

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

PRINTED: 03/28/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185146	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  03/15/2013
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NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE & REHAB-FOUNTAIN CIRCLE	STREET ADDRESS, CITY, STATE, ZIP CODE 200 GLENWAY ROAD WINCHESTER, KY 40391
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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**

A Relicensure Survey was conducted 03/12/13 through 03/15/13 with deficiencies cited.

**F 252 483.15(h)(1) SS=E SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT**

The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.

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 provide a safe, clean, comfortable and homelike environment. Observation of resident rooms 204, 206, 208, 121, 117, and 102 revealed cobwebs were present in corners of rooms with some containing dead or live insects. Observation of room 112 revealed clumps of brown substance hanging from the ceiling. In addition, observations in the vending hall revealed a large cobweb on the door opposite of the vending machines.

The findings include:  
Review of the facility's "Deep Clean Checkoff List", undated, revealed resident rooms would be deep cleaned monthly per set schedule. Further review revealed Procedures for deep cleaning a room; the housekeeper would clean the ceiling, baseboards, edges and walls. Attached to the checkoff list was a "Deep Clean Schedule".

**F 000 F 252**

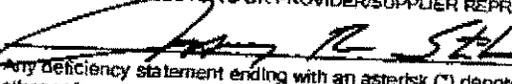
**Immediate Corrective Action For Residents Found To Be Affected**

- ◆ Resident #8's and resident #16's rooms were cleaned by the housekeeping stakeholders on 03/13/13.
- ◆ Resident #8's and resident #16's rooms were treated by the contracted Pest Control agency on 03/19/13.

**Identification of Other Residents With The Potential to be Affected**

- ◆ Given the scope of the identified alleged discrepancies, all residents have the potential to be affected. However, Housekeeping Supervisor was notified of findings of cobwebs in rooms 102, 117, 121, 204, 206, 208, and the vending hall doorway. Also, Housekeeping Supervisor was made aware of the substance on the ceiling of room 112. All identified rooms were cleaned immediately and all other rooms throughout the facility were inspected by the

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE ADMINISTRATOR	(X6) DATE 04/07/2013
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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 252 Continued From page 1  
undated, that listed each room and the date each room would be cleaned each month.

Interview with Housekeeping Manager, on 03/13/13 at 3:00 PM, revealed there was no policy on daily room cleaning, but his expectation was for staff to dust from ceiling to floor to include bathrooms, lights, bed frames, windows, blinds, bed tables as well as empty the trash.

Observation, on 03/13/13 at 2:45 PM, revealed a large cobweb was present on the green door across the hall from the vending machines.

Observation, on 03/13/13 at 3:00 PM, revealed resident room 204 contained a cobweb in the back corner of the room, dead insects as well as small brown circular sacs were observed in this cobweb.

Observation, on 03/13/13 at 3:10 PM, revealed resident room 208 contained a large cobweb extending from the front corner of the room above bed A to the center of the room, where it was attached to the privacy curtain. Along this cobweb in room 208 were dead insects as well as small brown circular sacs. Further observation at 3:12 PM revealed inside room 206, above the sink was a spider web with a moving brown spider present in the web.

Observation of room 112, on 03/15/13 at 1:50 PM, revealed five (5) clumps of a dried brown substance were hanging from the ceiling over the resident bed.

Observation of room 121, on 03/15/13 at 1:52 PM, revealed cobwebs were present in three (3)

F 252

Housekeeping Supervisor and cleaned accordingly on 03/15/13 thru 03/22/13.

**Measures Taken To Assure There Will Not Be a Recurrence**

- ◆ Entire facility was treated by the contracted Pest Control agency on 03/19/13.
- ◆ Contract Housekeeping Services Company's contract was terminated effective 04/01/2013 with provision of those services being brought back in-house on same date.
- ◆ On 03/18/13 the Housekeeping Supervisor conducted an in-service to housekeeping/laundry stakeholders to include but not limited to; for the proper methods of sanitizing a bathroom, the 7-step daily washroom cleaning, checking of supplies, emptying trash, dust mopping floors, clean and sanitizing sinks and tubs, cleaning and sanitizing commodes, spot cleaning walls and/or partitions, checking all corners for cobwebs/debris, and damp mopping floor. No stakeholder

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F 252: Continued From page 2  
ceiling corners of the room. Observation of room 117, on 03/15/13 at 1:54 PM, revealed cobwebs were present across the ceiling over the head of the bed. In addition, observation of room 102, on 03/15/13 at 1:58 PM, revealed cobwebs were present in two (2) ceiling corners of the room.

Interview with Resident #8's family (Resident #8 resided in room 204), on 03/15/13 at 9:45 AM, revealed the family member felt the facility could be cleaner. Resident #8's family member reported he/she had noticed resident rooms were not cleaned well. The family member also reported he/she had noticed dirt present in the corners of resident rooms.

Interview with Resident #16 who lived in room 208, on 03/15/13 at 9:10 AM, revealed he/she had noticed cobwebs with insects above his/her bed. Resident #16 also stated, he/she didn't tell anyone because he/she did not want to get staff members in trouble. Resident #16 reported housekeeping cleaned his/her room daily, but seemed rushed. He/she reported the ceilings in his/her room were not cleaned very often.

Interview with the Pest Control Technician, on 03/15/13 at 1:00 PM, revealed he visited the facility monthly and noticed the corners of the rooms and areas behind furniture were not cleaned very well. The contracted Pest Control Technician, also reported he had mentioned this concern to the facility before, but did not remember who he reported this to.

Interview with Housekeeper #1, on 03/13/13 at 3:00 PM, revealed all resident rooms were cleaned daily from ceiling to floor. Housekeeper

F 252: member will be allowed to work without being in-serviced. The facility does not employ agency staff; however, if the facility should employ agency staff, the agency staff will receive the in-service prior to working.

- On 03/19/13, the Staff Development Coordinator conducted education with facility stakeholders on clean-home like environment, and pest control. Education will be ongoing until all stakeholders have attended. No stakeholder will be permitted to work without being in-serviced.
- On 04/02/13, the Quality Assurance/Process Improvement Nurse (QAPIN) and Director of Nursing (DON) conducted an in-service with the environmental stakeholders to include but not limited to; audits that would be completed on a daily basis to validate resident rooms and other areas of the facility had been cleaned.

**Monitoring Changes To Assure Continuing Compliance**

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F 252 Continued From page 3  
#1 stated the tall duster was to be used daily in resident rooms to knock down cobwebs.

Interview with Maintenance Director, on 03/13/13 at 3:05 PM, revealed the cobwebs noted in the resident rooms were from a lack of high dusting. He reported it appeared high dusting in resident rooms had not been completed in a while.

Interview with Housekeeping Manager, on 03/13/13 at 3:10 PM, revealed resident rooms were cleaned daily. The Housekeeping Manager reported staff were to look up and clean vertically from the ceiling to the floor. He also reported staff were to dust the corners of the room daily and call the pest control company if they saw insects. However, the Housekeeping Manger agreed it appeared proper cleaning of resident rooms was not being performed. The Housekeeping Manager stated he would address vertical to floor cleaning with housekeeping staff and add concerns observed by surveyors to his next project list.

Interview with the Administrator, on 03/15/13 at 1:15 PM, revealed the Housekeeping Manager was responsible for ensuring rooms were cleaned as they should be. The Administrator stated her expectation was for the entire room to be cleaned daily.

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- The Environmental Services Director (ESD) will conduct an audit of 10% of rooms on each unit as well as spot checking of general purpose areas throughout the facility to ensure all are properly sanitized and cleaned appropriately. The QAPIN, Assistant Director of Nursing (ADON) or Unit Manager (UM) will oversee the auditing process and validate that rooms are being cleaned properly and to maintain a home like environment.
- These audits will continue for a three (3) month period or until substantial compliance has been determined by the Process Improvement Committee (PIC). Members of the Process Improvement Committee (PIC) include, but are not limited to, the Administrator, DON, ADON, QAPIN, Staff Development Coordinator (SDC), Medical Director (MD), Social Services Director (SSD), Dietary Manager

F 323 483.25(h) FREE OF ACCIDENT  
SS-E 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 (DM), Registered Dietitian (RD)

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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 ensure the environment remained free of accident hazards as possible. Observation on initial tour, on 03/12/12 revealed the two hundred (200) hall shower room had one sharps container with five (5) razor handles protruding outward from the lid. Observations, on 03/13/13 revealed hot water temperatures on the two-hundred (200) hall as high as one-hundred eighteen (118) degrees Fahrenheit (F).

The findings include:

1. Review of the facility policy, "Biohazard/Regulated Waste Disposal", dated 09/19/12, revealed regulated waste including sharps containers were appropriately handled, labeled, stored and disposed of per Federal and/or State regulation. Additional review of the policy revealed regulated waste containers were prepared for disposal when the container was three-fourths (3/4) full.

Observation on initial tour, on 03/12/13 at 2:00 PM revealed the two-hundred (200) hall shower room had a biohazard sharps container filled past the three-fourths (3/4) mark with five razor handles protruding outward from the lid and overfilled past the three fourth (3/4) marked area.

F 323: (F252 cont)

Quality of Life Director (QoLD), Business Office Manager (BOM), Plant Operations Director (POD), HSD, and Reflections Program Director (RPD). The results of these audits will be brought to the PIC bi-weekly for the next three (3) months, and then monthly for three months or until substantial compliance has been determined by the PIC.

**Date of Completion: 04-29-13**

F 323

**Immediate Corrective Action For Residents Found To Be Affected**

- ◆ Resident #16's water temperature was adjusted by the Maintenance Director on 03/15/13 to meet regulatory compliance.
- ◆ Resident #10 was assessed by the nurse for any signs of injury relative to the sharps container. No injuries were noted.

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F 323	Continued From page 5 Observation, on 03/15/13 at 9:45 PM, revealed Resident #10 was in his/her wheelchair and self propelled towards a medication cart. Further observation revealed when Resident #10 reached the medication cart he/she began manipulating the lid on the sharps container.  Interview, on 03/12/13 at 2:20 PM, with Unit Manager #4 revealed housekeeping emptied the sharps container and she did not know why it was still full. Additional interview, on 03/15/13 at 10:30 AM, revealed there were two residents on the two-hundred (200) hall that wandered, including Resident #10. Further interview revealed staff were to empty the sharps container when it was three fourths (3/4) full and the nurses had the key to the sharps container and housekeeping placed them in the red bags. She further stated the five (5) razors protruding from the sharps container should not of been there and it should of been emptied.  Interview, on 03/12/13 at 2:25 PM, with Housekeeper # 20 revealed the nurses were responsible for emptying when full.  Interview, on 03/12/13 at 2:30 PM, with State Registered Nurses Assistant (SRNA) #7 revealed the nurses were responsible for emptying the sharps containers.  Interview with Licensed Practical Nurse (LPN) # 2, on 03/12/13 at 2:40 PM, revealed she did not know who was responsible for emptying the sharps containers. During the interview Unit Manager #4 requested the key to the sharps container from LPN # 2.	F 323	<b>Identification of Other Residents With The Potential to be Affected</b>  ♦ All residents residing on the Lilac Community have the potential to be affected as a defective mixing valve was the issue identified. However, all residents were assessed on 03/15/13 by the ADON and UM with no burns identified.  ♦ The Maintenance Director checked water temperatures throughout the entire facility on 03/15/13 to validate regulatory compliance with water temperatures, no further issues were noted.  ♦ The QAPIN conducted an initial audit of sharps container on 03/15/13, and found no further issues.  <b>Measures Taken To Assure There Will Not Be a Recurrence</b>  ♦ On 03/15/13, the Maintenance Director installed a replacement mixing valve and adjusted water temperatures in all resident's room		

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2. Interview with the Administrator, on 03/13/13 at 12:25 PM, revealed the facility followed the guidelines for hot water temperatures from 902 KAR 20:046.

Review of 902 KAR 20:046 Section 15, Mechanical Requirements, subsection four (4)(h) revealed plumbing fixtures which required hot water and were intended for patient (resident) use should be supplied with water which was controlled to provide a maximum water temperature of one-hundred ten (110) degrees Fahrenheit at the fixture.

Interview during a resident group meeting, on 03/13/13 at 10:05 AM, revealed three (3) of nine (9) alert and oriented residents stated water temperatures were too hot at times and sometimes during showers they were cold and then suddenly turn hot.

Observation, on 03/13/13 at 11:05 AM, with Maintenance Director # 7 revealed room 205 temperature was one-hundred eighteen (118) degrees F, room 208 was one-hundred sixteen (116) degrees F, room 206 was ninety (90) degrees F, room 221 was eight-seven (87) degrees F at the water fixtures.

Interview with Resident #16, on 03/15/13 at 9:00 AM, revealed his/her water temperature at the sink had been too hot lately; however, he/she had never been burned.

Review of the facility's logs titled, "Weekly Hot Water Temperature Readings", from 02/01/13 through 03/01/13, revealed hot water temperature readings in resident's rooms ranging from 100.1

F 323 residing on the Lilac Community, to meet regulatory compliance.

- On 03/19/13, the SDC conducted education with facility stakeholders on maintaining a safe environment for residents and specifically replacing sharps containers when ¾ full. Education will be ongoing until all stakeholders have attended. No stakeholder will be allowed to work without being in-serviced.

**Monitoring Changes To Assure Continuing Compliance**

- The POD, QAPIN, ADON and/or UM will audit water temperatures on the Lilac Community daily, Monday through Friday and weekly water temperatures will be checked and validated for compliance for the other communities of the facility.
- The Supply Clerk, ADON, UM, QAPIN and/or DON will audit Sharp Containers on a daily basis, Monday through Friday, and replace as needed.
- These audits will continue daily for

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F 323	Continued From page 7 degrees F to 108.7 degrees F. Review of the logs, dated 03/08/13, revealed hot water temperatures were taken at the faucets in resident's rooms including rooms 217 and 201 of the 200 hall. Further record review revealed the 200 hall temperatures ranged between 105 degrees F to 110 degrees F, indicating a slightly higher temperature than previous five (5) weeks.  Interview with Maintenance Director #7, on 03/13/13 at 12:30 PM, revealed something must have been wrong with the mixing valves and he needed to go immediately and adjust the temperatures because they should not be over one-hundred ten (110) degrees F. He stated he checked water temperatures randomly every Friday and wouldn't of caught the elevated temperatures until Friday the 15th, indicating he should have checked them more frequently since the temperatures had slightly increased the prior week.	F 323	or until substantial compliance has been determined by the PIC. Members of the PIC include, but are not limited to, the Administrator, DON, ADON, QAPIN, SDC, MD, SSD, DM, RD, QoLD, BOM, POD, ESD, and RPD. The results of these audits will be brought to the PIC every other week for the next three (3) months, and then monthly for three months or until substantial compliance has been determined by the PIC.	04-29-13	
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>Immediate Corrective Action For Residents Found To Be Affected</b>  ◆ Unsampld Resident A's wash basin was discarded 03/13/13.  ◆ Resident #12 was assessed on 03/13/13 by ADON and UM to have no active infection.  ◆ Unsampld Resident D was assessed on 03/13/13 by the ADON and UM to have no active infection		

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actions related to infections.

(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.

(c) Linens  
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:  
Based on observation, interview, record review and review of the facility policies it was determined the facility failed to maintain an effective infection control program to help prevent the development and transmission of disease and infection.

Observation during initial tour, on 03/12/13, revealed the bathroom located near the activities/restorative offices had two (2) dried wash cloths in the tub with a brown substance on them. In addition, there was a wash basin in the bathtub, labeled with Unsampled Resident A's

F 441 Identification of Other Residents With The Potential to be Affected

- Given the scope of the alleged identified discrepancies, all residents have the potential to be affected. However, on 03/13/13, all public bathrooms were assessed for cleanliness and validated no personal items were left in the bathrooms, no other issues were identified.
- Infection control mapping will be updated daily Monday - Friday from 03/14/13 thru 04/10/13 (30 days) to identify any possible spikes in infections throughout the facility. None have been noted as of 04/05/13.
- Safety Committee will conduct safety inspection of the entire facility from 04/08/13 thru 04/12/13. Any items identified shall be corrected as necessary per regulatory guidelines.

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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	
F 441	Continued From page 9 name, even though the resident had been discharged from the facility thirty-six (36) hours earlier.  In addition, observation of the lunch meal, on 03/14/13, revealed poor infection control technique while feeding residents.  The findings include:  1. Review of the facility's policy titled "Work Practices: Laundry", dated 10/31/10, revealed linen and laundry would be handled in a manner to reduce the likelihood of recontamination. Guidelines for handling soiled linens stated contaminated laundry would be bagged at the location it was used. Further review of the policy revealed used articles would be enclosed in containers or bags to prevent inadvertent exposure to residents and to prevent contamination of the environment.  Interview, on 03/14/13 at 1:00 PM, revealed there was no policy or procedure in place related to the storage of basins. The Administrator stated wash basins would be labeled and bagged when not in use.  Observation of the unlocked bathroom located in the activities area during initial tour, on 03/12/13 at 2:00 PM, revealed there were two (2) dried wash cloths in the tub with a brown substance visible. Also inside the tub, was a basin labeled with Un-sampled Resident A's name written on the outside. Record review revealed Un-sampled Resident A was transferred from the facility to the hospital, on 03/11/13 at 2:30 AM, thirty-six (36) hours earlier.	F 441	<b>Measures Taken To Assure There Will Not Be a Recurrence</b>  ◆ Contract Housekeeping Services Company's contract was terminated effective 04/01/2013 with provision of those services being brought back in-house on same date.  ◆ On 03/18/13 the Housekeeping Supervisor conducted an in-service to housekeeping/laundry stakeholders to include but not limited to; infection control, for the proper methods of sanitizing a bathroom, the 7-step daily washroom cleaning, checking of supplies, emptying trash, dust mopping floors, clean and sanitizing sinks and tubs, cleaning and sanitizing commodes, spot cleaning walls and/or partitions, checking all corners for cobwebs/debris, and damp mopping floor. No stakeholder member will be allowed to work without being in-serviced.  ◆ On 03/19/13, the SDC conducted education with facility stakeholders on hand-washing, monitoring for prevention of infection and feeding		

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F 441	Continued From page 10  Interview with State Registered Nursing Assistant (SRNA) #6, on 03/12/13 at 2:15 PM, revealed the bathroom located near activities was used by residents and staff. SRNA #6 reported the resident rooms located near the activities area, did not have individual bathrooms. She stated the bathroom by activities was used to provide peri-care to residents. Upon entering the restroom by activities, SRNA #6 stated the soiled linens in the tub should have been bagged and placed with the dirty linens. She stated soiled linens should not be left in the tub. SRNA # stated the basin should have been in Un-sampled Resident A's room labeled and bagged.  Interview with Registered Nurse (RN) #1, on 03/12/13 at 2:20 PM, revealed the basin and the soiled wash cloths should not have been left in the bath tub. RN #1 stated soiled linens should be bagged immediately and put on the soiled linen cart. RN #1 stated basins used for resident care should be labeled and bagged to prevent spreading infections and disease.  Interview with the Regional Housekeeping Director, on 03/12/13 at 2:33 PM, revealed soiled linens and basins should not be placed directly in the tub. However, the Regional Housekeeping Director did not know when the restroom was last cleaned, and he was not aware of the cleaning schedules at the facility.  Interview with the District Manager of Housekeeping, on 03/12/13 at 2:35 PM, revealed he agreed the restroom by activities needed immediate attention to remove the soiled wash cloths and basin. The District Manager of	F 441	residents to include infection control techniques. Education will be ongoing until stakeholders have attended. No stakeholders will be allowed to work without being in-serviced.  <b>Monitoring Changes To Assure Continuing Compliance</b>  ♦ Audits will begin on 04/05/13 and will be completed by ADON, UM, Evening Shift Nurse Supervisor (ESNS), Weekend Nurse Supervisor (WNS), QAPIN and/or DON on a daily basis to validate proper infection control technique are utilized during meal times.  ♦ The ESD will conduct an audit of 10% of rooms on each unit as well as spot checking of general purpose areas throughout the facility to ensure all are properly sanitized and cleaned appropriately. The QAPIN, ADON or UM will oversee the auditing process and validate the prevention of the spread of infection.		

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F 441	<p>Continued From page 11</p> <p>Housekeeping reported basins should be bagged in resident rooms. In addition, he stated soiled linens should be bagged and placed in soiled linen cart.</p> <p>Interview with Infection Control Nurses #1 and #2, on 03/15/13 at 2:30 PM, revealed the expectation was for staff to bag soiled wash cloths and place in the soiled linens after use. Furthermore, Infection Control Nurses #1 and #2 stated Un-sampled Resident A's basin should have been discarded. The Infection Control Nurses both reported basins should be labeled and bagged in Resident rooms when not in use.</p> <p>2. Review of the facility "Hand Hygiene/Handwashing" Policy, revised 08/31/11, revealed handwashing was the single most important procedure for preventing the spread of infection. Further review revealed if soap and water were not available and hands were not visibly soiled, an alcohol based hand rub may be used for routine decontamination. The Policy stated hand hygiene was to be performed between patient contacts and when otherwise indicated to avoid transfer of microorganisms to other patients or environments.</p> <p>Observation of the lunch meal service, on 03/14/13 at 1:00 PM, SRNA #6 wiped Resident #12's mouth with a napkin and without washing or sanitizing her hands, proceeded to pick up a container of milk and while holding the straw in the milk, placed the straw in Unsampled Resident D's mouth.</p> <p>Interview, on 03/14/13 at 1:10 PM, with SRNA #6 revealed she should have washed or sanitized</p>	F 441	<p>◆ These audits will continue for a three (3) month period or until substantial compliance has been determined by the PIC. Members of the PIC include, but are not limited to, the Administrator, DON, ADON, QAPIN, SDC, MD, SSD, DM, RD, QoLD, BOM, POD, ESD, and RPD. The results of these audits will be brought to the PIC bi-weekly for the next three (3) months, and then monthly for three months or until substantial compliance has been determined by the PIC.</p> <p><b>Date of Completion:</b></p>	04-29-13	

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F 441	<p>Continued From page 12 her hands after wiping Resident #12's mouth and prior to assisting Unsampled Resident D.</p> <p>Interview on 03/15/13 at 2:45 PM with the Director of Nursing (DON) revealed the facility needed to do further education related to feeding residents.</p>	F 441	<p><b>F 465</b> <b>Immediate Corrective Action For Residents Found To Be Affected</b></p> <ul style="list-style-type: none"> <li>No resident(s) identified. Given this is a restricted area, only stakeholders would have been affected.</li> </ul>	
F 465 SS=D	<p>483.70(h) <b>SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON</b></p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>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 provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. During environmental rounds, on 03/13/13, observation of the laundry room revealed a build up of dust and lint around and under the roller storage bins in the floor of the alcove by the dryers. The environmental rounds also revealed, the door of the alcove leading into the area behind the dryers was ajar. The door was attached to the door frame but not attached to the wall on the side with the hinges, allowing the door to pull away from the frame and wall while attempting to open it. This same door, accessing the rear of the dryer units, was blocked by storage bins and bath blankets which had</p>	F 465	<p><b>Identification of Other Residents With The Potential to be Affected</b></p> <ul style="list-style-type: none"> <li>Given this is a restricted area, only stakeholders would have been affected.</li> <li>POD conducted safety inspection of the entire facility to include all doors and frames within the facility on 04/02/13 to assure all were in proper working order. No other issues were identified.</li> </ul> <p><b>Measures Taken To Assure There Will Not Be a Recurrence</b></p> <ul style="list-style-type: none"> <li>Laundry area and area behind dryers was cleaned and all linens were cleaned and stored appropriately on 03/15/13 as directed by the QAPIN.</li> </ul>	

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F 465: Continued From page 13  
been piled high in the bin and had spilled over onto the floor blocking access.

The findings include:

Review of the facility's Preventative Maintenance Task Sheet tool, undated, revealed the electrical disconnects should be labeled and accessible. Review of this tool further revealed, the lint should be removed from the walls, ceiling, floor and behind the dryer area. The Preventative Maintenance Sheet was to be done on a weekly basis.

Observation of the laundry room, on 03/13/13 at 3:15 PM, revealed there were three (3) plastic hollered bins containing bath blankets in the alcove leading to the room behind the dryers. The bath blankets were piled unsecured on top of the bins and overflowing onto the floor in front of the bins blocking the access door leading behind the dryers. The door frame leading to the dryers was not secured to the wall allowing the door to pull away from the frame and wall. Removal of the plastic bins and bath blankets revealed an accumulation of dust and lint on the floor, wall, door, and door frame. The room behind the dryers revealed an accumulation of dust and lint.

Interview with Laundry Staff #1, on 03/13/13 at 3:35 PM, revealed she does not clean behind the dryers. Further interview revealed she generally worked the evening shift and the access to the back of the dryers had been blocked for two (2) or three (3) months. Additionally, Laundry Staff #1 revealed, she had not seen maintenance clean the back of the dryers.

- F 465:
- ◆ New door was installed at the dryer area by POD on 03/22/13.
  - ◆ Contract Housekeeping Services Company's contract was terminated effective 04/01/2013 with provision of those services being brought back in-house on same date.
  - ◆ On 03/13/13 the Housekeeping Supervisor conducted an in-service to housekeeping/laundry stakeholders to include but not limited to; infection control and safety in the laundry area to keep the pathways clear to the doorways behind the dryers and laundry. All new employees will receive the in-service prior to working.
  - ◆ On 03/18/13 the Housekeeping Supervisor conducted an in-service to housekeeping/laundry stakeholders to include but not limited to; for the proper methods of sanitizing a bathroom, the 7-step daily washroom cleaning, checking of supplies, emptying trash, dust mopping floors, clean and sanitizing

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F 465 Continued From page 14

Interview with the Maintenance Assistance, on 3/14/13 at 9:50 AM, revealed it was his responsibility to clean behind the dryers each Friday. Further interview revealed Friday 03/08/13 was the last day the rear of the dryers had been cleaned. He further stated that the door was blocked on 03/08/13 and that he advised someone in the laundry that the door was blocked but did not remember who he advised.

Interview with the House Keeping Manager, on 03/13/13 at 3:15 PM, revealed the door should not have been blocked. Further interview revealed he had never been in the room behind the dryers and it was the responsibility of Maintenance to clean.

Interview with the Maintenance Director, on 03/14/13 at 10:15 AM, revealed it was the maintenance department's responsibility to clean behind the dryers. Further interview revealed, the rear of the dryers were cleaned each Friday on evening shift. Additionally, the Maintenance Director revealed the door should not have been blocked.

Interview with the Administrator, on 03/15/13 at 1:00 PM, revealed it was the responsibility of the laundry staff to clean the laundry facilities and the responsibility of maintenance to clean behind the dryers once each week. Further interview revealed, cleaning the floors of the laundry of facility was part of the cleaning schedule and the House Keeping Supervisor was responsible for ensuring the schedule was followed.

F 465

sinks and tubs, cleaning and sanitizing commodes, spot cleaning walls and/or partitions, checking all corners for cobwebs/debris, and damp mopping floor. No stakeholder member will be allowed to work without being in-serviced.

**Monitoring Changes To Assure Continuing Compliance**

- ◆ ESD and/or POD will review all restricted areas at least weekly to assure all areas are safe, functional, sanitary and comfortable.
- ◆ These audits will continue for a three (3) month period or until substantial compliance has been determined by the PIC. Members of the PIC include, but are not limited to, the Administrator, DON, ADON, QAFIN, SDC, MD, SSD, DM, RD, QoLD, BOM, POD, ESD, and RPD. The results of these audits will be brought to the PIC bi-weekly for the next three (3) months, and then monthly for three months or until substantial compliance has been determined by the PIC.

F 469 483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM

F 469

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F 469 Continued From page 15  
The facility must maintain an effective pest control program so that the facility is free of pests and rodents.

This REQUIREMENT is not met as evidenced by:  
Based on observation, interview, record review and review of the facility's policy it was determined the facility failed to maintain an effective pest control program. Observations, on 03/13/13, revealed cobwebs which contained spiders, insect sacs, and dead insects were present in resident rooms 204, 206 and 208.

The findings include:

Review of the facility's policy titled, "Pest Control" dated 10/31/08, revealed routine inspections would be conducted periodically for evidence of pest. Further review of the policy revealed insect/pest sightings were to be reported to the housekeeping/maintenance supervisor.

Interview with Housekeeping Manager, on 03/13/13 at 3:00 PM, revealed there was no policy or procedure on daily room cleaning. he indicated it was his expectation for housekeeping staff to dust from ceiling to floor, including bathrooms, lights, bed frames, windows, blinds, and bed tables as well as empty the trash.

Review of the contracted pest control company Customer Service Report, dated 02/12/13 (thirty days earlier), revealed structural concerns were noted. Further review of the report revealed problems noted included holes/gaps around

(F465 cont)  
F 469 Date of Completion: 04-29-13

**F 469 Immediate Corrective Action For Residents Found To Be Affected**

- ◆ Resident #15, 8 and 16 received complete skin assessments by Signature Clinical Consultants on 04/01/13 through 04/05/13 with no issues identified.

**Identification of Other Residents With The Potential to be Affected**

- ◆ Signature Care Consultants conducted skin assessments for 100% of the resident population on 04/01/13 through 04/05/13 with no other residents identified.

**Measures Taken To Assure There Will Not Be a Recurrence**

- ◆ Contract Housekeeping Services Company's contract was terminated effective 04/01/2013 with provision

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F 469	<p>Continued From page 16</p> <p>window frames and downspouts as well as gaps under exit doors. Continued review of the report revealed recommendations were made to seal holes to prevent pest entry. Sanitation issues noted on this report included leaves collected around exterior of the building resulting in harborage for insects and mice. Another recommendation was made to keep areas clear to prevent pest attraction.</p> <p>Observation, on 03/13/13 at 3:00 PM, revealed resident room 204 contained a cobweb in the back ceiling corner of the room. This web contained dead insects as well as small brown circular sacs.</p> <p>Observation of room 208, on 03/13/13 at 3:10 PM, revealed a cobweb extending from the front corner of the room above bed A to the center of the room, where it proceeded down the privacy curtain. Throughout the cobweb in room 208 were dead insects as well as small brown circular sacs. Another observation was noted at this time in room 206. Inside room 206, above the sink was a spider web with a moving brown spider present in the web.</p> <p>During a resident group, conducted on 03/13/13 at 10:05, interview with Resident #15 (who resided in room 206) revealed spiders and insects were present in her room. Resident #15 slated she believed the spiders were entering her room through the outside wall around her heating and cooling unit.</p> <p>Interview with Resident #8's family (Resident #8 resided in room 204), on 03/15/13 at 9:45 AM, revealed the family member felt the facility could</p>	F 469	<p>of those services being brought back in-house on same date.</p> <ul style="list-style-type: none"> <li>On 03/18/13 the Housekeeping Supervisor conducted an in-service to housekeeping/laundry stakeholders to include but not limited to; for the proper methods of sanitizing a bathroom, the 7-step daily washroom cleaning, checking of supplies, emptying trash, dust mopping floors, clean and sanitizing sinks and tubs, cleaning and sanitizing commodes, spot cleaning walls and/or partitions, checking all corners for cobwebs/debris, and damp mopping floor. No stakeholder member will be allowed to work without being in-serviced. The facility does not employ agency staff; however, if the facility should employ agency staff, the agency staff will receive the in-service prior to working.</li> <li>On 03/19/13, the Staff Development Coordinator conducted education with facility stakeholders on clean-home like environment, and pest control. Education will be ongoing until all stakeholders have attended.</li> </ul>		

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F 469 Continued From page 17  
be cleaner. Resident #8's family member reported he/she had noticed resident rooms were not cleaned well. The family member also reported he/she had noticed dirt present in the corners of resident rooms.

Interview with Resident #16 who lived in room 208, on 03/15/13 at 9:10 AM, revealed he/she had noticed cobwebs with insects above his/her bed. Resident #16 stated, he/she didn't report this to anyone because he/she feared staff members would get in trouble. Resident #16 reported the ceilings in his/her room were rarely cleaned.

Interview with Pest Control Technician, on 03/15/13 at 1:00 PM, revealed he serviced the facility monthly. The Pest Control Technician reported he noticed the corners of the rooms and areas behind furniture were not cleaned appropriately. Furthermore, he reported when he received specific complaints concerning pest in rooms, he would normally find the rooms were not being cleaned to prevent pest. Also, the Pest Control Technician reported he suggested to the facility to add door sweeps, and other items to help with building structure issues that result in pest control problems. The Pest Control Technician stated he had been contacted by the facility on the date of the interview to service resident rooms related to spider/insect concerns.

Interview with Housekeeper #1, on 03/13/13 at 3:00 PM, revealed all resident rooms were cleaned daily from ceiling to floor. Housekeeper #1 stated the tall duster was to be used daily in resident rooms to knock down cobwebs. Although, Housekeeper #1 was responsible for cleaning the rooms observed to have cobwebs,

F 469 No stakeholder will be permitted to work without being in-serviced.

- On 04/02/13, the QAPIN and DON conducted an in-service with the environmental stakeholders to include but not limited to; audits that would be completed on a daily basis to validate resident rooms and other areas of the facility had been cleaned
- Entire facility was treated by the contracted Pest Control agency on 03/19/13.
- Structural concerns identified by the contract pest control company on 02/12/13 will be corrected on 04/08/13 thru 04/19/13.

**Monitoring Changes To Assure Continuing Compliance**

- Administrator will review contract pest control company report monthly to assure recommendations are implemented.
- The ESD will conduct an audit of

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NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE & REHAB-FOUNTAIN CIRCLE			STREET ADDRESS, CITY, STATE, ZIP CODE 200 GLENWAY ROAD WINCHESTER, KY 40391		
(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 469	<p>Continued From page 18</p> <p>she was unable to explain why this had been missed.</p> <p>Interview with Maintenance Director, on 03/13/13 at 3:05 PM, revealed the cobwebs noted in resident rooms were from a lack of high dusting. He reported it appeared high dusting in resident rooms had not been conducted in a while. He denied having noted issues with pest in resident rooms.</p> <p>Interview with Housekeeping Manager, on 03/13/13 at 3:10 PM, revealed resident rooms were cleaned every day. The Housekeeping Manager reported staff were to enter the room and proceed with cleaning from the ceiling to the floor. He also reported staff were to dust the corners of the room daily and call the pest control company if they see insects. The Housekeeping Manager denied having received recent complaint of pest. The Housekeeping Manger agreed it appeared proper cleaning of resident rooms was not being performed. The Housekeeping Manager stated he would address vertical to floor cleaning in resident rooms with housekeeping staff.</p> <p>Interview with the Administrator, on 03/15/13 at 1:15 PM, revealed the Housekeeping Manager was responsible for maintaining cleanliness of resident rooms. The Administrator revealed her expectation was for all resident rooms to be cleaned every day. The Administrator reported the facility was contracted with a company to provide pest control services monthly and she denied knowledge of any pest control issues or complaints.</p>	F 469	<p>10% of rooms on each unit as well as spot checking of general purpose areas throughout the facility to ensure all are properly sanitized and cleaned appropriately and free on insects. The QAPIN, ADON or UM will oversee the auditing process and validate that rooms are being cleaned properly and pest free.</p> <ul style="list-style-type: none"> <li>◆ These audits will continue for a three (3) month period or until substantial compliance has been determined by the PIC. Members of the PIC include, but are not limited to, the Administrator, DON, ADON, QAPIN, SDC, MD, SSD, DM, RD, QoLD, Business Office Manager (BOM), POD, ESD, and RPD. The results of these audits will be brought to the PIC bi-weekly for the next three (3) months, and then monthly for three months or until substantial compliance has been determined by the PIC.</li> </ul>	04-29-13	

Date of Completion:

04-29-13

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

PRINTED: 03/28/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185146	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING 0101  B. WING _____	(X3) DATE SURVEY COMPLETED  03/13/2013
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NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE & REHAB-FOUNTAIN CIRCLE	STREET ADDRESS, CITY, STATE, ZIP CODE 200 GLENWAY ROAD WINCHESTER, KY 40391
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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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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>Building: 01</p> <p>Plan Approval: 2/23/68</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One Story, Type II (222) Protected with one (1) room basement.</p> <p>SMOKE COMPARTMENTS: Sixteen (16)</p> <p>COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM</p> <p>FULLY SPRINKLERED, SUPERVISED (Wet and Dry SYSTEM)</p> <p>EMERGENCY POWER: Three (3) Type II Natural Gas</p> <p>A life safety code survey was conducted on 03/13/13. The facility was found to be in compliance with Title 42, Code of Federal Regulations, 483.70 (a) ET seq (Life Safety from Fire). The facility is licensed for one hundred seventy-nine (179) beds and the census was one hundred seventeen (117) on the day of the survey.</p>	K 000	<p>RECEIVED</p> <p>APR - 8 2013</p> <p>BY: _____</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE Administration	(X6) DATE 04/07/2013
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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.