

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

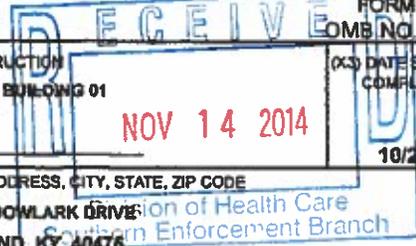
PRINTED: 01/22/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185061</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>10/23/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>KENWOOD HEALTH AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>130 MEADOWLARK DRIVE RICHMOND, KY 40475</b>		
(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  A standard health survey was conducted on 10/21-23/14. The facility was in substantial compliance with no deficient practice identified.	F 000			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

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

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NAME OF PROVIDER OR SUPPLIER  KENWOOD HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 130 MEADOWLARK DRIVE RICHMOND, KY 40476
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR §483.70 (a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1985</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One story, Type III (200)</p> <p>SMOKE COMPARTMENTS: 8</p> <p>COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM</p> <p>FULLY SPRINKLERED, SUPERVISED (WET &amp; DRY SYSTEM)</p> <p>EMERGENCY POWER: Type II diesel generator</p> <p>A Life Safety Code Survey was initiated and concluded on 10/21/14. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility was found not in substantial compliance with the Requirements for Participation for Medicare and Medicaid.</p> <p>Deficiencies were cited with the highest deficiency identified at "E" level.</p>	K 000	<p>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.</p>	
K 021 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or</p>	K 021	<p>1. Facility will obtain bids to install new self-closing doors leading to the kitchen and dishwashing area to ensure that doors to a hazardous area</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 11/14/14
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NAME OF PROVIDER OR SUPPLIER  KENWOOD HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 130 MEADOWLARK DRIVE RICHMOND, KY 40475	
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K 021	<p>Continued From page 1</p> <p>hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of:</p> <p>a) the required manual fire alarm system;</p> <p>b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and</p> <p>c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure that doors to a hazardous area were maintained as required. This deficient practice affected one (1) of eight (8) smoke compartments, staff, and other occupants of the building. The facility has the capacity for 93 beds with a census of 86 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code tour on 10/21/14 at 10:55 AM, with the Director of Maintenance (DOM), a door leading to the kitchen area was observed to be held open by a food cart and a door to an adjacent dishwashing area was observed to be held open in the same manner. Doors that open to or affect corridors/exits are required to be held open in an approved manner</p>	K 021	<p>are maintained as required and held open by devices arranged to automatically close upon activation. The facility will obtain bids to replace the two other kitchen doors that open directly to the corridor and do not automatically latch. The installation will be scheduled and completed once bids are obtained from contractors.</p> <p>2. A one time audit of hazardous areas was completed by the Administrator and Maintenance Supervisor on 11/13/14 to identify that doors to a hazardous area are maintained as required and held open by devices arranged to automatically close upon activation. No other issues were identified.</p> <p>3. The Maintenance department will audit hazardous areas weekly beginning week of 11/17/14 and on-going to ensure that doors to a hazardous area were maintained as required and held open by devices arranged to automatically close upon activation. Any issue identified will be addressed immediately. The Administrator reviewed the requirements and re-educated the maintenance supervisor and dietary staff regarding doors to a hazardous area are maintained as required and held open by devices arranged to automatically close upon activation on 11/13/14.</p>	

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K 021	<p>Continued From page 2</p> <p>to help prevent smoke/fire from entering these areas. An interview with the DOM on 10/21/14 at 10:55 AM revealed he was not aware of the requirements pertaining to hazardous area doors. During the survey two other kitchen doors that opened directly on to the corridor/exit were observed not to automatically latch as required.</p> <p>The findings were reported to the Administrator during exit.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>3.3.13.2 Area, Hazardous. An area of a structure or building that poses a degree of hazard greater than that normal to the general occupancy of the building or structure, such as areas used for the storage or use of combustibles or flammables; toxic, noxious, or corrosive materials; or heat-producing appliances.</p> <p>8.2.3.2.3 2 Where a 20-minute fire protection-rated door is required in existing buildings, an existing 13/4-in. (4.4-cm) solid, bonded wood-core door, or an existing steel-clad (tin-clad) wood door, or an existing solid-core steel door with positive latch and closer shall be permitted.</p> <p>19.2.2.2.6* Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier, or hazardous area enclosure shall be permitted to be held open only by an automatic release device that complies with 7.2.1.8.2. The automatic sprinkler system, if provided, and the fire alarm system, and the systems required by 7.2.1.8.2 shall be arranged to initiate the closing action of</p>	K 021	<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 week of 11/19/14 and ongoing until issue is resolved or satisfactory.</p> <p>5. Date of Compliance: 12/06/14</p>	

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K 021  K 025 SS=E	<p>Continued From page 3</p> <p>all such doors throughout the smoke compartment or throughout the entire facility.</p> <p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain smoke barrier doors and smoke barrier walls with at least a one-half hour fire resistance rating as required. This deficient practice affected five (5) of eight (8) smoke compartments, staff, and approximately fifty (50) residents. The facility has the capacity for 93 beds with a census of 86 the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code survey on 10/21/14 at 10:35 AM with the Director of Maintenance (DOM), a smoke barrier door to the Barber Shop was observed not to have a door-closing device as required. Doors in smoke barrier walls are required to be properly maintained with a door-closing device to help prevent fire and</p>	K 021  K 025	<p>K 025</p> <p>1. Door closing devices will be installed on the doors to the Barber Shop and Administrator's office to help prevent fire and smoke from spreading to other areas of the facility by the facility's maintenance staff by 11/21/14. Facility will obtain bids to install a self-closing fire door between the Dining and Main Dining rooms to help prevent fire and smoke from spreading to other areas of the facility. The installation will be scheduled and completed once bids are obtained from contractors.</p> <p>2. A one time audit of every smoke barrier door and smoke barrier wall was completed by the Administrator and Maintenance Director on 11/13/14 to identify smoke barriers are properly maintained to help prevent fire and smoke from spreading to other areas of the facility. No other issues were identified.</p> <p>3. The Maintenance department will audit all areas weekly beginning week of 11/17/14 and ongoing to ensure smoke barriers are properly maintained to help prevent fire and smoke from spreading to other areas of the facility. Any issue identified will be addressed immediately. The Administrator reviewed the requirements and re-educated the</p>	

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K 025	Continued From page 4 smoke from spreading to other areas of the facility. An interview with the DOM on 10/21/14 at 10:35 AM revealed he was not aware these types of doors required a door-closing device. During the survey a smoke barrier door to the Administrator's office was observed not to have a door-closing device.  On 10/21/14 at 10:40 AM, an approximate 7-foot by 7-foot section of smoke barrier wall was observed to be missing between the Dining and Main Dining rooms due to previous remodeling. Smoke barrier walls are required to be properly maintained to help prevent fire and smoke from spreading to other areas of the facility. An interview with the DOM on 10/21/14 at 10:40 AM revealed he was not aware this missing section would be part of a smoke barrier wall.  The findings were revealed to the Administrator upon exit.  Reference: NFPA 101 (2000 Edition).  19.3.7.3 Any required smoke barrier shall be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than 1/2 hour.  8.3.4.3* Doors in smoke barriers shall be self-closing or automatic-closing in accordance with 7.2.1.8 and shall comply with the provisions of 7.2.1.	K 025	maintenance supervisor regarding smoke barrier walls are properly maintained on 11/13/14.  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 week of 11/19/14 and ongoing until issue is resolved or satisfactory.  5. Date of Compliance: 12/06/14	
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested	K 062	K 062  1. The facility's sprinkler maintenance vendor, Brown's	

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K 062	<p>Continued From page 5</p> <p>periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the fire sprinkler system by NFPA standards. This deficient practice has the potential to have a negative effect on the facility's sprinkler system. The facility has the capacity for 93 beds with a census of 86 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code survey on 10/21/14, at 12:10 PM with the Director of Maintenance (DOM) a cover was observed to be missing from the fire department connection located on the exterior of the facility. This connection may be used by the fire department to add more water to the facility's sprinkler system in case of fire. These covers help ensure foreign material does not get into the facility's fire sprinkler system.</p> <p>An interview with the DOM on 10/21/14, at 12:10 PM revealed he was not aware the cover was missing.</p> <p>The findings were revealed to the Administrator upon exit.</p> <p>Reference: NFPA 25 (1998 Edition).</p> <p>9-7.1 Fire department connections shall be inspected quarterly. The inspection shall verify the</p>	K 062	<p>Sprinkler, was notified of the missing cover for the fire department connection and asked to order a replacement cover by the Maintenance Supervisor on 10/21/14. The cover was installed by maintenance staff on 11/12/14.</p> <p>2. A one time audit of the facility's sprinkler system was completed by the Administrator and Maintenance Supervisor on 11/13/14 to identify that the sprinkler system is in reliable operating condition and no additional fire department connection covers were missing. No other issues were identified.</p> <p>3. The Maintenance department will audit the facility's sprinkler system weekly beginning the week of 11/04/13 and ongoing to ensure the sprinkler system is in reliable operating condition and no additional fire department connection covers were missing. Any issue identified will be addressed immediately. The Administrator reviewed the requirements and re-educated the maintenance supervisor regarding the sprinkler system is in reliable operating condition and fire department connection covers are in place on 11/13/14.</p> <p>4. The Quality Assurance Team (consisting of at least the Administrator, Medical Director,</p>	

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K 062	Continued From page 6 following: (a) The fire department connections are visible and accessible. (b) Couplings or swivels are not damaged and rotate smoothly. (c) Plugs or caps are in place and undamaged. (d) Gaskets are in place and in good condition. (e) Identification signs are in place. (f) The check valve is not leaking. (g) The automatic drain valve is in place and operating properly.	K 062	Director of Nursing, Social Services Director, Dietary Manager and Maintenance Supervisor) will review all audit findings and revise current plan at least monthly beginning week of 11/19/14 and ongoing until issue is resolved or satisfactory.  5. Date of Compliance: 12/06/14	