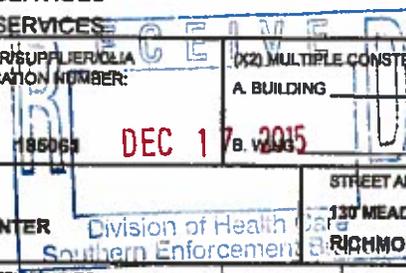


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/01/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185063	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/13/2015
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NAME OF PROVIDER OR SUPPLIER KENWOOD HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 137 MEADOWLARK DRIVE RICHMOND, KY 40475
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(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
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F 000	INITIAL COMMENTS	F 000	Disclaimer: Preparation and/or execution of the Plan of Correction does not constitute admission or agreement by the Provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared and/or executed solely because the provisions of federal and state law require it. The Provider maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor is it of such character as to limit the facilities capability to render adequate care.	
F 242 SS=D	<p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES</p> <p>The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility policy, it was determined the facility failed to afford the right to choose activities and schedules, consistent with his or her interests, assessments, and plans of care and make choices about aspects of his or her life in the facility that are significant for two (2) of nineteen (19) sampled residents (Resident #9 and Resident #15). The facility, after assessing Residents #9 and #15 as enjoying multiple different indoor activities, failed to afford the residents the opportunity to enjoy all indoor activities. Resident #9 was not afforded the opportunity to watch the news without being interrupted by another resident changing the channel, powering the television on and off, or changing the volume level. Resident #9 was also subjected to a religious program and rituals he/she did not want to listen to. Resident #15 was not afforded the opportunity to watch a</p>	F 242	<p>F242</p> <ol style="list-style-type: none"> 1. Resident # 9 agreed to a room change and was moved by housekeeping to another room on 11/13/15 with a more compatible roommate. This move corrected the issue with Resident # 15 operating the remote to Resident # 9 TV. Resident #9 and Resident #15 were interviewed by the Activities Director on 11/16/15 to ensure that the changes were satisfactory and the residents' right to choose activities and schedule, and choices about aspects of his or her life are met. No concerns were noted from Resident # 9 or Resident #15. 2. An audit of residents with a BIM score of 9 or above will be completed by 12/4/15 by the Activities Director 	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 12/11/15
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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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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 242	<p>Continued From page 1</p> <p>religious program without being interrupted by another resident changing the channel, powering the television on and off, or changing the volume level.</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Bill of Rights," dated 07/01/09, revealed residents had the right to receive care from the facility in a manner that promotes, maintains, and enhances the residents' dignity. The policy also stated residents had the right to choose care that was consistent with the residents' assessments and plans of care.</p> <p>Review of Resident #9's medical record revealed the facility admitted the resident on 02/10/15 with diagnoses of history of falling, cerebrovascular disease, hyperlipidemia, mood disorder, overactive bladder, anxiety disorder, transient cerebral ischemic attack, and chronic pain. Review of the quarterly Minimum Data Set (MDS) assessment dated 09/29/15, revealed the resident's daily decision-making capabilities were intact which indicated Resident #9 was able to be interviewed. Review of the significant change MDS assessment dated 03/12/15 revealed Resident #9's activity preferences were as follows: doing things with groups of people, going outside, music, news, reading, animals, and participating in religious services or practices. Review of the resident's plan of care, revised on 09/28/15, revealed the following interventions for activities: State Registered Nurse Aides (SRNAs) and Activities staff would assist and provided Resident #9 with self-initiated activity and supplies as desires.</p> <p>Review of Resident #15's medical record</p>	F 242	<p>to ensure that residents' right to choose activities and schedule, and choices about aspects of his or her life are met. An audit of residents rooms will be completed by 12/4/15 by Activities Director to identify if any other residents have issues with the TV remote operating multiple TV's causing issues with programming that would affect their religious preferences. Any issue identified will be addressed immediately for correction. The Activities Director/Assistant will interview new residents upon admission and quarterly thereafter to ensure that residents' right to choose activities and schedule, and choices about aspects of his or her life are met and to identify any issues with room mate compatibility. The interviews will be initiated on 12/3/15. Activity preferences and schedule will also be reviewed in the monthly Resident Council meeting for three (3) months beginning in December 2015 to identify if changes need to be made to meet resident preferences.</p> <p>3. Education will be completed for facility nursing and housekeeping staff by the Activities Director/Assistant on notifying Activities or Social service of any knowledge that residents' right to choose activities and schedule, and choices about aspects of his or her life are not met. Education was</p>	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/13/2015
NAME OF PROVIDER OR SUPPLIER KENWOOD HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 130 MEADOWLARK DRIVE RICHMOND, KY 40475		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 242	<p>Continued From page 2</p> <p>revealed the facility admitted the resident on 08/03/14 with diagnosis of "urinary incontinence, personal history of diseases of the ms sys conn tiss, anxiety disorder, hemorrhoids, major depressive disorder, nutritional anemia, constipation, and dementia." Review of the quarterly Minimum Data Set (MDS) assessment dated 10/09/15, revealed the resident's daily decision-making capabilities were intact which indicated Resident #15 was able to be interviewed. Review of the Annual MDS assessment dated 03/28/15 revealed Resident #15's activity preferences were as follows: doing things with groups of people, going outside, music, news, reading, animals, and participating in religious services or practices. Review of the resident's Care Plan dated 10/12/15 revealed the resident preferred his/her own daily routine and groups as desired. The care plan had the following interventions for Resident #15 related to activities: State Registered Nurse Aides (SRNAs) and Activities staff would assist Resident #15 to engage resident in group activities, give the resident verbal reminders of activity before commencement of the activity, and offer activity programs directed toward specific interests of the resident. The care plan further stated that Resident #15 enjoyed TV, religion (Catholic), and visits.</p> <p>Observation on 11/12/15 at 8:50 AM in the room of Residents #9 and #15 revealed when Resident #9 adjusted the volume on his/her television, it also adjusted the volume on Resident #15's television.</p> <p>Observation on 11/13/15 at 11:05 AM revealed that Resident #15 used his/her remote to turn the television off and when he/she turned off the</p>	F 242	<p>initiated on 12/3/15 and completed on 12/8/15. A random audit of ten (10) residents a month for three (3) months with a BLMs score of 9 or above will be completed by the Activities to ensure that residents' right to choose activities and schedule, and choices about aspects of his or her life are met. Any issues identified will be addressed immediately. This audit will begin the week of 12/14/15.</p> <p>4. The Quality Assurance Team consisting of at least the Administrator, Medical Director, Director of Nursing, Social Services Director, Dietary Manager and Maintenance Supervisor will review all audit findings and revise current plan at least monthly beginning 12/16//15 and ongoing until issue is resolved or satisfactory.</p> <p>5. Date of completion: 12/17/15</p>		

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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 40478	
(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 242	<p>Continued From page 3</p> <p>television, the television for Resident #9 came on. Observation further revealed the televisions were the same brand and model, and that both remotes would control both televisions.</p> <p>Interview with Resident #9 on 11/11/15 at 10:07 AM and 11/12/15 at 8:50 AM revealed that his/her roommate was Resident #15. Resident #9 stated he/she did not like the religious programs that Resident #15 watched and that Resident #15 controls the television and does not allow Resident #9 to watch the news at times. Resident #9 stated he/she reported this to staff "several times."</p> <p>Interview with Resident #15 on 11/11/15 at 10:13 AM revealed that he/she tried to watch mass every morning, but Resident #9 sometimes changed the channel on his/her TV when watching mass.</p> <p>Interview with Licensed Practical Nurse (LPN) #5 on 11/13/15 at 4:35 PM revealed that she had worked at the facility for five years and last week Resident #9 made a comment that he/she did not want to be around Resident #15 because he/she "was catholic and did not want to hear that stuff."</p> <p>Interview with LPN #6 on 11/13/15 at 3:16 PM revealed that she had worked at the facility for seven years. She stated that Resident #9 and Resident #15 usually "fuss" about the TV.</p> <p>Interview with the Director of Nursing (DON) on 11/13/15 at 6:45 PM revealed that she was aware that Resident #9 wanted a room change but the resident was never happy and always wanted to change rooms. The DON stated she was not aware of the issues with the remote controls.</p>	F 242		

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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 242	Continued From page 4	F 242			
F 253 SS=E	<p>483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy review, it was determined the facility failed to provide housekeeping and maintenance services to maintain a sanitary and orderly interior. Observations on 11/11/15 revealed one wheelchair with a torn and scratched armrest, one door that was chipped, air conditioner filters and vents full of dust and debris, a broken bug guard, and a dirty water machine faucet.</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Procedure: Maintenance Work Orders," dated 01/31/14, revealed work orders were to be completed by any staff member that identified a need for maintenance or equipment repair. Interview with the Maintenance Director on 11/13/15 at 5:42 PM revealed there was no policy on preventive maintenance. The Maintenance Director stated</p>	F 253	<p>F253</p> <p>1. No specific resident was identified. Any resident might have the potential to be affected. The wheelchair with a torn and scratched armrest was repaired by maintenance on 11/16/15. The door that was chipped was repaired by maintenance on 12/8/15. The air conditioner filters and vents were cleaned by housekeeping beginning on 11/23/15 and completed by 12/8/15. The broken bug guard was removed by maintenance on 12/8/15. The dirty water machine faucet was cleaned by housekeeping on 11/13/15</p> <p>2. A one time environmental audit of the center will be conducted by the Administrator, Maintenance Director, and Housekeeping Director by 12/11/15 to identify any wheelchairs in need of repair, doors with chips, dirty air conditioner filters or vents, broken bug guards, or water fountains in need of cleaning. Any issues identified will be addressed immediately.</p>		

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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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F 253	<p>Continued From page 5</p> <p>he relied on the TELS computer system (system utilized by the facility to document maintenance concerns) for alerts regarding repairs or maintenance issues.</p> <p>Observations during the environmental tour on 11/13/15 at 3:19 PM revealed a wheelchair, being used by a resident, with a torn and scratched armrest. Further observation on 11/13/15 at 4:00 PM revealed the water faucet head in Hallway B which was available for staff, residents, and visitors to use, had black and orange colored buildup around the spout where the water came out and needed to be cleaned. Further observation on 11/13/15 at 4:10 PM revealed the bug guard covering a light hanging on the wall on A Hall outside of a resident's room was in need of repair. Further observation on 11/13/15 at 4:50 PM revealed air conditioner vents and filters in five resident rooms needing to be cleaned.</p> <p>Interviews with the Maintenance Director on 11/13/15 at 5:00 PM revealed he was aware of some concerns of a torn wheelchair needing repair. The Maintenance Director stated parts were ordered and he was waiting on them to come in. Further interview revealed the Maintenance Director did not document items that were identified to be in need of repair; however, the facility used the TELS system for staff to enter all work orders in the computer and the Maintenance Director ran a report every morning allowing him to see what needed repair.</p> <p>Interview with the facility's Administrator on 11/13/15 at 6:41 PM revealed he was not aware of the wheelchair and door in need of repair. Further interview revealed staff was required to report defects and equipment not working to</p>	F 253	<p>3. The Administrator will revise the room rounds process, beginning 12/14/15, where the Management Team completes assigned daily room rounds, Monday thru Fridays, to identify any issues and to ensure repairs are completed timely, all rooms and common areas are clean, orderly and comfortable. The results of the rounds will be reviewed by the interdisciplinary team during morning stand-up meetings to address any issues identified during the rounds. The Administrator will re-educate the housekeeping and maintenance supervisor regarding cleaning and making needed repairs by 12/11/15. Re-education will be completed for staff by Education Training Director on completing work orders and notifying maintenance when equipment is in need of repair by 12/15/15.</p> <p>The Housekeeping Supervisor will re-educate housekeeping staff regarding cleaning and reporting needed repairs by 12/15/15.</p> <p>The Administrator will make weekly rounds for three (3) weeks beginning the week of 12/14/2015 to ensure center cleanliness and to identify needed repairs. Any issues identified will be corrected immediately.</p> <p>4. The Quality Assurance Team consisting of at least the Administrator, Medical Director, Director of Nursing, Social Services Director, Dietary Manager and</p>		

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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 253	Continued From page 6 Maintenance staff through the TELS system. Further interview with the Administrator revealed Maintenance staff was responsible for repairing and/or replacing all equipment in need of repairs.	F 253	Maintenance Supervisor will review all audit findings and revise current plan at least monthly beginning 12/16//15 and ongoing until issue is resolved or satisfactory.		
F 284 SS=D	483.20(l)(3) ANTICIPATE DISCHARGE: POST-DISCHARGE PLAN When the facility anticipates discharge a resident must have a discharge summary that includes a post-discharge plan of care that is developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the Social Services Director Position Description, it was determined the facility failed to ensure a Discharge Plan of Care was developed for one (1) of twenty (20) sampled residents (Resident #20). Resident #20 was admitted on 10/19/15, with plans to discharge back to the community. However, review of Resident #20's care plan revealed no discharge care plan had been developed by the facility. The findings include: Review of the "Social Services Director Position Description," undated, revealed in the event a resident was discharged from the facility, the Social Services Director was responsible for developing an organized discharge plan. Review of the closed medical record for Resident #20 revealed the resident was discharged home	F 284	5. Date of completion: 12/17/15 F284 1. Resident #20 was contacted by the Social Services Director on 12/8/15 regarding no discharge plan and her discharge back home. Resident states doing fine at home and was satisfied with the assistance provided by facility staff in her discharge back home. 2. An audit of in house residents will be completed by the Social Services Director/Assistant to identify that discharge plan of care was developed and in place. The audit was completed on 11/30/15. No issues were identified. 3. The Social Services Director/Assistant will audit new admit care plans within the first seventy-two (72) hours of admission weekly for four (4) weeks to ensure that appropriate discharge planning is evident per care plans and meet the residents specific discharge goals. The audits will begin the week of 12/07/15. Ongoing, the Social Services Director/Assistant will validate that care plans are available		

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F 284	Continued From page 7 from the facility on 11/03/15 with home health services to follow. Review of Resident #20's admission Minimum Data Set (MDS) assessment dated 10/26/15 revealed the resident planned to be discharged home. Interview with the facility's Social Worker on 11/13/15, at 3:35 PM, revealed she was responsible for developing a discharge care plan for residents who planned to be discharged from the facility. The Social Worker stated Resident #20 planned to return home upon admission, and should have had a discharge care plan developed upon admission to the facility. The Social Worker stated she had "just missed it." Interview conducted with the Administrator on 11/13/15, at 6:45 PM, revealed it was the Social Worker's responsibility to develop a discharge care plan when a resident planned to return home. The Administrator stated all discharged residents' medical records were reviewed after discharge, and the facility had not identified any concerns with discharge plans not being developed for residents. The Administrator stated Resident #20's medical record had not yet been reviewed.	F 284	for residents with discharge plans to home within the first 7 days of admission. Re-education will be completed by the Administrator to the Social Services Director/Assistant regarding discharge planning and when the facility anticipates discharge the facility must have an individualized discharge plan that is developed with the participation of the resident to meet his or needs upon discharge. Completion date 12/11/15. 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 12/16/15 and ongoing until issue is resolved or satisfactory. 5. Date of completion: 12/17/15		
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.	F 323	F323 1. Resident A: A lock was placed on the unlocked electrical panel by the Maintenance Director on 11/13/15. An additional key pad lockset was placed on the door leading into the room by maintenance on 11/23/15.		

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F 323	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review, and review of the facility's policy, it was determined the facility failed to ensure that the residents' environment remained as free of accident hazards as possible for one (1) unsampled resident, Resident A, that the facility assessed to "wander" throughout the facility. On 11/13/15, an electrical circuit breaker box was discovered to be unlocked on the A Hall and accessible to residents of the facility. The findings include: Review of the facility's policy titled "Procedure: Maintenance Work Orders," dated 01/31/14, revealed that work orders would be completed by any staff member that identifies a need for maintenance or equipment repair. Interview with the Maintenance Supervisor on 11/13/15 at 11:55 AM revealed the work order was completed by entering a maintenance order into the TELS system (system utilized by the facility to communicate maintenance needs) and was then assigned to the Maintenance Department. Once the Maintenance Department received the work order, the work was scheduled to be completed. Once the repairs were completed, the work order was closed. The policy stated the Administrator reviewed and monitored for incomplete work orders as necessary. However, the electrical circuit breaker box was not addressed in the policy. Observation conducted on 11/13/15 at 11:55 AM	F 323	2. Any resident might have the potential to be affected. A one time environmental audit of the center will be conducted by the Administrator and Maintenance Director by 12/11/15 to identify that other electrical panels are locked and residents' environment remain as free of accident hazards as possible. Any issues identified will be addressed immediately. 3. The Maintenance Director/Assistant will complete a facility wide tour Monday-Friday for four (4) weeks beginning week of 12/14/15 to ensure that all resident accessible areas remain free of potential accident hazards. Any issues identified will be immediately corrected. Ongoing, during daily room rounds by Management Team, residential and common areas will be observed for any potential hazards and any concerns identified will be corrected immediately. Education will be completed by the Administrator by 12/11/15 with the Management Team on potential safety hazards and how to address if identified. Re-education will be completed by the Administrator by 12/11/15 with the Maintenance Director and Management Team to ensure that the residents' environment remains free of accident hazards.		

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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		
(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 323	Continued From page 9 revealed that an electrical circuit breaker box on the A Hall was unlocked and accessible to residents on that hallway. Further investigation revealed there was an open space between the box cover and the electrical breakers when the door was open exposing electrical wiring. There were not any residents in the A Hall during the observations. Review of a list provided by the facility Administrator revealed the facility assessed one resident as a "wanderer" (Resident A) and stated this resident wandered throughout the facility, including the A Hall. Interview conducted with Maintenance Supervisor on 11/13/15 at 11:55 AM revealed the Maintenance staff was aware that the breaker box was unlocked. The Maintenance Supervisor stated the box should have been locked and was probably left unlocked when they installed a new ice machine on 11/05/15. Interview conducted with the Director of Nursing (DON) and Administrator on 11/13/15 at 11:49 AM revealed that the breaker box should have been locked and that it was an oversight that the box was unlocked.	F 323	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 12/16//15 and ongoing until issue is resolved or satisfactory. 5. Date of completion: 12/17/15		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	F371 1. No specific resident was identified. Any resident might have the potential to be affected. 2. A one time audit of the dietary department was completed by the Dietary Manager to identify any		

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F 371	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of facility policies, and review of the 2009 United States FDA (Food and Drug Administration) Food Code, it was determined the facility failed to store, prepare, distribute, and serve food under sanitary conditions for twenty (20) of eighty-four (84) residents of the facility who received nutrition from the kitchen. Observations in the kitchen on 11/11/15 revealed dietary staff had touched up to twenty (20) cups and glasses on the lip contact areas with their bare skin while setting up resident trays on the tray line. In addition, staff was observed touching saucers on the food contact area and touching margarine pats with bare hands. Staff was observed not wearing hair nets in the kitchen or not wearing hair nets properly. The findings include: Review of the facility's policy titled "Good Sanitation to Serve Food Safely," not dated, revealed staff was to handle glassware and dishes properly. Food contact areas of plates, bowls, or cups should not be touched. The policy directed that dishes should only be held by the bottom or the edge, cups should be held by their handles, and glassware should be held by the middle, bottom, or stem. Staff was directed to always wear gloves or use tongs when handling food that is cooked or ready to eat. In addition,	F 371	additional issues with preparing food under sanitary conditions and following sanitary food preparation. Any issues identified with staff will be immediately corrected. Completion date 12/11/15. 3. Re-education was completed for dietary staff by the Dietary Manager on 12/8/15 regarding policy to store, prepare, distribute, and serve food under sanitary condition to include handling glassware and dished properly, use of gloves, handling food properly, washing hands, and proper use of hair and beard nets. A weekly dietary sanitation audit will be completed for four (4) weeks by the Dietary Manager to validate that staff are following adequate sanitation when preparing food, wearing gloves to prepare food and serving and wear appropriate hair nets. Dietary Manager will also validate that non-dietary employees that enter the kitchen wear appropriate hair netting. The sanitation audits will begin the week of 12/11/15. A sign was placed on the kitchen door stating Dietary Employees Only by the Dietary Manager on 11/30/15. 4. The Quality Assurance Team consisting of at least the Administrator, Medical Director, Director of Nursing, Social Services Director, Dietary Manager and		

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NAME OF PROVIDER OR SUPPLIER KENWOOD HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 138 MEADOWLARK DRIVE RICHMOND, KY 40475	
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F 371	<p>Continued From page 11</p> <p>the policy directed that staff keep all hair (including bangs) covered and pulled back.</p> <p>Review of the 2009 FDA Food Code revealed Chapter 4-904.11 stated, "Cleaned and sanitized utensils shall be handled, displayed, and dispensed so that contamination of food and lip-contact surfaces is prevented."</p> <p>1. Observations of the tray line on 11/11/15 at 11:53 AM revealed Cook #1 placing bread and butter pats onto saucers toward the end of the line. Cook #1 was not wearing gloves and was observed touching the food contact area of saucers and bowls at least ten times, picking up butter pats at least ten times with bare hands, and touching the exposed edges of the butter. Cook #1 was observed to leave the line at least three times and failed to wash his hands when returning to the line and continuing to serve resident food. During this meal service observation, Cook #1 was not wearing a hair net or a beard guard properly, leaving his beard and hair exposed while in the kitchen. Dietary Aide #2 was observed at the end of the tray line not wearing gloves. Dietary Aide #2 was placing glasses and cups on the trays and he was observed at least 20 times to touch the glasses and cups on the lip contact area with his bare hands. Dietary Aide #2 was also observed to leave the tray line at least four times. Dietary Aide #2 returned to the tray line without washing his hands or putting on gloves and continued placing cups/glasses on resident trays. The Dietary Aide was observed to touch his face five times during the tray line service and did not wash his hands after touching his face but continued placing cups/glasses on resident trays.</p>	F 371	<p>Maintenance Supervisor will review all audit findings and revise current plan at least monthly beginning 12/16//15 and ongoing until issue is resolved or satisfactory.</p> <p>5. Date of completion: 12/17/15</p>	

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F 371	<p>Continued From page 12</p> <p>Interview with Cook #1 on 11/11/15 at 12:18 PM revealed he had been employed at the facility less than two months. He stated he should have been wearing gloves and should have washed his hands when leaving the line. According to Cook #1, he thought he was wearing the hairnet properly.</p> <p>Interview with Dietary Aide #2 on 11/11/15 at 12:21 PM revealed he had been employed at the facility less than five months. The Dietary Aide said he should not have been picking the cups and glasses up from the top and should have washed his hands before returning to the line. According to Dietary Aide #2, he was nervous.</p> <p>2. Observation on 11/12/15 at 8:09 AM revealed State Registered Nurse Aide (SRNA) #2 was inside the kitchen during breakfast tray line not wearing a hairnet.</p> <p>Interview with SRNA #2 at 11/12/15 at 8:13 AM revealed, "I should have been wearing a hairnet while in the kitchen."</p> <p>Interview with the Dietary Manager (DM) on 11/13/15 at 9:06 AM revealed that she had been there over 30 years and staff was trained on kitchen sanitation upon hire and annually. Cook #1 and Dietary Aide #2 had received this training but failed to use proper sanitation when on the serving line. The Dietary Manager stated she monitored sanitation by observing employees while in the kitchen and had not identified any problems with hand sanitation but had noticed from time to time hairnets not being worn properly. Cook #1 and Dietary Aide #2 should have both washed their hands and really should not have been leaving the serving line. The</p>	F 371		

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F 371	Continued From page 13 Dietary Manager stated all staff should have hairnets on properly and beard guards tucking in all exposed hair when entering the kitchen. The Dietary Manager further stated staff should have been handling the cups and glasses by the bottom or middle, and not by the lip contact area, and should have been wearing gloves while on the line.	F 371			
F 411 SS=D	483.55(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS The facility must assist residents in obtaining routine and 24-hour emergency dental care. A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on interview and record review and review of facility policy, it was determined the facility failed to ensure one (1) twenty (20) sampled residents (Resident #7) had the opportunity to receive routine dental services. Review of the medical record for Resident #7 revealed no evidence the resident received an annual evaluation by a dentist.	F 411	F411 1. Resident #7 responsible party was notified by social services on 11/23/15 to schedule and provide the opportunity for routine dental services. The responsible party declined outside dental services with a preference for next on-site service. 2. An audit of residents will be completed by the Social Services Director/Assistant to identify that residents had the opportunity to receive routine dental services. The audit was completed on 11/30/15. No issues were identified. 3. Upon admission and quarterly, residents will be assessed for oral/dental care by Unit Manager and a list compiled for Social Services to coordinate visit. Upon assessment, any resident identified for need will have a consult provided by a licensed professional, either by the on-site dental provider or by an outside dental provider as preferred by the resident or responsible party, and		

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F 411	<p>Continued From page 14</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Ancillary Services," undated, revealed each resident would receive routine dental care as needed, and the findings would be documented in the resident's medical record.</p> <p>Review of Resident #7's medical record revealed the facility admitted the resident on 10/31/14, with diagnoses that included Alzheimer's Dementia, Seizure Disorder, and Pulmonary Embolism. Review of a significant change in condition Minimum Data Set (MDS) assessment dated 09/27/15 revealed no concerns had been identified by the facility related to Resident #7's oral cavity.</p> <p>Interview with the Social Worker on 11/13/15, at 3:35 PM, revealed she was responsible for scheduling dental appointments for residents. The Social Worker stated Resident #7 had been on the list of residents sent to the dentist but when the dental service sent back a list of residents the dentist would be seeing, Resident #7 was not on the list. The Social Worker stated she was responsible for checking the list to ensure all residents who were required to be seen by the dentist were seen. She stated she had missed identifying that Resident #7 was not on the list.</p> <p>Interview conducted with the Director of Nursing (DON) on 11/13/15, at 6:40 PM, revealed the Social Worker was responsible for scheduling all dentist appointments and the Social Worker would schedule the resident for an appointment unless the resident or the family had refused.</p>	F 411	<p>documented in the resident medical record. Social Services will validate that dental services have been offered upon completing quarterly and annual assessments. An audit of all new admission will be completed by Social Service Director for three (3) months and ongoing during the residents' quarterly assessments to ensure that dental services are being offered and documented if received and/or refused in the medical record. The audit will begin the week of 12/7/15. Re-education will be completed for licensed staff regarding dental care and identifying need for dental care by the Education Training Director by 12/11/15.</p> <p>4. The Quality Assurance Team consisting of at least the Administrator, Medical Director, Director of Nursing, Social Services Director, Dietary Manager and Maintenance Supervisor will review all audit findings and revise current plan at least monthly beginning 12/16//15 and ongoing until issue is resolved or satisfactory.</p> <p>5. Date of completion: 12/17/15</p>		

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F 411	Continued From page 15 Interview conducted with the Administrator on 11/13/15, at 6:45 PM revealed the Social Worker was responsible for scheduling dental appointments for the residents. The Administrator stated he had not identified any concerns with residents not receiving routine dental care.	F 411		
F 463 SS=E	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy it was determined the facility failed to ensure a call light in the C Hall shower room was accessible. Observations on 11/13/15 revealed the communication system was blocked by a supply cart. The findings include: Observation of the C Hall shower room on 11/13/15 at 3:56 PM revealed the call light pull cord was blocked by a supply cart. Review of the Facility Policy titled "Answering the Call Light," (undated) revealed that the call light was to be within easy reach of the resident. Interview with State Registered Nurse Aide (SRNA) #1 on 11/13/15 at 4:00 PM revealed that	F 463	F463 1. No specific resident was identified. The supply cabinet in front of the call light in the C Hall shower room was moved away from the call light maintenance on 11/13/15. 2. Any resident might have the potential to be affected. A one time environmental audit of the center will be conducted by the Administrator and Maintenance Director by 12/11/15 to identify that other call lights are accessible. Any issues identified will be addressed immediately. 3. The Administrator will revise the room rounds process where the Management Team completes assigned daily room rounds including shower rooms, Monday thru Fridays beginning the week of 12/14/2015, to identify any issues with items blocking call lights to ensure that residents have access to call lights at all times. Any issues identified will be immediately corrected. Re-education will be completed for	

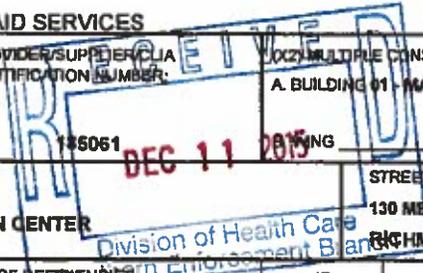
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F 463	Continued From page 16 he had been employed by the facility since February 2015 and the supply cart had been in front of the call light since that time. Interview with the Housekeeping Supervisor on 11/13/15 at 4:05 PM revealed he was unaware of the supply cart blocking the call light. Interview with the Director of Nursing (DON) and Administrator on 11/13/15 at 6:41 PM revealed they were not aware that the call light system was blocked in the shower room.	F 463	facility staff having contact with call lights by the Education Training Director regarding position of call light and that no items should block access to call light. Completion date 12/15/15. 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 12/16//15 and ongoing until issue is resolved or satisfactory. 5. Date of completion: 12/17/15		

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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 (200) SMOKE COMPARTMENTS: 8 COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM FULLY SPRINKLERED, SUPERVISED (WET & DRY SYSTEM) EMERGENCY POWER: Type II diesel generator A Life Safety Code Survey was initiated and concluded on 11/12/15. 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. The facility has the capacity for 93 beds with a census of 84 on the day of the survey. Deficiencies were cited with the highest deficiency identified at "D" level.	K 000	Disclaimer: Preparation and/or execution of the Plan of Correction does not constitute admission or agreement by the Provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared and/or executed solely because the provisions of federal and state law require it. The Provider maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor is it of such character as to limit the facilities capability to render adequate care.	
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD	K 018		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Glenn Cox* TITLE: Administrator DATE: 12/11/14

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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K 018	<p>Continued From page 1</p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1½ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure corridor room doors would resist the passage of smoke, according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of eight smoke compartments, eleven (11) residents, staff, and visitors.</p> <p>The findings include: Observation on 11/12/15 at 3:00 PM revealed the corridor doors to resident rooms E7 and E8 had a gap larger than one-half inch when closed.</p>	K 018	<ol style="list-style-type: none"> 1. The larger than one-half inch gaps on resident room doors E7 and E8 were repaired by maintenance on 12/7/15. 2. A one time audit of the facility's corridor doors was completed by the Administrator and Maintenance Supervisor on 12/9/15 to identify that the corridor room doors would resist the passage of smoke and no gaps were larger than one-half inches when closed. No other gaps larger than one-half inch were identified. 3. The Maintenance department will audit corridor doors weekly beginning the week of 12/14/15 and on-going to ensure that the corridor room doors will resist the passage of smoke and no gaps are larger than one-half inches when closed. Any issue identified will be addressed immediately. The Administrator reviewed the requirements and re-educated the maintenance supervisor on 12/9/15 regarding corridor room doors are to resist the passage of smoke and no gaps are larger than one-half inches when closed. 4. The Quality Assurance Team (consisting of at least the Administrator, Medical Director, Director of Nursing, Social Services Director, Dietary Manager and 	

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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 018	<p>Continued From page 2</p> <p>Interview with the Maintenance Director revealed resident room doors are inspected monthly to ensure they function and are meeting the requirements for life safety and no problems had been identified.</p> <p>The findings were acknowledged by the Administrator during the exit conference.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors.</p> <p>Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials.</p> <p>Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke.</p> <p>Survey and Certification letter from Centers for Medicare & Medicaid Services: 07-18</p>	K 018	<p>Maintenance Supervisor) will review all audit findings and revise current plan at least monthly beginning week of 12/16/15 and ongoing until issue is resolved or satisfactory.</p> <p>5. Date of Compliance: 12/17/15</p>	

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185061	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 11/12/2015
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 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>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</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure automatic sprinkler systems were maintained according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect two (2) of eight (8) smoke compartments, twenty-one (21) residents, staff, and visitors.</p> <p>The findings include:</p> <p>Observation on 11/12/15 at 1:18 PM, with the Maintenance Director revealed two automatic sprinkler heads covered in dust, located in the A Hall shower room. Interview with the Maintenance Director revealed staff inspects automatic sprinkler heads monthly for buildup of dust.</p> <p>Observation on 11/12/15 at 1:47 PM, with the Maintenance Director revealed two automatic sprinkler heads blocked by food items in the freezer area. Interview with the Maintenance Director revealed staff inspects automatic sprinkler heads monthly for items blocking the automatic sprinkler heads and no problems had been identified.</p> <p>2-2.1.1* Sprinklers shall be inspected from the</p>	K 062	<p>K 062</p> <ol style="list-style-type: none"> 1. The two automatic sprinkler heads covered in dust, located in the A Hall shower room, were replaced on 12/9/15 with new sprinkler heads by the facility's sprinkler maintenance vendor, Brown's Sprinkler. The food items blocking the two automatic sprinkler heads in the freezer area were removed by dietary staff on 11/12/15. 2. A one time audit of the facility's sprinkler system was completed by the Administrator and Maintenance Supervisor on 12/9/15 to identify that the sprinkler system is in reliable operating condition and maintained according to NFPA standards, to include automatic sprinkler heads are dust free and not blocked by any items. Any issue identified was immediately addressed. 3. The Maintenance department will audit the facility's sprinkler system weekly beginning the week of 12/14/15 and ongoing to ensure the sprinkler system is in reliable operating condition and maintained according to NFPA standards, to include automatic sprinkler heads are dust free and not blocked by any items. Any issue identified will be addressed immediately. The Administrator reviewed the 	

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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 062	Continued From page 4 floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation. Exception No. 1:* Sprinklers installed in concealed spaces such as above suspended ceilings shall not require inspection. Exception No. 2: Sprinklers installed in areas that are inaccessible for safety considerations due to process operations shall be inspected during each scheduled shutdown.	K 062	requirements and re-educated the Maintenance Supervisor and Dietary Manager regarding the sprinkler system is in reliable operating condition and maintained according to NFPA standards on 12/9/15. 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.	
K 072 SS=D	2-2.1.2* Unacceptable obstructions to spray patterns shall be corrected. NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exit corridors were free and clear of obstructions, according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of eight (8) smoke compartments, twenty-one (21) residents, staff, and visitors.	K 072	5. Date of Compliance: 12/17/15 K 072 1. The treatment cart was removed from the A Hall corridor by nursing staff on 11/12/15. 2. A one time environmental audit was completed by the Administrator, Maintenance Director, and Housekeeping Director on 12/9/15 to identify that exit corridors were free and clear of obstructions, to include treatment carts. No issues were identified. 3. The Maintenance department will audit exit corridors doors weekly	

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K 072	<p>Continued From page 5</p> <p>The findings include:</p> <p>Observation on 11/12/15 at 1:15 PM, with the Maintenance Director revealed a treatment cart which was unattended and not in use on the A Hall corridor. Interview with a CNA revealed the treatment cart was routinely stored on the A Hall when not in use.</p> <p>The findings were acknowledged by the Administrator during the exit conference.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>7.1.10.1* Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.</p>	K 072	<p>beginning the week of 12/14/15 and on-going to ensure that that exit corridors are free and clear of obstructions.</p> <p>Any issue identified will be addressed immediately.</p> <p>The Education Training Director will educate facility staff regarding exit corridors are to remain free and clear of obstructions, including treatment carts. Education will be completed by 12/14/15.</p> <p>4. The Quality Assurance Team (consisting of at least the Administrator, Medical Director, Director of Nursing, Social Services Director, Dietary Manager and Maintenance Supervisor) will review all audit findings and revise current plan at least monthly beginning week of 11/19/14 and ongoing until issue is resolved or satisfactory.</p> <p>5. Date of Compliance: 12/17/15</p>	