

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

09/09/2011  
FORM APPROVED  
OMB NO. 0938-0391

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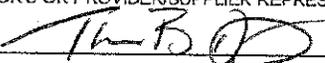
SEP 19 2011

08/25/2011

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  08/25/2011
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NAME OF PROVIDER OR SUPPLIER  KENWOOD HEALTH AND REHABILITATION CENTER	STREET ADDRESS 130 MEADOW LARK DRIVE RICHMOND, KY 40475
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F 000	INITIAL COMMENTS  A standard health survey was conducted on 08/23-25/11. Deficiencies were identified with the highest scope and severity at "E" level.	F 000		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY  The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to promote care in a manner to maintain or enhance each resident's dignity and respect for one of twenty-two sampled residents (Resident #4).  The findings include:  1. A review of the medical record revealed the facility readmitted Resident #4 on 12/28/10, with diagnoses to include Fracture of the right ankle, nasal bone Fracture, Atrial Fibrillation, Hypertension, Depression, Anxiety, and Psychosis.  A review of the quarterly comprehensive assessment completed on 06/03/11, revealed Resident #4's Brief Interview for Mental Status	F 241	<p><b>F 241</b> <b>Corrective Actions for Targeted Resident(s):</b> Resident #4 call lights have been answered timely and resident has had no further incontinent episodes.</p> <p><b>Identification of Other Residents with Potential to Be Affected:</b> Social Services to complete a one time interview all cognitive residents by 10/2/2011 to identify any resident that is waiting too long for call light to be answered and needs are being met. Any issue identified will be immediately addressed.</p> <p><b>Systemic Changes:</b> Education Training Director to re educate nursing staff regarding answering call lights timely and ensuring all resident needs are met by 10/3/2011. Six (6) call light audits to be completed by Administrator and Director of Nursing three(3) times a week x 4 weeks then two times a week x 2 weeks to ensure call lights are being answered timely beginning week of 10/3/2011. Social Services to interview 3 residents a week related to timely</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 9/19/11
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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 241	<p>Continued From page 1</p> <p>(BIMS) score was 15, which indicated the resident was cognitively intact. Further review of the quarterly assessment revealed the facility assessed Resident #4 to require extensive assistance of two staff members for transfers, toileting, and personal hygiene needs.</p> <p>Resident #4 was observed on 08/23/11, at 11:00 AM, sitting in a wheelchair with both legs extended. The resident's right leg was observed to have surgical pins and a gauze/Ace wrap on the right leg. A clock was observed to be on the wall facing the resident's bed.</p> <p>An interview conducted with Resident #4 on 08/23/11, at 11:15 AM, revealed direct care staff did not answer call lights timely. Resident #4 stated he/she waited for one and one-half hours during the breakfast meal on 08/23/11, for staff to assist the resident with toileting. Resident #4 stated he/she verified the time by looking at the clock in the resident's room. Resident #4 stated he/she could not wait and had an accident as a result of the staff's slow response. Resident #4 further stated he/she felt "small and embarrassed" as a result of the incontinence episode.</p> <p>An interview conducted with Certified Nurse Aide (CNA) #10 on 08/24/11, at 2:00 PM, revealed Resident #4 turned on the call light during the breakfast meal on 08/23/11. CNA #10 stated she and another CNA were passing the breakfast trays and could not respond to the resident's call light. The CNA stated when the resident's call light was answered the resident had already had a bowel movement in the resident's brief. CNA #10 acknowledged the resident waited over an</p>	F 241	<p>call light answering three (3) times a week x four(4) weeks beginning week of 10/03/2011.</p> <p><b>Monitoring:</b> Quality Assurance Committee (Director of Nursing, Administrator, Unit Manager, Dietary Manager, Business Office Manager) to meet every two (2) weeks beginning week of 10/3/2011 x 2 then one(1) time a month to review audit findings and revise plan as needed.</p>	10/08/11

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F 241	Continued From page 2 hour before staff responded to the resident.	F 241			
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES  The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to provide a sanitary, orderly, and comfortable interior. Observations revealed commode anchor screws were exposed, drywall was chipped and marred, lights over the bathroom sinks were not working, exhaust fans had an excessive buildup of dust, bathroom door facings were scraped exposing splintered wood, sink basins were stained, a faucet dripped continuously, a bathroom ceiling and wall were stained/soiled, a formica finish on a resident closet door was chipped, and cracks were observed in sink basins.  The findings include:	F 253	<b>F 253</b> <b>Corrective Actions for Targeted Resident(s):</b> All residents are at risk for potential harm. The following areas have all been repaired, replaced or fixed. Protruding commode screws have been cut down and covered with cap in rooms A4, B1, B8, C5, D10, and E6; Bathroom sink lights over sinks in A4, B2, and C8 have been repaired or replaced; Resident room ceiling in C5 has been painted, The door facings in residents rooms A4, A6, B2, B7, B10 and D6 and in shower rooms on A, B, D and E halls have been smoothed to remove all exposed sharp edges; resident room A6 has had entry door sanded and repaired to remove chipped and exposed splintered wood; Exhaust fan in A10 and D6 bathrooms have been cleaned and dust removed; the supply closet doors in shower rooms A and E have been removed; Sink basins in rooms B1, B2, and C9 have had rust removed or sink replaced. Sink basins in C4 and C8 have been replaced; The faucet in B1 has been repaired to prevent leaking; Drywall in C2 and E9 has been repaired and painted; Tissue bar in C2 has been replaced; The imoleum in C9 has been replaced; the chipped Formica at the base of		

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F 253	<p>Continued From page 3</p> <p>Review of the facility's policy titled Work Order Request/Inservice (not dated) revealed work order request forms were used to notify Maintenance and Housekeeping of areas that needed to be cleaned/repaired. The policy directed staff to complete the work order form to ensure Departments were notified of any area that could harm a resident, visitor, or employee. The work order forms were located at every nurses' station and were to be completed by any employee of the facility.</p> <p>During the environmental tour of the facility on 08/23-25/11, the following items were observed in need of repair:</p> <ul style="list-style-type: none"> <li>-Commode anchor screws were protruding one-half to two inches in the bathrooms located in resident rooms A4, B1, B7, B8 C5, D10, and E6.</li> <li>-The lights over the bathroom sinks in resident rooms A4, B2, and C8 did not work.</li> <li>-The ceiling in resident room C5 was observed to be soiled with a tan substance.</li> <li>-The bathroom door facings were scraped and exposed sharp, splintered wood in resident rooms A4, A6, B2, B7, B10, and D6, and in resident shower rooms A, B, D, and E.</li> <li>-The entry door to resident room A6 was chipped and exposed splintered wood.</li> <li>-The exhaust fan in resident bathrooms A10 and D6 were observed to have an excessive buildup of dust.</li> </ul>	F 253	<p>closet doors in C8 and C12 has been repaired or replaced; the wall in B6 has been cleaned to remove brown substance; The tile grout in D hall shower room has had black substance removed; The peeling drywall underneath the AC in E2 has been replaced or repaired.</p> <p><b>Identification of Other Residents with Potential to Be Affected:</b> A complete audit will be completed by 9/23/11 of the residents rooms and shower rooms for commode screws protruding, lights not working, stained ceilings, all door facings with exposed sharp edges, dusty exhaust fans, cracked vinyl overlay on doors, sink basins stained or cracked, leaking faucets, drywall peeling and or cracked and in need of repair, toilet paper holders missing, piece of floor linoleum missing, chipped Formica, soiled walls and dirty tile grout. Any residents rooms or shower rooms found to have any of the above problems will be repaired and or the broken item replaced.</p> <p><b>Systemic Changes:</b> Maintenance Supervisor(MS) and staff received write up for poor performance. Administrator and MS will tour weekly for 30 days to</p>	

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F 253	Continued From page 4 -The vinyl overlay on the supply closet doors in shower rooms A and E was cracked and detached from the door at the door knobs and exposed sharp edges. -The sink basins in resident bathrooms B1, B2, and C9 were observed to have a rust-colored stain and the sink basins in resident bathrooms C4 and C8 were cracked. -The facet in resident room B1 was observed to drip continuously. -The drywall above both resident beds in room C2 was observed to have deep crevices and the drywall above resident bed 2 in room E9 was scraped. -The tissue paper bar was missing in resident bathroom C2. -A section of the floor linoleum was missing at the bathroom threshold in resident room C9. -Chipped formica was observed at the base of the closet doors in resident rooms C8 and C12. -The wall in resident room B6 was soiled with a dried brownish substance. -The tile grout in the D Wing shower room was observed to have a black substance on it. -The drywall was peeling underneath the air-conditioning unit in resident room E2.  An interview conducted with the Maintenance Supervisor (MS) on 08/25/11, at 2:00 PM,	F 253	identify areas that need work and once every 2 weeks for next 60 days. All areas identified will be repaired immediately with administrator validation. RDO will tour center once monthly for next 90 days to validate all repairs.  <b>Monitoring:</b> Quality Assurance Committee will review the finding from the Administrator and MS weekly tours for the next 30 days in the November meeting and the every two week tour for the next 60 days at the December 2011 and January 2012 meetings.	10/08/11

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F 253	Continued From page 5 revealed the facility utilized a work order system. The MS stated any staff member could obtain a work order at the nurses' station to inform the Maintenance Department of anything that needed to be repaired. The MS stated staff also informed him verbally or by phone of items in need of repair. The MS revealed rounds were conducted by the Maintenance Department approximately four times a day and the box that contained work orders and kept at the nurses' station was checked several times during the day. A review of facility work orders revealed the above concerns had not been identified by the facility. In addition, the MS confirmed work orders had not been completed for the identified concerns and had not been identified during the rounds made by the Maintenance staff.	F 253		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and review of facility policy and Material Safety Data Sheets (MSDS), it was determined the facility failed to ensure residents' environment remained as free from accident hazards as possible. Observation during the environmental tour revealed the facility	F 323	<b>F 323</b> <b><u>Corrective Actions for Targeted Resident(s):</u></b> No resident was identified. All residents had the potential to be affected. On 8/24/2011 a key code lock was placed on all shower room doors.  <b><u>Identification of Other Residents with Potential to Be Affected:</u></b> A one time audit of all shower rooms to identify that they are locked will be completed by the Administrator 10/2/2011. Administrator to complete a one time audit of all work orders by 10/2/2011 and that the work orders are completed timely. Any issue found will be immediately corrected.  <b><u>Systemic Changes:</u></b> Education and Training Director to re educate nursing staff regarding policy for chemical storage and ensuring all chemicals are locked, ensuring all shower rooms are locked and that Maintenance Work orders are complete and is completed timely by 10/2/2011. Administrator to check all shower rooms at least one time a day five (5) times a week x 4 weeks and	

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F 323	<p>Continued From page 6</p> <p>failed to ensure disinfectant spray, personal cleanser, mouthwash, shaving cream, deodorant, shampoo, disposable razors, denture cleanser tablets, and sharp manicure sticks were secured/locked and not accessible to residents.</p> <p>The findings include:</p> <p>Review of the facility policy entitled Hazardous Drug/Chemicals (revised 05/10/10) failed to reveal instructions related to storage of cleaning supplies or personal hygiene products.</p> <p>Observation on 08/24/11, at 10:40 AM, revealed a storage closet was unsecured/unlocked in the shower room located on the D Wing. A chain with a broken key was secured to the wall beside the storage closet door. The storage closet contained the following: a partially used spray container of Ecolab Disinfectant Cleaner, two 8-ounce containers of Secura Personal Cleanser, eleven 4-ounce containers of McKesson mouthwash, nine bottles of McKesson skin care lotion, fifteen 1.5-ounce cans of McKesson shaving cream, 11 containers of McKesson antiperspirant/deodorant, 19 bottles of McKesson shampoo/body wash, 45 disposable razors, an unopened box of McKesson denture cleanser tablets that contained 40 tablets, a box of approximately 50 sharp manicure sticks, and a commode plunger.</p> <p>Further observation of the Ecolab Disinfectant Cleaner container revealed in bold letters, "Do Not Drink," and a warning label to inform the product was hazardous to humans and domestic animals.</p>	F 323	<p>ensure chemicals are stored per policy in 10 random rooms three (3) times a week x 4 weeks beginning week of 10/3/2011. Administrator to check all work orders one(1) time a week x 4 weeks to ensure they are completed correctly and timely completed beginning the week of 10/3/2011.</p> <p><b>Monitoring:</b> Quality Assurance Committee (Director of Nursing, Administrator, Unit Manager, Dietary Manager, Business Office Manager) to meet every two (2) weeks beginning week of 10/3/2011 x 2 then one(1) time a month to review audit findings and revise plan as needed.</p>	10/08/11	

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F 323	<p>Continued From page 7</p> <p>Review of the facility's Census and Condition Record dated 08/23/11, revealed 45 residents had a diagnosis of Dementia. Review of the facility's list recorded in the Elopement Book, stored at each nurses' station, revealed 17 residents were assessed to exhibit wandering behaviors. Further observation revealed an unsampled resident's room (D10), located two doors from the unlocked/unsecured shower room closet, had a velcro stop sign door guard applied to the entry door frame to prevent wandering residents from entering the resident's room.</p> <p>Interview on 08/24/11, at 10:45 AM, with CNA #1 revealed she had given two residents a shower in the D Wing shower room. CNA #1 stated the key to the storage closet had been broken for approximately five months and she had verbally notified the Maintenance staff of the broken key. CNA #1 stated a work order should be completed but she had not had time to fill out the form. CNA #1 stated the items in the storage closet could harm residents if the items were swallowed.</p> <p>Interview on 08/24/11, at 10:50 AM, with the D Wing Unit Coordinator (UC) revealed the UC had no knowledge the storage closet key was broken. The UC stated she conducted routine checks of resident rooms but the shower rooms were not routinely monitored. The UC revealed the storage closet should be locked when not in use and residents should not have access to the items stored in the closet.</p> <p>Interview on 08/24/11, at 11:20 AM, with the Maintenance Supervisor (MS) revealed he had changed the locked on the shower room storage closet in the past. The MS stated staff frequently</p>	F 323		

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F 323	<p>Continued From page 8</p> <p>left the key in the lock and when the shower room door was opened the door would hit the storage closet door knob and break the key. The MS stated he did not know the key was broken but had worked on drywall in the closet recently and the door was not locked when he entered the shower room. The MS stated if residents drank any items stored in the closet it could be fatal to the resident.</p> <p>Observation on 08/24/11, at 1:00 PM, revealed a new door knob/lock had been installed on the storage closet door and the door was locked. A new key was attached to the chain beside the closet door. However, observation on 08/24/11, at 5:30 PM, revealed the storage closet was unsecured/unlocked.</p> <p>Review of the MSDS for Ecolab Disinfectant Cleaner revealed misuse of the disinfectant could cause severe eye irritation and the product could be moderately irritating to the respiratory system if inhaled.</p> <p>Further review of the MSDS information for Secura Personal Cleanser, Skin Care Cream, and Shampoo/Body Wash revealed the products could cause moderate irritation to the eyes and if ingested the products could cause gastric disturbances. Review of the MSDS information for Denture Cleanser Tablets revealed misuse of the product could cause moderate to severe irritation of eyes and skin. The MSDS directed staff to contact the Poison Control Center and seek medical attention immediately if the Denture Cleanser Tablets were ingested or inhaled.</p> <p>Interview on 08/24/11, at 5:50 PM, with CNA #2</p>	F 323		

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F 323	Continued From page 9 and CNA #3 revealed the CNAs provided a shower to a male resident at approximately 4:30 PM. CNA #2 stated after the resident's shower was completed she obtained lotion from the storage closet for the resident. CNA #2 stated she failed to lock the door to the storage closet and the items stored in the closet could be harmful to residents.  Interview on 08/24/11, at 6:05 PM, with the UC revealed the UC had monitored the shower room once since notified of the broken key at 10:50 AM, and the storage closet was locked. The UC stated showers had been provided to residents and the closet door should be kept locked at all times.	F 323		
F 353 SS=D	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS  The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.  The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:  Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.  Except when waived under paragraph (c) of this section, the facility must designate a licensed	F 353	<b>F 353</b> <b><u>Corrective Actions for Targeted Resident(s):</u></b> Resident #4 call lights have been answered timely and resident has had no further incontinent episodes. Resident #14 call lights have been answered timely and resident has had no further difficulties with turning and repositioning.  <b><u>Identification of Other Residents with Potential to Be Affected:</u></b> Social Services to complete a one time interview of all cognitive residents by 10/2/2011 to identify any resident that is waiting too long for call light to be answered and needs are being met. Any issue identified will be immediately addressed.  <b><u>Systemic Changes:</u></b> Education Training Director to re educate nursing staff regarding answering call lights timely and ensuring all resident needs are met by 10/3/2011. Six (6) call light audits to be completed by Administrator and Director of Nursing three(3) times a week x 4 weeks then two times a	

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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		
(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 353	<p>Continued From page 10 nurse to serve as a charge nurse on each tour of duty.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for two of twenty-two sampled residents (Residents #4 and #14).</p> <p>The findings include:</p> <p>1. Resident #4 was observed on 08/23/11, at 11:00 AM, sitting in a wheelchair with both legs extended. A clock was observed to be on the wall facing the resident's bed.</p> <p>An interview was conducted with Resident #4 on 08/23/11, at 11:15 AM. The resident reported the direct care staff did not answer call lights timely due to not having enough staff. Resident #4 stated he/she had activated the call light during the breakfast meal on 08/23/11, and had to wait for one and one-half hours for staff assistance with toileting. The resident stated he/she had checked the clock in the resident's room to verify the time the resident had to wait. Resident #4 stated he/she had an incontinence episode due to having to wait for staff assistance and he/she felt "small and embarrassed." The resident further stated he/she had experienced incontinence episodes more than one time.</p> <p>An interview conducted with Certified Nurse Aide (CNA) #10 on 08/24/11, at 2:00 PM, verified</p>	F 353	<p>week x 2 weeks to ensure call lights are being answered timely beginning week of 10/3/2011. Social Services to interview 3 residents a week related to timely call light answering three (3) times a week x four(4) weeks beginning week of 10/03/2011. Additionally, the Staffing Coordinator will be utilized as relief on C Hall during peak hours to ensure resident call lights are responded to quickly.</p> <p><b>Monitoring:</b> Social Services will conduct an interview in November, and December 2011 with all cognitive residents to identify any resident that is waiting too long for call light to be answered and needs are being met. Any issue identified will be immediately addressed. Findings will be reported to the QA committee once beginning in November 2011 and will continue until January 2012, unless the QA committee determines to review further.</p>	10/08/11	

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F 353	<p>Continued From page 11</p> <p>Resident #4 waited for more than one hour on 08/23/11, for assistance with toileting due to staff not being available. CNA #10 stated resident call lights were not answered timely due to only two CNAs being scheduled and no one was available to assist with answering call lights during meal times. In addition, CNA #10 stated on some days all of the residents were not gotten out of bed daily, nail care could not be provided as needed, and some showers had to be carried over to the next shift or the next day. CNA #10 stated he/she had reported the staffing concerns to the administrator.</p> <p>Interview conducted with CNA #9 on 08/23/11, at 12:00 PM, revealed two CNAs were normally scheduled to work the 7:00 AM to 3:00 PM shift on the C Hall. CNA #9 stated the C Hall was considered the "Rehab" Hall and the residents required more assistance. CNA #9 further stated call lights could not be answered timely during meal times or when showers were provided for the residents due to lack of staff.</p> <p>An interview conducted with the Unit Manager (UM) on 08/25/11, at 4:00 PM, revealed residents on the C Hall were "heavy" care residents. The UM stated it was difficult for the two CNAs to provide all the resident care needs appropriately. The UM also stated she tried to assist the CNAs as much as possible, but staff was not able to deliver meals timely to the residents, to respond to call lights timely, and to provide showers as scheduled for the residents. The UM further stated she had discussed staffing concerns with administrative staff.</p> <p>2. Resident #14 was observed lying in bed on</p>	F 353		

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F 353	Continued From page 12 08/25/11, at 5:50 PM. The resident was observed to be obese and required a bariatric bed.  Interview conducted with Resident #14 on 08/25/11, at 6:00 PM, revealed staff was slow to answer the call lights and to provide assistance with turning/repositioning. Resident #14 stated he/she had waited 20 to 25 minutes for staff to respond to the resident's call light. Resident #14 stated he/she was legally blind and wore a "talking" watch to determine the time.  An interview was conducted with the Director of Nurses (DON) on 08/25/11, at 7:10 PM. The DON stated she had been employed at the facility since 07/11. The DON stated the staffing pattern for the C-Hall was two CNAs during the 7:00 AM to 3:00 PM shift, two CNAs during the 3:00 PM to 11:00 PM shift, and one CNA for the 11:00 PM to 7:00 AM shift. The DON also stated the unit had 20 beds and had not been at 100 percent capacity until the past two weeks. The DON stated even though the unit was a "heavy" care unit, she had not received any reports from staff that resident care needs were not provided in a timely manner for the residents.  An interview was conducted with the Facility Administrator on 08/25/11, at 7:50 PM. The Administrator stated the C Hall census fluctuated and the unit had recently been at 100 percent capacity. The Administrator stated he had not received any reports related to inadequate staffing.	F 353		
F 364 SS=D	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP	F 364	<b>F 364</b> <b><u>Corrective Actions for Targeted Resident(s):</u></b> Resident #13 has had her meals served timely and has had no further concerns with the temperature of the food.  <b><u>Identification of Other Residents with Potential to Be Affected:</u></b> Social Services and Nutrition Service Manager are to complete a one time interview all cognitive residents by 10/2/2011 to identify any resident who's food temperature is cold. Any issue identified will be immediately addressed.  <b><u>Systemic Changes:</u></b> The Unit Manger, Weekend Manager, Clinical Reimbursement Nurse, Unit Manager, or other Administrative Nursing Staff have been assigned to the C hall dining room during meals to ensure residents trays are passed timely.  <b><u>Monitoring:</u></b> Social Services and Nutrition Service Manager will conduct interviews in November, and December 2011 with all cognitive residents to identify any resident who's food temperature is cold.	

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F 364	<p>Continued From page 13</p> <p>Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and a review of facility policy, the facility failed to provide foods on the C Wing hall that were palatable and at the proper temperatures. On 08/25/11, at 9:20 AM, observation of the breakfast meal was conducted and revealed foods were not served at the preferred temperatures to allow for food palatability and resident satisfaction.</p> <p>The findings include:</p> <p>A review of the Test Tray Policy/Quality Validation (dated July 2011) revealed Point of Service temperatures were to be 135 degrees for hot foods and 41 degrees for cold foods.</p> <p>An interview was conducted with Resident #13 on 08/25/11, at 9:00 AM, and revealed residents often had to wait long periods of time for their breakfast trays and the breakfast foods that should be hot were cold when they were served to the residents. Resident #13 stated the residents complained during the past Resident Council meeting and the service time had improved. However, Resident #13 stated staff was again taking longer to serve the trays and the foods were cold again.</p> <p>On 08/25/11, at 9:20 AM, during observation of a</p>	F 364	<p>Any issue identified will be immediately addressed.</p> <p>Findings will be reported to the QA committee once per month beginning in November 2011 and will continue until January 2012, unless the QA committee determines to review further.</p>	10/08/11
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F 364	Continued From page 14 meal tray pass, the facility's Dietary Services Manager obtained temperatures of foods from the meal tray that was served last and the palatability of the foods was assessed. At that time the scrambled eggs were found to be at 98 degrees. The scrambled eggs were tasted and the texture was rubbery and tough. The temperature of the French toast was checked and was 84 degrees. The French toast texture was tough. The temperature of the sausage links was obtained and was noted to be 90 degrees. The sausage links were dry and had a tough texture. The milk was 52 degrees and unpalatable. The orange juice temperature was 60 degrees, and tasted bland and too warm.  An interview was conducted with the State Registered Nursing Assistant (SRNA) on 08/25/11, at 9:15 AM. The SRNA stated the trays took longer to pass because there was not enough staff to pass the trays.	F 364	<b>F 441</b> <u>Corrective Actions for Targeted Resident(s):</u> No specific resident was identified.  <u>Identification of Other Residents with Potential to Be Affected:</u> A one time medication pass audit will be completed by the Education Training Director to monitor at least six(6) Licensed Personnel by 10/02/2011 administering medications to identify any Licensed Personnel not washing hands during medication pass. Any issue identified will be immediately corrected.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective	F 441	<b>Systemic Changes:</b> Education Training Director to re educate nursing staff regarding infection control policy specifically focusing on hand washing by 10/02/2011. Director of Nursing to monitor at least 2 Licensed Personnel per week x 4 weeks beginning week of 10/2/2011 administering medications to ensure infection control policy is being followed.	

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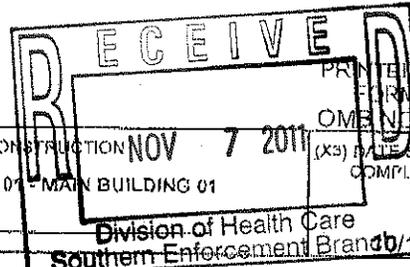
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F 441	<p>Continued From page 15 actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure staff washed or sanitized hands after direct resident contact for which handwashing was indicated by accepted professional practice. Observation during medication pass on 08/25/11, revealed staff failed to wash/sanitize hands between resident contact.</p> <p>The findings include:  Review of the facility's policy and procedure</p>	F 441	<p>Education Training Director to ensure hand washing competency during medication pass for all Licensed personnel by 10/3/2011.</p> <p><b>Monitoring:</b> Quality Assurance Committee (Director of Nursing, Administrator, Unit Manager, Dietary Manager, Business Office Manager) to meet every two (2) weeks beginning week of 10/3/2011 x 2 then one(1) time a month to review audit findings and revise plan as needed.</p>	10/08/11

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F 441	<p>Continued From page 16</p> <p>related to medication administration with an effective date of 12/01/07, revealed staff was required to follow the facility's infection control policy related to handwashing, prior to preparing or administering medication.</p> <p>Observation of a medication pass on 08/25/11, at 8:55 AM, revealed Licensed Practical Nurse (LPN) #1 entered resident room B4 to administer oral medications to the unsampled resident in bed 2. The LPN adjusted the resident's oxygen cannula and then proceeded to administer the medications to the resident. The LPN placed the medication cup in the trash and returned to the medication cart and failed to wash her hands after resident contact.</p> <p>An interview conducted on 08/25/11, at 9:00 AM, with LPN #1 revealed the LPN was knowledgeable of the requirement to wash her hands after resident contact. The LPN acknowledged she failed to wash her hands during the observation and should have washed her hands prior to leaving the resident's room and before the preparation of medications to be delivered to other residents.</p> <p>An interview conducted with the Director of Nursing (DON) on 08/25/11, at 9:25 AM, revealed staff was expected to wash/sanitize hands after any resident contact, and prior to preparing and after administering medications to a resident. The DON revealed the facility conducted handwashing in-services at least annually.</p>	F 441		

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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 (000)</p> <p>SMOKE COMPARTMENTS: Six</p> <p>COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM</p> <p>FULLY SPRINKLED, SUPERVISED (WET &amp; DRY SYSTEM)</p> <p>EMERGENCY POWER: Type II diesel generator</p> <p>A life safety code revisit was conducted on 10/13/11. 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>The facility alleged compliance effective 10/08/11, for deficiencies cited on 08/23/11. The revisit on 10/13/11 revealed K025 and K062 were not corrected.</p> <p>Deficiencies were cited with the highest</p>	(K 000)		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Christy King, NHA* TITLE: \_\_\_\_\_ DATE: 11/7/11

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.

Received Time Nov. 7. 2011 10:07AM No. 3413

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{K 025}	<p>Continued From page 2</p> <p>building. Deficient practice was cited on 04/28/09 and 08/23/11, for damage to the fire/smoke barrier walls. The plan of correction received from the facility on 09/19/11, stated this wall would be repaired by 10/08/11.</p> <p>An interview with the DOM on 10/13/11, at 11:30 AM, revealed the DOM was not aware the fire/smoke barrier wall needed to be repaired by the date given in the plan of correction.</p> <p>An interview with the Administrator on 10/13/11, at 12:15 PM, revealed the Administrator thought the DOM knew the date that the wall needed to be repaired by and was not aware the wall had not been repaired.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows:</p> <p>(a) The space between the penetrating item and the smoke barrier shall</p> <ol style="list-style-type: none"> <li>1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or</li> <li>2. Be protected by an approved device designed for the specific purpose.</li> </ol> <p>(b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall</p> <ol style="list-style-type: none"> <li>1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or</li> <li>2. Be protected by an approved device designed for the specific purpose.</li> </ol>	{K 025}			

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(K 000)	Continued From page 1 deficiency identified at "F" level.	(K 000)		
(K 025) SS=E	<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, interview, and review of the facility's plan of correction, the facility failed to maintain smoke barriers with at least a one-half hour fire resistance rating as required. This deficient practice affected two of six smoke compartments, staff, and approximately thirty residents. The facility has the capacity for 93 beds with a census of 90 on the day of the survey.</p> <p>The findings include:</p> <p>Observation on 10/13/11, at 11:30 AM, with the Director of Maintenance (DOM), revealed an unsealed penetration of electrical conduit in the attic area above the fire/smoke barrier doors in the B Wing of the facility. In a fire situation, unsealed penetrations of smoke barriers aid in the spread of smoke and fire to other parts of the</p>	(K 025)	<p><b>K025</b></p> <ol style="list-style-type: none"> <li>1. The unsealed penetration of electrical conduit in the attic area above the fire/smoke barrier doors in B Wing has been Repaired and sealed with a one-half hour fire resistant rated product.</li> <li>2. All smoke barrier walls were inspected by new Maintenance Director and any areas of concern were repaired as above.</li> <li>3. The Maintenance Director and or his assistant will inspect all smoke barrier walls at least quarterly beginning November 2011. These areas will also be checked for penetrations when any outside contractor has accessed the attic.</li> <li>4. QA committee will monitor that these checks are completed and brought to QA meeting for review.</li> <li>5. Date of Compliance 11/9/11</li> </ol>	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185061	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  R 10/13/2011
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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{K 025}	Continued From page 3 (c) Where designs take transmission of vibration into consideration, any vibration isolation shall 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for the specific purpose.	{K 025}	K062  1. Please see attached for the required full flow trip test completed on 11/4/11. The time for the water to reach the test opening is 33 seconds. Three attachments. 2. Three year inspection to be scheduled for 2014.  1. The blown-in insulation mounded in close proximity to the sprinkler head area in D Wing attic has been removed. A and E wing attic areas had the blown-in and batted insulation removed from around the sprinkler heads. The insulation inside the A wing sprinkler head has been removed. 2. All attic sprinkler heads were examined for insulation in close proximity or mounded around sprinkler heads and for insulation inside sprinkler head by Fire Protection Specialist and new Maintenance Director, this was completed 11/3/11. 3. The Maintenance director and or his assistant will inspect all sprinkler heads at least quarterly beginning November 2011. Sprinkler heads will also be examined after any outside contractor has accessed areas in attic. 4. QA committee will monitor that quarterly sprinkler head inspections are completed and brought to meeting for review. 5. Date of Compliance 11/9/11	
(K 062) SS=FF	NFPA 101 LIFE SAFETY CODE STANDARD  Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5  This STANDARD is not met as evidenced by: Based on observation, interview, and a review of the facility's Plan of Correction, the facility failed to ensure the sprinkler system was maintained according to NFPA standards. This deficient practice affected six of six smoke compartments, staff, and all the residents. The facility has the capacity for 93 beds with a census of 90 on the day of the survey.  The findings include:  1. During the Life Safety Code survey on 08/23/11, deficient practice was identified due to no evidence that a full flow trip test had been performed on the facility's sprinkler system. This test is required every three years to ensure the sprinkler system is operating as intended. The facility issued a plan of correction for the deficient practice on 09/19/11. The plan of correction revealed a full flow trip test had been completed and an accelerator was recommended to decrease the time it took for the water to reach	{K 062}		

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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 062)	<p>Continued From page 4</p> <p>the test outlet. An accelerator ensures the flow of water from the sprinkler system is adequate. The plan of correction stated a bid was being obtained to purchase and install an accelerator and alleged compliance effective 10/08/11.</p> <p>Interview with the Director of Maintenance (DOM) on 10/13/11, at 11:20 AM, during a revisit at the facility revealed an accelerator had not been installed on the sprinkler system. The DOM stated the original contractor was not available and someone else had to be contracted to make the repairs to the sprinkler system. The DOM did not know when the new contractor would be making the repairs.</p> <p>An interview with the Administrator on 10/13/11, at 12:15 PM, revealed she was aware the repairs to the sprinkler system had not been made.</p> <p>2. On 10/13/11, at 11:40 AM, blown-in insulation was observed to be mounded in close proximity to the sprinkler head in the attic area of D Wing. Observation of the A and E Wing attic area revealed blown-in and batted insulation was mounded around the sprinkler heads. In addition, a sprinkler head in the attic of the A Wing was observed to have insulation inside the sprinkler head. This could prevent the spray pattern from reaching the hazard in a fire situation.</p> <p>Deficient practice was cited on 04/28/09 and 08/23/11, because sprinkler heads were covered with insulation. An interview with the DOM on 10/13/11, at 11:40 AM, revealed the DOM uncovered the sprinkler heads but was not aware that the insulation should not have been mounded around the sprinkler heads. An</p>	(K 062)		

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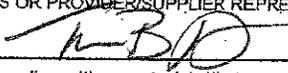
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NAME OF PROVIDER OR SUPPLIER  KENWOOD HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 130 MEADOWLARK DRIVE RICHMOND, KY 40475		
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(K 062)	Continued From page 5 Interview with the Administrator on 10/13/11, at 12:15 PM, revealed the Administrator was not aware there was still a problem with the sprinkler heads in the attic area.  Reference: NFPA 13 (1999 Edition).  4-6.1.4 Obstruction to Discharge. Automatic sprinklers shall not be obstructed by auxiliary devices, piping, insulation, and so forth, from detecting fire or from proper distribution of water.  Reference: NFPA 25 (1998 Edition).  Table 9-1 Summary of Valves, Valve Components, and Trim Inspection, Testing, and Maintenance Trip test                      Annually Full flow trip test            3 years	(K 062)			

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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 000	INITIAL COMMENTS  CFR: 42 CFR §483.70 (a)  BUILDING: 01  PLAN APPROVAL: 1985  SURVEY UNDER: 2000 Existing  FACILITY TYPE: SNF/NF  TYPE OF STRUCTURE: One story, Type III (000)  SMOKE COMPARTMENTS: Six  COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM  FULLY SPRINKLED, SUPERVISED (WET & DRY SYSTEM)  EMERGENCY POWER: Type II diesel generator  A life safety code survey was initiated and concluded on 08/23/11. 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.  Deficiencies were cited with the highest deficiency identified at "F" level.	K 000	<div style="border: 1px solid black; padding: 5px; text-align: center;"> <b>RECEIVED</b>                  SEP 09 2011                  Division of Health Care                  Southern District Branch             </div> <p><b>K 025</b> <b>Corrective Actions for Targeted Resident(s):</b> The unsealed penetration of electrical conduit in the attic area above fire/smoke doors in B wing were repaired and sealed with a one-half hour fire resistant rated product as required. This repair was performed by the Maintenance Director and his assistant on September 19, 2011. The Maintenance Director and his assistant made the access panels in C wing more reasonably accessible to ensure fire and smoke barrier walls can be inspected and repaired as required.</p> <p><b>Identification of Other Residents with Potential to Be Affected:</b> All smoke barrier walls were inspected by the Maintenance Director and his assistant. The facility was inspected by the Maintenance Director and his assistant to ensure no other fire/smoke barrier walls were not accessible.</p>		
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Smoke barriers are constructed to provide at least a one half hour fire resistance rating in	K 025			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE:  TITLE: Administrator (X6) DATE: 09/19/11

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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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 025	<p>Continued From page 1</p> <p>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, the facility failed to maintain smoke barriers with at least a one-half hour fire resistance rating as required. This deficient practice affected three of six smoke compartments, staff, and approximately 50 residents. The facility has the capacity for 93 beds with a census of 90 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code survey on 08/23/11, at 10:55 AM, with the Director of Maintenance (DOM), an unsealed penetration of electrical conduit was observed in the attic area above the fire/smoke barrier doors in the B Wing of the facility. The C Wing fire/smoke barrier wall was not reasonably accessible for inspection. In a fire situation, unsealed penetrations of smoke barriers aid in the spread of smoke and fire to other parts of the building. The facility must provide reasonable access to fire/smoke barrier walls for maintenance and inspection purposes. An interview with the DOM on 08/23/11, at 10:55</p>	K 025	<p><b>Systemic Changes:</b> The Maintenance Director and or his assistant will inspect all smoke barrier walls at least quarterly beginning October 2011, to ensure all penetrations are sealed. The Maintenance Director and or his assistant will inspect all smoke barrier walls after any outside contractor has accessed areas where smoke barrier walls are located.</p> <p><b>Monitoring:</b> The Maintenance Director will bring his quarterly inspection report of smoke barrier walls to the Quality Assurance Committee beginning October 2011 and continuing for three quarters unless the QA Committee sees a need to continue to monitor the inspections.</p>	10/08/11

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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 025	<p>Continued From page 2</p> <p>AM, revealed the DOM was not aware the fire/smoke barrier wall needed to be repaired. The DOM stated the C Wing fire/smoke barrier wall was a nightmare to get to and the fire/smoke barrier walls were not included in the maintenance schedule.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows:</p> <p>(a) The space between the penetrating item and the smoke barrier shall</p> <ol style="list-style-type: none"> <li>1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or</li> <li>2. Be protected by an approved device designed for the specific purpose.</li> </ol> <p>(b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall</p> <ol style="list-style-type: none"> <li>1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or</li> <li>2. Be protected by an approved device designed for the specific purpose.</li> </ol> <p>(c) Where designs take transmission of vibration into consideration, any vibration isolation shall</p> <ol style="list-style-type: none"> <li>1. Be made on either side of the smoke barrier, or</li> <li>2. Be made by an approved device designed for the specific purpose.</li> </ol> <p>19.1.1.3 Total Concept. All health care facilities shall be designed, constructed, maintained, and operated to</p>	K 025		
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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	
(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 025	Continued From page 3 minimize the possibility of a fire emergency requiring the evacuation of occupants. Because the safety of health care occupants cannot be ensured adequately by dependence on evacuation of the building, their protection from fire shall be provided by appropriate arrangement of facilities, adequate staffing, and development of operating and maintenance procedures composed of the following: (1) Design, construction, and compartmentation (2) Provision for detection, alarm, and extinguishment (3) Fire prevention and the planning, training, and drilling programs for the isolation of fire, transfer of occupants to areas of refuge, or evacuation of the building	K 025	<p><b>K 062</b> <u>Corrective Actions for Targeted Resident(s):</u> The sprinkler heads located in the attic above A, B, D, and E halls have had the blown in insulation removed by the Maintenance Director and his assistant. The full flow trip test of the sprinkler system was performed by Browne Sprinkler system on September 14, 2011. An accelerator was recommended to decrease the time it takes the water to reach the test outlet. The Maintenance Director is obtaining a bid to have the accelerator purchased and installed.</p> <p><u>Identification of Other Residents with Potential to Be Affected:</u> The Maintenance Director and his assistant inspected all sprinkler heads in the attic to ensure they were not covered with blown in insulation or any other product. All other reports required to be performed such as the Full flow Trip test were reviewed by the Maintenance Director to ensure they were completed as required.</p>	
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5  This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the sprinkler system was maintained according to NFPA standards. This deficient practice affected six of six smoke compartments, staff, and all the residents. The facility has the capacity for 93 beds with a census of 90 on the day of the survey.  The findings include:	K 062		

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K 062	<p>Continued From page 4</p> <p>During the Life Safety Code survey on 08/23/11, at 11:20 AM, with the Director of Maintenance (DOM), a sprinkler head located in the attic area in the E Hall corridor was observed to be covered with blown-in insulation. This would prevent the sprinkler head from reacting as intended in a fire situation. An interview with the DOM on 08/23/11, at 11:20 AM, revealed the DOM was unaware this section of the attic was sprinkler protected and was not aware insulation was covering the sprinkler head. During the survey sprinkler heads were observed to be covered with blown-in insulation in the A, B, and D Hall attic areas of the facility. The facility was cited on 04/28/09, for the same deficient practice.</p> <p>A record review on 08/23/11, at 3:30 PM, with the DOM revealed no documentation that a full flow trip test had been performed on the facility's sprinkler system. This test is required every three years to ensure the sprinkler system is operating as intended. An interview with the DOM on 08/23/11, at 3:30 PM, revealed the DOM was not aware of this testing requirement.</p> <p>Reference: NFPA 13 (1999 Edition).</p> <p>4-6.1.4 Obstruction to Discharge. Automatic sprinklers shall not be obstructed by auxiliary devices, piping, insulation, and so forth, from detecting fire or from proper distribution of water.</p> <p>Reference: NFPA 25 (1998 Edition).</p> <p>Table 9-1 Summary of Valves, Valve</p>	K 062	<p><b>Systemic Changes:</b> The Maintenance Director and or his assistant will inspect all sprinkler heads at least quarterly beginning October 2011, to ensure they are not covered with blown in insulation or any other product. The Maintenance Director and or his assistant will inspect all sprinkler heads after any outside contractor has accessed areas where sprinkler heads are located. The full flow trip test was added to The Equipment Lifecycle System (TELS) monthly report and will come up on this report in three years when due again.</p> <p><b>Monitoring:</b> The Maintenance Director will bring his quarterly inspection report of sprinkler heads to the Quality Assurance Committee beginning October 2011 and continuing for three quarters unless the QA Committee sees a need to continue to monitor the inspections. The Maintenance Director will bring a copy of his monthly TELS report to the QA committee once per month for the next three months beginning October 2011.</p>	10/08/11	

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K 062	Continued From page 5 Components, and Trim Inspection, Testing, and Maintenance Trip test                      Annually Full flow trip test            3 years	K 062		