701		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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 314	<p>Continued From page 5</p> <p>The next skin assessment was not performed until Thursday, May 26, 2011 where it was documented the resident now had a pressure ulcer. In addition, review of the May 2011 Treatment Administration Record (TAR) revealed no documented evidence the wound treatment was completed on 05/31/11.</p> <p>Review of the pressure ulcer documentation form initiated on 05/25/11 revealed the pressure ulcer continued to increase in size and became a 50% covered with eschar (06/08/11), then 100% slough (06/15/11). The wound treatment was not changed until after the daughter spoke with the physician on 06/02/11.</p> <p>Continued interview with Resident #4's daughter, on 07/20/11 at 11:00 AM, revealed the daughter had surgery (05/23/11) and was unable to visit the resident for awhile. Upon her return visit to the facility on 06/02/11, the daughter found the wound on the resident's back was now "black". The daughter stated she took a picture of the resident's wound and emailed a friend who is a wound care specialist. The nurse told the daughter the wound was necrotic. On 06/02/11, the daughter spoke with the physician, nurse manager and the Director of Nursing and stated she could get no answers.</p> <p>Review of the physician's progress note dated 06/02/11 revealed the open area was now a Stage III thoracic spine decubitus with necrotic tissue in the center of the wound and redness on the sides. The physician documented, "spoke with daughter who found the decubitus and she is upset." The physician documented the daughter had spoken with a wound care nurse and</p>	F 314			



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

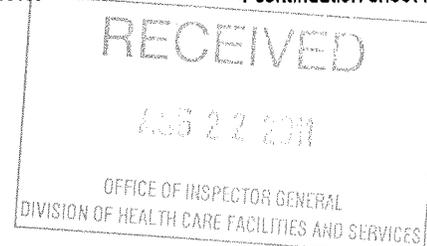
PRINTED: 08/02/2011
FORM APPROVED
OMB NO. 0938-0391

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 07/20/2011	
NAME OF PROVIDER OR SUPPLIER KENSINGTON MANOR CARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 225 SAINT JOHN ROAD ELIZABETHTOWN, KY 42701		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
F 314	<p>Continued From page 6</p> <p>recommended the present wound care orders: Santyl, (collagenase) ointment daily, cover with wet saline gauze packing and foam. The physician also ordered the resident not to be up for more than one (1) hour at a time. The physician documented the daughter told him the resident's skin was clear without any pressure ulcers when the resident was admitted to the nursing facility. Interview with the physician (who is the facility's Medical Director) on 07/20/11 at 5:15 PM, revealed the daughter came to him on the above date and was upset because the resident had a pressure ulcer. The daughter told the physician she was the one who found the pressure ulcer and was upset because she said it had started as a red area.</p> <p>Continued review of the pressure ulcer documentation form initiated on 05/25/11 revealed the wound treatment was not changed until after the daughter spoke with the physician on 06/02/11.</p> <p>Interview with the daughter on 07/20/11 at 11:00 AM revealed she spoke with the Administrator on 06/03/11 and reported her concerns regarding the resident's pressure ulcer development. The daughter stated she went through the proper chain of command by speaking with a nurse, then the Director of Nursing, and then the Administrator. However, the daughter stated upon her visits, she found the resident sitting in the wheelchair for extended periods of time without a pillow or cushion to the resident's back. She stated the resident's curved spine rubbed the back of the wheelchair causing friction.</p> <p>Interview with the Administrator of the Nursing Facility, on 07/20/11 at 7:50 PM, revealed she</p>	F 314		



DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 08/02/2011
FORM APPROVED
OMB NO. 0938-0391

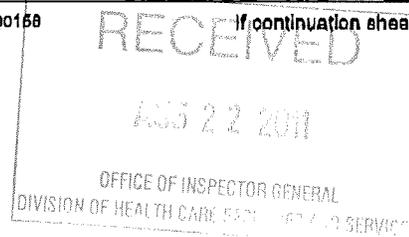
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185443	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/20/2011
NAME OF PROVIDER OR SUPPLIER KENSINGTON MANOR CARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 225 SAINT JOHN ROAD ELIZABETHTOWN, KY 42701	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
F 314	<p>Continued From page 7</p> <p>was not aware of the pressure sore development until 06/03/11 when the daughter came to her with concerns. She stated she went with the daughter the evening of 06/03/11 and assessed the wound herself (she is a nurse). The administrator stated the wound was dark red with no eschar.</p> <p>Continued review of the closed clinical record revealed, on 06/15/11, the facility faxed a notification of change to the physician that stated moderate amount of yellow/tan foul odor drainage was observed in Resident #4's wound. The physician ordered a wound culture and sensitivity. However, the facility did not collect the wound culture until 06/17/11 due to no culture swabs available. The wound culture results were received by the facility on 06/19/11 that revealed heavy growth of Proteus Mirabilis and Enterococcus (bacteria). The results were reported to the physician; however, the physician did not order any treatment because the daughter had informed the nursing facility that she was taking the resident to an acute hospital for treatment the next day.</p> <p>Continued interview with the daughter, on 07/20/11 at 11:00 AM, revealed the resident's wound was not getting better. She stated she had a nurse wound specialist (who was a friend) assess the resident's wound on 06/19/11 and was told it was "bad". She made the decision to transfer the resident to an acute hospital for wound evaluation and treatment. Review of a nurses' note dated 06/20/11 revealed at 12:55 PM, Resident #4 was transported to an acute hospital.</p> <p>Review of the acute hospital documentation</p>	F 314	



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

PRINTED: 08/02/2011
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 07/20/2011
NAME OF PROVIDER OR SUPPLIER KENSINGTON MANOR CARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 225 SAINT JOHN ROAD ELIZABETHTOWN, KY 42701		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
F 314	<p>Continued From page 8</p> <p>(history and physical dated 06/20/11) revealed the resident was admitted with a Stage IV pressure ulcer with infection and sepsis, electrolyte abnormalities, and severe dehydration. The resident was admitted for IV (intravenous) fluids, antibiotics, and possible debridement. Review of the hospital's skin assessment conducted upon admission on 06/20/11 revealed the wound opening measured 2 by 2 centimeters (cm). The wound had erythema (redness) with significant amount of undermining around the wound which measured 7 by 7 cm with foul-smelling drainage. A plastic surgeon was consulted; however, due to the resident's age and medical condition, surgical intervention was not appropriate. The resident was treated at this acute hospital and then transferred to another hospital specializing in wound care on 06/24/11 for further wound evaluation and treatment.</p> <p>Continued interview with the daughter, on 07/20/11, revealed the resident suffered pain and discomfort because of the pressure ulcer formation. She stated the resident had to be transfused with one unit of packed red blood cells and treated for severe dehydration and electrolyte imbalance at the hospital. The daughter indicated the nursing facility failed to provide measures to prevent the pressure ulcer formation and did not take appropriate actions once the pressure ulcer developed. She revealed the resident remained in the hospital for almost a month. The daughter stated the resident experienced a lot of pain due to the infected wound and had to endure multiple treatments.</p> <p>Interview with the Director of Nursing (DON), on 07/20/11 at 7:50 PM, revealed there was no</p>	F 314		



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

PRINTED: 08/02/2011
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 07/20/2011	
NAME OF PROVIDER OR SUPPLIER KENSINGTON MANOR CARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 226 SAINT JOHN ROAD ELIZABETHTOWN, KY 42701		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
F 314	<p>Continued From page 9</p> <p>monitoring of the skin assessment forms to ensure they are completed as scheduled. The DON reviewed the pressure ulcer care plan with the surveyor and stated friction, as listed under the problem list, could be referring to the resident's back. She stated she thought a cushion was provided in the wheelchair; however, review of the care plan revealed a foam back cushion was not provided until 06/25/11, after the resident had developed a pressure ulcer on the back. A derma saver was placed on the resident's wheelchair on 06/01/11, and an air mattress was ordered on 06/02/11.</p> <p>Interview with the Administrator on 07/20/11 at 7:50 PM revealed no investigation of the resident's pressure ulcer development had been conducted. When the Administrator and the Director of Nursing was asked what their root cause analysis was for the pressure ulcer development, they did not give an answer. The Administrator did not indicate an "incident" report was completed according to the facility's policy and protocol for skin care management. In addition, the identified risk for the resident (the resident's back deformity and friction from the wheelchair) was not addressed on the care plan with individualized interventions developed to prevent skin breakdown until after the resident developed a pressure ulcer on the back. The Administrator stated she was sure the staff had utilized a pillow in the resident's wheelchair; however, she had no documented evidence to support that statement. She stated the weekly skin assessments are forward to the DON and she thought they were being monitored for compliance.</p>	F 314		

