

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

PRINTED: 02/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185443	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/29/2015
NAME OF PROVIDER OR SUPPLIER KENSINGTON CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 225 SAINT JOHN ROAD ELIZABETHTOWN, KY 42701	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Kensington Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."	
F 281 SS=D	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interviews, record review, it was determined the facility failed to develop an initial care plan that would address the needs for two (2) of four (4) sampled residents, Resident #1 and #4. The facility failed to provide assistance to residents assistance with bathing and personal hygiene.</p> <p>The findings include:</p> <p>The facility did not provide a specific policy for development of the care plan.</p> <p>1. A closed record review of Resident #1's clinical record revealed the facility admitted the resident on 01/09/15 status post a left shoulder replacement surgery on 01/06/15. The facility assessed the resident to need assistance with bathing, dressing, and personal hygiene.</p> <p>Review of the initial care plan, dated 01/10/15, revealed the facility did not developed a care plan with interventions to assist Resident #1 with bathing, dressing, or personal hygiene.</p>	F 281	<p>F281</p> <p>1. Resident # 1 is longer in the facility. Resident #4 comprehensive care plan was reviewed and updated by Clinical Reimbursement Coordinator on 02/09/15. To reflect current care needs to include bathing, grooming, dressing and personal hygiene.</p> <p>2. All residents of the facility have the potential to be affected. All residents care plans have been reviewed by the Director of Nursing, Assistant Director of Nursing, Unit Managers and the MDS Nurses on or before 02/09/15 To determine care plans were initiated and reflected the current care needs of the residents to include assistance with bathing, grooming, dressing and personal hygiene. No concerns were identified.</p> <p>Re-education will be provided to Nursing Department including the Director of Nursing, Assistant Director of Nursing, Unit Managers and Licensed Nurses by the Nurse Practice Educator on or before 02/23/15. The re-education will include the facility care plan policy. A post-test will be given by the Nurse Practice Educator to determine competency.</p> <p>F281 cont. on next page</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Vicki Bradley* TITLE *Administrator* (X6) DATE *2/20/15*

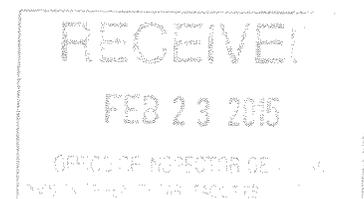
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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.

BTB

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

PRINTED: 02/12/2015
FORM APPROVED
OMB NO. 0938-0391

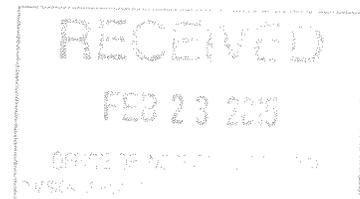
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185443	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/29/2015
NAME OF PROVIDER OR SUPPLIER KENSINGTON CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 225 SAINT JOHN ROAD ELIZABETHTOWN, KY 42701		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 281	Continued From page 1 Review of the Resident Functional Performance Record for Resident #1, for the dates of January 9-14, 2015, revealed the staff documented the resident did not receive a shower or bed bath for the six (6) days the resident was in the facility. Refer to F-312. 2. Review of Resident #4's care plan, dated 01/10/15, revealed the facility did not developed a care plan with interventions to assist Resident #1 with bathing, dressing, or personal hygiene. Review of the Resident's Function Performance Record, from January 10-29, 2015, revealed the resident did not receive a shower/bath for the first five (5) days after admission. Interview with Nurse Aide #1, on 01/29/15 at 3:25 PM, revealed she had showered the resident yesterday in the bathroom located in the resident's room. She did not know about the other days the resident didn't get a shower. Interview with the Rehab Unit Manager, on 01/29/15 at 5:50 PM, revealed the staff nurse who admitted the resident should have developed the initial care plan. She stated she was new to this position and had not provided oversight to ensure the initial care plans were completed.	F 281	F281 cont. from previous page The Director of Nursing, Assistant Director of Nursing, MDS Nurses, Unit Managers or charge nurse will review new admissions and readmissions for the initiation of the care plan to address assistance with bathing, grooming, dressing, and personal hygiene daily times 4 weeks, then weekly times 4 weeks then bi-weekly for 8 weeks, then monthly for 3 months then as determined by the monthly Performance Improvement Committee with corrective action provided upon discovery. 4. The Director of Nursing or Assistant Director of Nursing will submit a summary of the findings to the Performance Improvement Committee consisting of the Administrator, Medical Director, Director of Nursing, Assistant Director of Nursing, Social Service Director, Clinical Reimbursement Manager, Admissions Director, Business Office Manager, Human Resource Assistant, Health Information Manager, Dietary Manager, Maintenance Director, and Recreation Director, monthly x 6 months for further review and recommendations.	02/24/15	
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	F 312	F 312 1. Resident #1 is no longer in the facility. Resident #4 ADLs were re-assessed, care plan and Kardex was updated by Director of Nursing on 01/30/15 to resident' current status to include assistance needed to maintain good nutrition, bathing, grooming, dressing and personal hygiene. F 312 continued on next page		



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

PRINTED: 02/12/2015
FORM APPROVED
OMB NO. 0938-0391

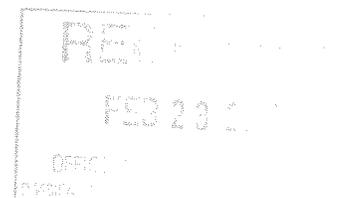
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185443	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/29/2015
NAME OF PROVIDER OR SUPPLIER KENSINGTON CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 225 SAINT JOHN ROAD ELIZABETHTOWN, KY 42701		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 312	<p>Continued From page 2</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review and review of the facility policies, it was determined the facility failed to ensure two (2) of four (4) sampled residents received assistance with showers/baths as requested. The facility assessed Resident #1 and #4 to need assistance with ADLs; however, the residents did not receive their scheduled showers.</p> <p>The findings include:</p> <p>Review of the facility's ADL Policy, revision date of 10/01/10, revealed a licensed nurse would evaluate each resident's ADL function upon admission and with significant changes. A program of assistance and instructions would be implemented as appropriate. Showers, bed bath, grooming and dressing would be included. The purpose would be to maintain the resident's functional level and dignity.</p> <p>Review of the facility's ADL: Shower Policy, effective date of 12/01/06, revealed a shower was provided for residents who wished to participate. A shower was given according to a pre-determined schedule and as needed or requested. The purpose of the policy was to provide/assist residents with routine hygiene. The policy detailed the shower procedure and instructed the staff to document the shower.</p> <p>Review of the facility's Grievance/Concern Policy, effective date of 03/01/02, revealed all residents and/or responsible parties may voice grievances/concerns and recommend changes</p>	F 312	<p>F 312 cont. from previous page</p> <p>2. All residents of the facility have the potential to be affected. Residents assessed to be dependent with Activities of daily living have been reviewed by the Director of Nursing, Assistant Director of Nursing, Unit Managers, MDS Nurses and Charges Nurses 01/30/15 to determine residents Care Plan and Kardex reflect assistance needed with nutrition, grooming and personal and oral hygiene. Areas of concern were corrected when identified. Resident Functional Performance Records were reviewed at this time to determine if residents had received showers and assistance provided based on care needs. Concerns were corrected when identified. Review of grievance and complaint log by the Administrator on 01/30/15 with no corrective action required.</p> <p>3. The Facility Administrator and Nursing Department consisting of the Director of Nursing, Assistant Director of Nursing, Unit Managers, MDS Nurses, Licensed Nurse and Nursing Assistants received re-education conducted by the Nurse Practice Educator on or before 02/23/15 regarding Activities of Daily Living for Dependent residents, Care Plan development, Kardex and completion of documentation and follow up on the Resident Functional Performance Record to include observation and provision of assistance including documentation of bathing and grooming. Reporting of Grievances/Concern Policy will be reviewed at this time. A Post-Test will be administered following the re-education by the Nurse Practice Educator to determine competency.</p> <p>The Director of Nursing, Assistant Director of Nursing, or Unit Managers will audit 5 residents Care Plans, Kardex and Resident Functional Performance Record including observation and provision of assistance 5 times a week for 4 weeks, 3 times a week for 8 weeks, bi-weekly for 8 weeks, 1 time a week for 8 weeks then monthly for 3 months to determine ADL care is provided to Dependent Residents.</p> <p>F 312 continued on next page</p>		



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

PRINTED: 02/12/2015
FORM APPROVED
OMB NO. 0938-0391

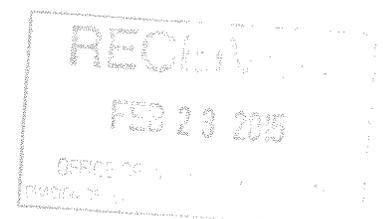
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185443	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/29/2015
NAME OF PROVIDER OR SUPPLIER KENSINGTON CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 225 SAINT JOHN ROAD ELIZABETHTOWN, KY 42701		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 312	<p>Continued From page 3</p> <p>through an orderly and timely process. A concern is defined as a formal expression of concern regarding the well being of a customer. The policy defined the purpose was to inform staff of potential or existing problem areas, so corrective action may be taken immediately.</p> <p>1. A closed record review of Resident #1's clinical record revealed the facility admitted the resident on 01/09/15 for rehab services. The resident had a left shoulder replacement surgery on 01/06/15 and required after care with therapy services. Review of the physician's narrative History and Physical, dated 01/09/15, revealed the physician documented the resident would require assistance with bathing and dressing and was dependent for ambulation. The physician ordered non-weight bearing to the left upper extremity and the resident was to wear a sling to the left shoulder at all times for four (4) to six (6) weeks. Review of the nursing admission assessment, dated 01/09/15, revealed the nurse assessed the resident to require assistance with mobility and had functional limitation in range of motion to the upper left extremity.</p> <p>Review of a Prospective Payment System (PPS) assessment, dated 01/14/15, revealed the facility assessed the resident to be cognitively intact with a Brief Interview for Mental Status (BIMS) score of fifteen (15) out of a possible fifteen (15). The facility assessed the resident to exhibit no behaviors. The facility assessed the resident to require extensive assistance with transfers, ambulation, toilet use, personal hygiene, and dressing. The facility coded the section for bathing as the activity did not occur with no support provided.</p>	F 312	<p>F 312 cont. from previous page</p> <p>3. continued... Any areas of concern will be corrected when identified. Grievance and complaint log will be reviewed Monday to Friday for concern addressing ADLS by the Social Services Director, Director of Nurses or Administrator with corrective action if indicated.</p> <p>4. The Director of Nursing or the Assistant Director of Nursing will submit a summary of findings to the Performance Improvement Committee consisting of the Administrator, Medical Director, Director of Nursing, Assistant Director of Nursing, Social Service Director, Clinical Reimbursement Manager, Admissions Director, Business Office Manager, Human Resource Assistant, Health Information Manager, Dietary Manager, Maintenance Director, and Recreation Director, monthly x 6 months for further review and recommendations</p>	02/24/15	



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

PRINTED: 02/12/2015
FORM APPROVED
OMB NO. 0938-0391

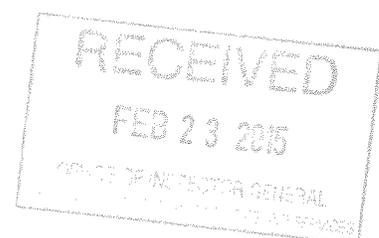
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185443	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/29/2015
NAME OF PROVIDER OR SUPPLIER KENSINGTON CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 225 SAINT JOHN ROAD ELIZABETHTOWN, KY 42701		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 312	<p>Continued From page 4</p> <p>Review of the initial care plan, dated 01/10/15, revealed the facility did not developed a care plan with interventions to assist Resident #1 with bathing, dressing, and personal hygiene. Review of the nurses' note, dated 01/14/15 at 11:15 AM, revealed Resident #1 was discharged to home.</p> <p>Review of the resident's Functional Performance Record, for the dates of 01/09/15 through 01/14/15, revealed the staff documented the resident did not receive a shower or bed bath for the six (6) days the resident was in the facility.</p> <p>Interview with the Administrator, on 01/29/15 at 4:46 PM, revealed she had received two (2) complaints regarding residents not getting a shower/bath. The Administrator said she was unaware of the problem with Resident #1. She could not recall if any staff had told her of a concern voiced by Resident #1's family. She stated a stand up meeting was held every morning, Monday-Friday. She indicated she would ask staff at the meeting if any concerns or grievance had been received from residents or families. She stated she would document in the computer and conduct a grievance investigation if anything had been brought to her attention. She reviewed the computer program and said there were no notes indicating the concern regarding Resident #1 had been brought to her attention. She didn't find anything documented about the resident's concerns. She stated all residents are scheduled to receive two (2) showers per week, but could have a shower/bath upon request. The Administrator stated the staff was supposed to document completion of a shower/bath on the performance log and if not documented, it would indicate the resident did not receive a shower/bath.</p>	F 312			



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

PRINTED: 02/12/2015
FORM APPROVED
OMB NO. 0938-0391

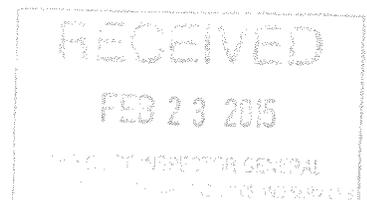
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185443	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/29/2015
NAME OF PROVIDER OR SUPPLIER KENSINGTON CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 225 SAINT JOHN ROAD ELIZABETHTOWN, KY 42701		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 312	Continued From page 5 A telephone interview with Resident#1, on 01/29/15 at 5:12 PM, revealed the resident had a "horrible stay" at the facility and went home prematurely because of his/her stay. The resident stated he/she was never offered a bath or shower the entire six (6) days the resident was there. The resident continued to state a family member had to come to the facility to give the resident a partial shower. The resident stated the facility staff never offered to bathe him/her and oral care was not provided. The resident stated the resident's bed had not been changed for the length of the resident's stay at the facility. The resident stated he/she had requested the bed linens to be changed but the staff only straighten the sheets and did not change them for the six days the resident was at the facility. The resident said he/she told the staff about not getting a bath and informed a family member who then complained to someone in the facility. The resident revealed there were no changes made and staff did not offer to assist him/her with bathing after the family member had spoken with facility staff. A post survey telephone interview with a family member, on 01/29/15 at 7:09 PM, revealed they had not visited Resident #1 onsite, but had called the family member several times during the resident's stay at the facility. The family member said they called the resident frequently and the resident would complain that they were not offered assistance with bathing. The family member said the resident told them that he/she had spoken with the Administrator and named them by name. The resident told the family member nothing changed after the meeting and the resident still was not offered assistance with bathing.	F 312			



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

PRINTED: 02/12/2015
FORM APPROVED
OMB NO. 0938-0391

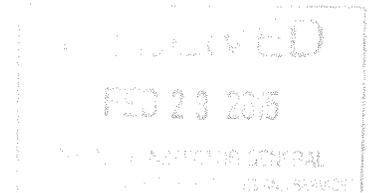
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185443	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/29/2015
NAME OF PROVIDER OR SUPPLIER KENSINGTON CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 225 SAINT JOHN ROAD ELIZABETHTOWN, KY 42701	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	<p>Continued From page 6</p> <p>2. Observation of Resident #4, on 01/29/15 at 3:20 PM, revealed the resident laying in bed awake, dressed in a clean hospital gown with no odors noted. Interview with the resident revealed the resident could only answer direct yes/no questions by shaking his/her head. The resident indicated there was a problem with receiving showers/baths. The resident's hair and nails appeared to be clean.</p> <p>Interview with the Administrator, on 01/29/15 at 4:46 PM, revealed she received a concern from Resident #4 on 01/28/15 regarding not getting showers, body odor, and hair dirty. She stated she spoke with the resident and validated the resident's concerns. She said the Beautician washed the resident's hair today, 01/29/15, and the resident received a shower. The Administrator stated once the problem was brought to her attention, she implemented action plans.</p> <p>Review of Resident #4's clinical record revealed the facility admitted the resident on 01/10/15 status post a Cerebrovascular Accident (CVA). Review of the Admission Minimum Data Set (MDS) dated 01/17/15, revealed the facility assessed the resident to have a BIMS score of two (2); however, the resident was mostly Aphasic and unable to answer those questions. The facility assessed the resident to require extensive assistance from staff for mobility, dressing, personal hygiene, and bathing. The facility assessed the resident to always be incontinent of bowel and bladder. Review of the care plan, dated 01/10/15, revealed no care plan was developed that indicated the staff would provide necessary services to assist the resident to maintain good hygiene. Review of the Resident</p>	F 312		



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

PRINTED: 02/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185443	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/29/2015
NAME OF PROVIDER OR SUPPLIER KENSINGTON CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 225 SAINT JOHN ROAD ELIZABETHTOWN, KY 42701		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 312	Continued From page 7 Function Performance Record revealed the resident did not receive a shower/bath for five (5) days from 01/10/15 through 01/15/15. Additional interview with the Administrator, on 01/29/14 at 5:39 PM, with the Director of Nursing (DON, and Assistant Director of Nursing (ADON) in attendance, revealed the ADON was responsible for oversight of the shower documentation. The Unit Managers and Charge Nurses provided supervision of the nurse aides to ensure tasks are completed. However, neither the ADON nor the Unit Managers had reviewed the shower/bath documentation to ensure showers were being given as scheduled.	F 312			
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, it was	F 514	F514 1. Resident #2, #3, and #4 Kardex were reviewed and update by the Director of Nursing, Assistant Director of Nursing or the Unit Managers and 01/30/15 to reflect current care needs. 2. All residents of the facility have the potential to be affected. The Director of Nursing Assistant Director of Nursing or Unit Managers reviewed all other residents'Kardex to determine if complete and reflective of current care needs of the residents on 01/30/15. No other areas of concern were identified. 3. The Unit Managers and Licensed Nurses were re-educated to the facility policy for completion and updating resident Kardex on or before 02/23/15 by the Director of Nursing and or the Nurse Practice Educator. A post- test was given by the Director of Nursing and or Nurse Practice Educator on or before 02/23/15 to determine competency F 514 continued on next page		



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

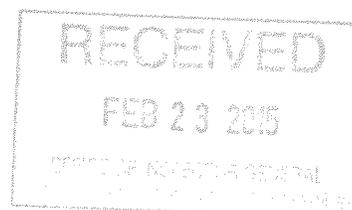
PRINTED: 02/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185443	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/29/2015
NAME OF PROVIDER OR SUPPLIER KENSINGTON CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 225 SAINT JOHN ROAD ELIZABETHTOWN, KY 42701		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 514	<p>Continued From page 8</p> <p>determined the facility failed to ensure the clinical records were complete and accurate to reflect the resident's functional status for three (3) of four (4) sampled residents. Residents # 2, #3, and #4. The facility failed to complete the Kardex report for these residents that would provide instructions to the direct care staff on how to care for each resident.</p> <p>The findings include:</p> <p>The facility did not provide a specific policy regarding completion of the clinical record.</p> <p>1. Review of Resident #2's clinical record revealed the facility admitted the resident on 01/08/15 for rehab services after a total knee replacement to the right knee. Review of the Admission Minimum Data Set (MDS), dated 01/15/15, revealed the resident required assistance with mobility, dressing, personal hygiene, toilet use, and bathing. The facility assessed the resident to be frequently incontinent of bladder and occasionally incontinent of bowel. The facility assessed the resident to have pain and required pain medication.</p> <p>Review of the MDS Kardex, utilized by the direct care staff to care for each resident, revealed the January 2015 Kardex for Resident #2 had not been completed with instructions to the direct care staff on the resident's cognition, vision, fall risk, communication, mobility function, Activities of Daily Living (ADL), Bowel and Bladder function, skin, oral/nutrition or physical restraints. The whole report was blank except for the resident's name.</p> <p>2. Review of Resident #3's clinical record</p>	F 514	<p>F 514 continued from previous page</p> <p>3. continued. The Director of Nursing, Assist Director of Nursing or Unit Managers will audit 10 resident Kardex 5 times weekly for 3 months, bi-weekly times 1 month, and then monthly times 2 months to determine the Kardex is complete and reflective of resident care needs. Areas of concern will be corrected when identified.</p> <p>4. The Director of Nursing or the Assistant Director of Nursing will submit a summary of findings to the Performance Improvement Committee consisting of the Administrator, Medical Director, Director of Nursing, Assistant Director of Nursing, Social Service Director, Clinical Reimbursement Manager, Admissions Director, Business Office Manager, Human Resource Assistant, Health Information Manager, Dietary Manager, Maintenance Director, and Recreation Director, monthly x 6 months for further review and recommendations.</p>	02/24/15	

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

PRINTED: 02/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185443	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/29/2015
NAME OF PROVIDER OR SUPPLIER KENSINGTON CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 225 SAINT JOHN ROAD ELIZABETHTOWN, KY 42701		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 514	<p>Continued From page 9</p> <p>revealed the facility admitted the resident on 01/08/15 with diagnoses of Respiratory Failure, Hepatic Encephalopathy, Cirrhosis, Alcohol Abuse, and Urinary Tract Infection. Review of the admission MDS assessment, dated 01/15/15, revealed the facility assessed the resident to need assistance with bed mobility, transfers, locomotion, dressing, hygiene, toilet use, and bathing. The facility assessed the resident to be frequently incontinent of bowel and bladder. The facility assessed the resident to have pain and the resident had a history of falling.</p> <p>Review of the January MDS Kardex for Resident #3 revealed the Kardex was not completed and provided no instructions to the direct care staff on how to care for the resident. The whole report was blank except for the resident's name.</p> <p>3. Review of Resident #4's clinical record revealed the facility admitted the resident on 01/10/15 for after care of a Cerebrovascular Accident (CVA). Review of the admission MDS, dated 01/17/15, revealed the resident required extensive assistance with bed mobility, transfers, dressing, personal hygiene, toilet use, and bathing. The facility assessed the resident to be frequently incontinent of bowel and bladder The facility assessed the resident to have pain and was placed on pain management.</p> <p>Review of the January MDS Kardex for Resident #4 revealed the Kardex was not completed and provided no instructions to the direct care staff on how to care for the resident except to brush teeth in the morning and night. The rest of the form was blank.</p> <p>Interview with the Director of Nursing (DON), on</p>	F 514			



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

PRINTED: 02/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185443	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/29/2015
NAME OF PROVIDER OR SUPPLIER KENSINGTON CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 225 SAINT JOHN ROAD ELIZABETHTOWN, KY 42701		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 514	Continued From page 10 01/29/15 at 5:39 PM, revealed the paper MDS Kardex was included in the admission packet for the nurse to fill out. She stated the nurse who admitted the resident was supposed to complete the Kardex when the nursing assessment was completed. The nurse should check all items that would apply to the resident. The computer generated MDS Kardex was completed with the admission MDS assessment and it should be checked for all areas that applied to the resident. The DON stated the Unit Managers were responsible for ensuring the Kardexs were completed. The monthly Kardex forms were checked during change over night and should be revised with each resident's change in status to accurately reflect the resident's functional status. Interview with the Unit Manager for the Rehab Unit, on 01/29/15 at 5:50 PM, revealed the nurses have been told that they are responsible for completing the paper Kardex with information about the resident when they conduct the admission nursing assessment. She stated she had checked for completion on a random basis, but would need to check daily to ensure the Kardexs were completed. She stated the Kardex was important because it provided specific information about each resident's care needs.	F 514			

