

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

PRINTED: 05/14/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185443</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>05/09/2013</b>
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NAME OF PROVIDER OR SUPPLIER  <b>KENSINGTON CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>225 SAINT JOHN ROAD ELIZABETHTOWN, KY 42701</b>
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F 000	INITIAL COMMENTS  An abbreviated survey was initiated on 05/08/13 and concluded on 05/09/13 to investigate KY20107 and KY20143. The Division of Health Care found the allegation for KY20107 to be substantiated with deficiencies cited. KY20143 was found to be unsubstantiated with no regulatory violations.	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 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES  The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.  This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's abuse policy, it was determined the facility failed to implement the policy for prevention of misappropriation of resident property for one (1) of three (3) sampled residents. A nurse failed to inform the Administrator and initiate an investigation when Resident #1 informed the nurse his/her I-phone was missing. The investigation was not initiated until six (6) hours later when the resident again reported the phone was missing to another staff member.  The findings include:  Review of the facility's abuse policy, revised	F 226	F 226  Resident #1 no longer resides at the center as of 5/6/2013. The center has offered reimbursement to Resident #1 for the expenses related to replacing the missing phone by the Administrator on 5/17/13. Licensed Practical Nurse #1 was re-educated on abuse policy-reporting immediately to Administrator/Director of Nursing/ Assistant Director Of Nursing Services or Nurse Supervisor on 9 May 2013 by the Director of Nursing.  The Administrator and Social Worker reviewed resident council minutes and grievances for the past three months to determine that there had been no additional concerns related to not reporting timely. There were no such additional concerns identified.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *X Magpie Thomas* TITLE: *X Admin* (X6) DATE: *5/27/13*

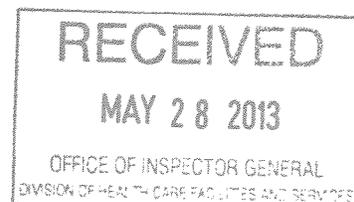
Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that the safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable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

MAY 28 2013  
Office of Inspector General  
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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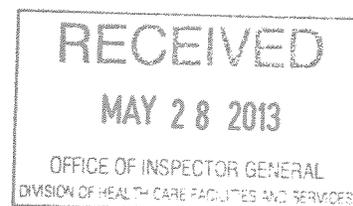
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F 226	<p>Continued From page 1</p> <p>January 2008, revealed the facility utilized the federal requirements under 42 CRF 483.13 to ensure all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property is reported immediately to the administrator of the center and to other officials, in accordance with state law. The policy specific to misappropriation of resident property included taking items from a resident. In addition, the policy instructed all employees of the center to report any known or suspected abuse, neglect, or misappropriation of resident property, immediately. According to the policy, this was a mandatory requirement for all employees of the center.</p> <p>Review of the facility's summary of investigation, provided to the State Survey Agency on 04/29/13, revealed the facility's investigation was initiated on 4/25/13 and concluded on 04/29/13. The facility's investigation stated the resident reported the cell phone missing at approximately 9:30 PM on 04/24/13 and interviews with staff revealed the resident's cell phone was last seen on 04/23/13. The police had been called and the resident's room, laundry, and trash had been searched without success.</p> <p>Review of the facility staff's written statements revealed LPN (License Practical Nurse) #1 had written, on 04/25/13 at 10:30 AM, she had been in Resident #1's room multiple times on 04/24/13. She wrote at approximately 3:30 PM, the resident activated the call light and she answered the call light. The resident asked the nurse if she saw his/her cell phone laying around anywhere. The nurse indicated she had searched the resident's</p>	F 226	<p>F 226 Continued</p> <p>Center staff, nursing and non-nursing were re-educated on center's abuse policy by the Administrator, Director of Nursing, Assistant Director of Nursing, and Supervisors regarding reporting immediately to the Administrator, Director of Nursing, Assistant Director of Nursing or Nurse Supervisor as of 5/23/2013.</p> <p>The Administrator and the Director of Nursing Services will document random interviews with staff regarding the abuse policy related to timely reporting allegations of abuse, including misappropriation, to the Administrator, Director of Nursing, Assistant Director of Nursing Services immediately to validate compliance, of at least five employees weekly for 12 weeks. Any concerns will be addressed when identified. A summary of this will be submitted by the Administrator and discussed by the Performance Improvement Committee monthly for further review and recommendations.</p> <p>5. Date of compliance: <b>5/24/2013</b></p> <p>Performance Improvement Committee Members: Administrator, Director of Nursing Services, Assistant Director of Nursing, Admissions Director, Social Services Director, Business Office Manager, Activity Director, Maintenance Director, Housekeeping Supervisor, Director of Nutritional Services, MDS Coordinator and Medical Records.</p>		



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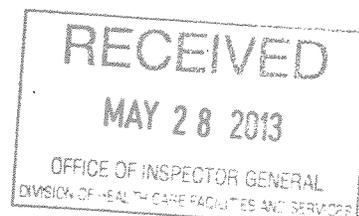
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F 226	<p>Continued From page 2</p> <p>bed, under the bed, and recliner and did not find the cell phone. The nurse's statement identified the nurse called the resident's cell phone number, but it went to voice mail.</p> <p>Interview with LPN #1, on 05/09/13 at 11:35 AM, revealed on 04/24/13, the resident had activated the call light and when she went in the room to answer the light, the resident requested to be assisted to the bathroom. At that time, the resident asked the nurse if she saw the cell phone in the room. The resident was sitting in a recliner, the nurse assisted the resident from the chair and searched the recliner for the cell phone without success. The nurse assisted the resident to the bathroom. While the resident was in the bathroom, with the resident's permission, LPN #1 stated she searched the recliner, bed, floor, night stand, bed side table, closet, and trash. The cell phone was not found.</p> <p>She attempted to call the resident's cell phone number, but it went straight to voice mail. The nurse stated the resident told her maybe his/her sister took the cell phone home with her last night. LPN #1 stated she did not call the sister to confirm if she had the phone as the sister always visits in the evenings. The nurse stated she did not tell the Director of Nursing (DON) nor the Administrator about the missing cell phone. The nurse stated she did not report because she thought maybe the resident's sister had taken the cell phone home with her to recharge the phone, as she routinely did. However, she again confirmed she did not call the sister to ask if she had the cell phone. When the nurse came back to work the next day and heard in report that the cell phone was still missing, she knew she should</p>	F 226			



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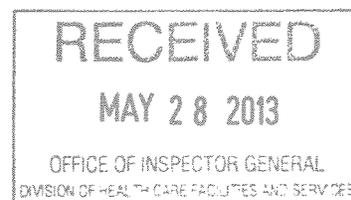
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F 226	Continued From page 3 have reported.  Interview with Resident #1, on 05/08/13 at 5:00 PM via telephone, revealed the cell phone was an I-phone #5 and it had never been found. The resident revealed a new cell phone had to be purchased. The resident stated on 04/24/13, he/she had gotten up to go to the bathroom, with the assistance of a nurse and a certified nursing assistant (CNA). The staff left and gave the resident privacy. While the resident was in the bathroom, he/she heard someone come into the room. The resident did not see the person, only heard them. When the resident had finished using the bathroom, staff assisted him/her back to the bed. She stated the cell phone was on the bedside table by his/her bed earlier that day.  When he/she came out of the bathroom, the phone was gone. She told the nurse it was missing and she searched the room including the bed, chair, bed side table, and closets. The cell phone was not found. The nurse then, called the resident's cell phone number, but it went to voice mail. The resident stated it was as if the phone was turned off. The resident also made the statement that maybe his/her sister had taken the cell phone home to be recharged. The resident stated he/she did not think anymore about the missing cell phone because at that time, he/she thought maybe the sister had the phone. Later that evening, the resident reported to a nurse that the cell phone was still missing. The nurse called the sister and the sister denied having the phone. The room was searched again, but the cell phone was not found. The resident stated the last time he/she recalled seeing the cell phone was that morning.	F 226			



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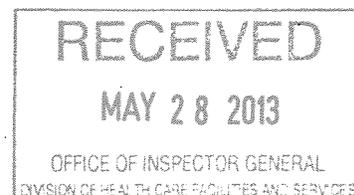
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F 226	Continued From page 4  Record review revealed the facility admitted Resident #1, on 04/19/13, for aftercare of a hip fracture. The facility assessed the resident to have no cognition deficit with a Brief Interview for Mental Status (BIMS) score of 13 out of 15.  Review of CNA #1's written statement, dated 04/25/13 at 8:55 AM, revealed the CNA assisted Resident #1 with a coffee spill during breakfast on 04/24/13. The CNA wrote she did see the I-phone on the bedside table. The resident had visitors, a man and a women. She later assisted LPN #1 with taking the resident to the bathroom. She wrote she did not remember seeing the cell phone anymore.  Interview with CNA #1, on 05/09/13 at 11:20 AM, revealed she was working on 04/24/13. She answered Resident #1's call light during the breakfast meal and found the resident had spilled his/her coffee. While she was cleaning the coffee spill, she saw the I-phone sitting on top of the bedside table. At approximately 10:30-11:00 AM, the resident request to be assisted to the bathroom. She did not notice if the cell phone was still on the bedside table.  Interview with the Administrator and DON, on 05/08/13 at 5:30 PM and 05/09/13 at 9:30 AM, revealed they were informed of the incident on 04/25/13. The Administrator stated they interviewed staff working on the date of 04/24/13 and called the Police. They were told the resident did not mention the cell phone missing until the evening of 04/24/13 (9:30 PM) and the resident told the staff the sister probably had the cell phone. The nurse (LPN#1) did not report the	F 226			



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F 226	<p>Continued From page 5</p> <p>incident because she didn't think it was an issue because the resident didn't appear to be upset and they thought the sister had the cell phone.</p> <p>The evening nurse (LPN #2) spoke with the resident and called the sister who said she did not have the resident's cell phone. The Administrator revealed the sister routinely took the resident's cell phone home to recharge. The administrator reviewed the inventory form that was completed upon admission of Resident #1 and found a cell phone was not listed. She stated the family must have brought the cell phone in later.</p> <p>The DON revealed the facility had not been concerned the phone was missing when LPN #1 talked to the resident because the resident told the nurse the sister probably had the cell phone. However, the facility did not call the sister and ask her if she had the phone until Resident #1 reported the cell phone missing the second time, six (6) hours after the resident first reported the phone missing. The Administrator stated the nurse should have reported the resident's cell phone was missing after a search of the resident's room did not recover the phone. She stated it was facility policy to report all allegations of misappropriation of resident property with prompt investigating and reporting to state agencies.</p> <p>The DON revealed LPN #1 had only worked at the facility since March 2013 and did receive training on the abuse policy and procedures on March 20, 2013. The Administrator provided evidence facility staff received training on abuse to include misappropriation of resident property</p>	F 226		



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F 226	Continued From page 6 January through March 2013.	F 226			

