#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

Findings include:

minds according CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO DADA-0001 STATEMENT OF DEFICIENCIES LIZZE PRIMATERISHES TERRITO g own E Sciences AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. DUM DINGS O MANAGO 195120 06/20/2013 NAME OF PROVIDER UR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3740 OLD HARTFORD RD KINDRED TRANSITIONAL CARE AND REHABILITATION - HIL OWENSBORO, KY 42303 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (YA) ID COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CHOSS REFERENCED TO THE APPROPRIATE UNIC TAG TAG CEPTOTENOM This Plan of Correction is the center's credible F 000 allegation of compliance. F 000 | INITIAL COMMENTS Preparation and/or execution of this plan of correction A recertification survey was conducted on does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions 06/18/13 through 06/20/13 to determine the set forth in the statement of deficiencies. The plan of facility's compliance with Federal requirements. correction is prepared and/or executed solely because The facility failed to meet the minimum it is required by the provisions of federal and state law. requirements for recertification with the highest scope and severity of an "D". 483.15(e)(1) REASONABLE ACCOMMODATION F 246 | F246 - Reasonable accommodation of 8/2/13 OF NEEDS/PREFERENCES SS=D needs/preferences A resident has the right to reside and receive 1. Corrective action for those residents found services in the facility with reasonable to have been affected: accommodations of individual needs and preferences, except when the health or safety of Residents #13, 26 and 27 received another the individual or other residents would be bed bath on 6/20/13 with an acceptable endangered. water temp. 2. Corrective action for those with potential to be affected: All residents have potential to be affected. Mixing valve was immediately dialed up to ensure a higher amount of hot water came This REQUIREMENT is not met as evidenced through the pipes. ph. Based on observation, interview, and review of 3. Systemic changes to ensure the deficient the facility's policy/procedure; it was determined the facility falled to ensure each resident received practice will not recur: reasonable accommodation of needs for one (1) resident (#13), in the selected sample of Nursing staff will be educated by the Staff twenty-four (24) residents and two (2) residents Development RN or Director of Nursing on (#26 and #27), not in the selected sample. The policy and procedure 65001on bathing and facility falled to provide bathing water at the showers and water temps between 105-110 appropriate temperature for one bed bath for degrees. The education will include staff Resident #13 and showers for Residents #26 and letting the water run to warm up prior to #27.

Any deficiency statement egding with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other sateguards provide springent protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days folioring the date of survey whether or not a plan of conscion is provided. For nothing fromes, the above findings and plans of conscions are discussible in the provided of the conscions of the conscions is required to the conscional in regulated to the conscional of the conscional in regulated to the conscional of t program padicinative

UNTED: 07/05/2013

	TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	} ' '		LE CONSTRUCTION		E SURVEY MPLETED
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<b>i</b>	ROMBER OR SUPPLIER D'TRANSITIONAL CAI	RE AND REHABILITATION - HIL		3	REET ADDRESS, CITY, STATE, ZIP CODE 1740 OLD HARTFORD RD DWENSBORO, KY 42303	•	
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	revealed basin with Fahrenheit (F.).  A review of the facilit revealed to adjust to adjust to adjust to a second to a second the second throughout the bathing temperature of the will be a second throughout the bathing pulled away and exhibited the bed be seen and the bed between all the shower resident shower down water and "even if the doesn't get warm end time.	ty Bed Bath policy/procedure water at 105-110 degrees  ty Shower policy/procedure emperature of water to 105  esident #13's bed bath, on it, revealed Resident #13 had al expressions of discomforting process related to the vater in the basin being cold, y stated the water was cold, libited gooseflesh on arms rocess. The State Registered in failed to change the basin occuptable temperature and aith until completion.  sident #13, on 06/19/13 at the basin water was cold ath. He/she stated the rater for his/her bed bath was	F	246	filing the basin or showering resident. Also, what to do if the residents compthe water temp. Any nursing staff that not received the education prior to 8/2 will be removed from the schedule an allowed to work until the education haprovided.  Social workers/Program Director will interview 2 residents a week on each 1 ensure residents are not uncomfortable water temps for the next three months residents will be asked about water tenduring the monthly resident council m for the next three months.  Maintenance director will check mixing valve daily (Monday- Friday) to ensure temps leaving water heater to resident is maintained at 110 degrees.  Maintenance director will log water to two rooms per unit weekly for resident two rooms per unit weekly for resident to ensure solutions are sustained:  The results of the resident interviews a water temps checked by maintenance water temps checked on the monthly PI meeting for three months or until compliance is achieved.	plain of thave 2/13 d not as been mall to e with and mps eeting floors mance mance will be	
	Maintenance Directo	r, revealed twenty (20) is (live (5) showers and					

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	/X2) MULTI A BURDIN		(X3) DATE SURVEY COMPLETED
٠		185120	n WING_		06/20/2013
	ROVIDER OR SUPPLIER D TRANSITIONAL CA	RE AND REHABILITATION - HIL	s	TREET ADDRESS, CITY, STATE, ZIP CODE 3740 OLD HARTFORD RD OWENSBORO, KY 42303	
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∺ 280 SS=D	twenty (20) areas rebelow 100 degrees blending.  An interview with SI PM, revealed the hour, especially in the haven't used it all ni and let it run for about sometimes.  An interview with SI PM, revealed she with the would test or eibow to make so she would throw it owater run for a while An interview with SI PM, revealed she to bath or shower. The the water run a minimater can be added 483.20(d)(3), 483.10 PARTICIPATE PLAIT The resident or othe incapacitated under	rooms)and ten (10) of the evealed water temperatures at the hot setting wilhout cold.  RNA #11. on 06/19/13 at 1:30 of water takes a while to warm a morning after the staff light, so staff have to turn it on but 5 minutes to get it warm.  RNA #2, on 06/20/13 at 3:00 evold ensure the water ed bath just like she would for the temperature on the wrist are it was warm enough. The water was not warm enough out and start over and let the eautility it got warm.  RNA #5, on 06/20/13 at 3:06 est the water before starting a ear. SRNA stated she has to let to warm it up.  D(k)(2) RIGHT TO NNING CARE-REVISE CP eright, unless adjudged erwise found to be the laws of the State, to ng care and treatment or	F 24	F280 — Right to participate Planning C Revise CP  1. Corrective action for those residents to have been affected:  Resident #8's care plan was immediate reviewed by the Interdisciplinary Team	found
Í		re plan must be developed   ne completion of the		updated on 6/20/13 to reflect that there no longer a need for a bed sensor alarm	was

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185120	B WING	3		06/	20/2013
	ROVIDER OR SUPPLIER D TRANSITIONAL CA	RE AND REHABILITATION - HIL		:	REET ADDRESS, CITY, STATE, ZIP CODE 3740 OLD HARTFORD RD OWENSBORO, KY 42303		
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F 260	Interdisciplinary tea physician, a registe- for the resident, and disciplines as deter and, to the extent p the resident, the resident ine resident.	ye 3 essment; orepared by an m, that includes the attending red nurse with resoonsibility t other appropriate staff in mined by the resident's needs, or recticable, the participation of sident's family or the resident's to can periodically reviewed am of qualified persons after		280	2. Corrective action for those with poto be affected:  House wide audit was conducted by not management on residents that were readmitted within the last three month ensure physician orders, care plans and SRNA assignment sheets were correct will be completed before July 26. Any concerns will be corrected at that time.  3. Systemic changes to ensure the deficient of the street will not recur:	ursing s to d . Audit	
	by: Based on observation and review of the facility comprehensive care revised for one residuance of twenty-for Findings include.  A review of the facility policy/procedure, date team of qualified percondition and effect interventions and reannually, with a sign or more frequently a patient and/or the repossible.	ly's Care Plans led 01/07/12, revealed the rsons monitored the patients' veness of the care plan vlsed the care plan quarterly, ificant change assessment, s needed with the input of the presentative, to the extent			MDS nurses will close the care plan where they are completing the discharge assessment. When a resident is re-admitted interdisciplinary Team will open the plan and update as needed based on the orders and resident assessments.  4. How the facility will monitor perform to ensure solutions are sustained:  MDS nurses will maintain a log with discharged and re-admitted residents will be turned in to the DNS/ADNS were this information will be tracked and truly the DNS to identify any further educations needed. Results will be present to the PI Meeting monthly for three months or longer until compliance is sustained.	itted   e care   mD   mance   hich   ekly.   ended   eation   ented   onths	
l İ	Record review revea	oled Resident #8 was					1

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI		LE CONSTRUCTION		re SURVEY MPLETED
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	to include Chronic I Anomaly of the Hear Failure. A review of Set (MDS), dated 0 assessed the reside independent with the review of the Fall End (MDS), and 00/06 sustained a fall while assistance. A review of ated 06/06/13, review of ated 06/06/13, review of atel times due awareness.  Further record review of the State I (SRNA) assignment and the Risk for Fall (SRNA) assignment and the Risk for Fall (SRNA), verified the Observations, on 06/12:00 PM, 3:10 PM, revealed Resident # sensor alarm visuali 06/20/13 at 10:15 Alambulated to the baland no alarm sound interview with Resid PM, revealed he/she and did not have an	ity on 02/28/13 with diagnoses Pancreatitis, Congenital art, and Congested Heart the quarterly Minimum Data 5/17/13, revealed the facility ent as cognitively Intact and ensfer and ambulation. A valuations, dated 06/02/13, 5/13, revealed the resident e ambulating without of the Physician's Orders, ealed an order for a sensor to decreased safety  w revealed the resident was ospital, on 06/07/13, with an of the Admission Orders 6/13, revealed the resident he facility on this date. A Registered Nurse Aide sincet, updated 06/16/13, is Care Plan, revised e sensor pad at all times.  1/19/13 at 8:40 AM, 10:20 AM, and 06/20/13 at 9:30 AM, 8 was in the bed with no zed. Observation, on M, revealed the resident throom without assistance ed.	F	280			

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
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{	PROVIDER OR SUPPLIER  D TRANSITIONAL CA	RE AND REHABILITATION - HIL		STREET ADDRESS, CITY, STATE, ZIP CODE 3740 OLD HARTFORD RD OWENSBORO, KY 42303		20,20 10
(X4) ID PREFIX TAC	VŪMBIDIFĒG RŪĒG)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SCIDENTIFYING INFORMATION)	ID PREFIX TAC	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION AUTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	8E	(X5) COMPLETION DATE
F 280	ordered after a fall, resident was sent to returned on 06/13/1 the alarm upon returned plan was not under responsibility to assignment sheats interview with the Alarm upon the resident #8 was coindependent, unless resident was sent of 06/07/13. The resident was responsible to assignment sheet at interview with the Di 06/20/13 at 2:15 PM	the sensor elarm was on (%/06/13. She revealed the other hospital on 06/07/13, and 3. The resident did not need on the facility; however, the pdated. She revealed it was update the care plans/SRNA upon re-admission.  ssistant Director of Nursing 3 at 1:55 PM, revealed gnitively intact and is he/she had an infection. The lut for an infection, on entid id not require an on return, 06/13/13. She ger #1 did the chart review re-admit to the facility and update the care plans/SRNA	F 20	30		
r 281 SS=D	assignment sheets re-admission. 483.20(k)(3)(i) SER' PROFESSIONAL S	VICES PROVIDED MEET	Ĕ 28	F281 - Services Provided Meet Profes Standards	ssional	8/2/13
		ed or arranged by the facility onal standards of quality.		1. Corrective action for those residents to have been affected:	found	
	by.	T is not met as evidenced on, interview, record review		Resident #5 was supplied with ear profor the oxygen tubing on 6/20/13. Car was updated by the DNS to show pote behavior for resident taking off the car protectors.	e plan ntial	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  185120  1851	CLIVILI	VOLOW MICRICHIAE	A MICDIONID SCRAIGES			<u></u>	MID INC	. 0330-0331
MAILE OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHABILITATION - HIL  PAGE OF PROVIDER OR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCIES OWENSBORO, KY 42303  PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE CONTROLLY TAXO  F 261  Continued From page 6 and a review of the facility policy, it was detarmined the facility talked to ensure services meet professional standards of quishly related to the fallure to carry out the physician orders for one (1) resident (#5), in the selected sample of twenty four (24) residents. The facility falled to follow the physician's orders for loam ear padding around the oxygen (O2) nasal cannula tubing for Resident #5. The facility falled to to follow the physician orders or implement per approved racinity protocot:  A record review revealed Resident #5 was admitted to the facility with diagnoses to include Seniio Dementia, Glaucoma, Psychosis and Depression.  Review of the quarterly Minimum Data Set (MDS) assessment, Gateo 05/03/13, revealed tine facility had assessed resident #5 as cognitively impaired and required extensive assistance with all activities of daily living.  Review of the Physician's orders, dated 05/01/13 tirrough 05/30/13, revealed Resident #5 was to have O2 at two (2) liters per minute (f/m) per mask cannulas continuous and form ear of minute (f/m) per mask cannulas continuous and form ear of minute (f/m) per mask cannulas continuous and form ear of minute (f/m) per mask cannulas continuous and form ear of profession will be entirely and cannulas continuous and form ear of profession and provided to work until the deduction prior to 82/13 will be removed from the schedule and not allowed to work until the education has been provided, and the deduction has been provided, and the deduction has been provided.				1				
INDRED TRANSITIONAL CARE AND REHABILITATION - HIL  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFIGENCY MIST BE PRECEDED BY FULL (EACH DEFIGENCY AUTOR) WILL BEQUILATORY OF LSC IDENTIFYING HIF CPMANION)  F 281  Continued From page 8 and a review of the facility policy, it was detarmined the facility failed to ensure services meet professional standards of quality related to the failure to carry out the physician orders for one (1) resident (#5), in the selected sample of look with physician's orders for loam ear padding around the oxygen (O2) nead cannula tubing for Resident #5.  Findings include:  Review of the facility policy titled, Oxygen I herapy and dated 8/31/12, revealed the previous and Depression.  Review of the quarterly Minimum Data Set (MOS) assessment, dated 05/03/13, revealed for facility hed assessed Resident #5 as cognitively impaired and required extensive assistance with ail includio 03/30/13, revealed Resident #5 was to have G2 at two (2) liters per minute (lim) per mask acumulas continuous and form ear minute (lim) per mask acumulas continuous and form ear minute (lim) per mask acumulas continuous and form ear minute (lim) per mask acumulas continuous and form ear minute (lim) per mask acumulas continuous and form ear minute (lim) per mask acumulas continuous and form ear minute (lim) per mask acumulas continuous and form ear minute (lim) per mask acumulas continuous and form ear minute (lim) per mask acumulas continuous and form ear minute (lim) per mask acumulas continuous and form ear minute (lim) per mask acumulas continuous and form ear minute (lim) per mask acumulas continuous and form ear minute (lim) per mask acumulas continuous and form ear minute (lim) per minute (lim) per mask acumulas continuous and form ear minute (lim) per minute			185120	B. WING	·		_06	20/2013
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F 281 Continued From page 8 and a review of the facility policy, it was determined the facility policy, it was determined the facility policy, it was determined the facility failed to ensure services meet professional standards of quality failed to the failure to carry out the physician orders for one (1) resident (#5), in the selected sample of liventy four (24) residents. The facility failed to follow the physician's orders for foam ear padding around the oxygen (O2) nasal cannula tubing for Resident #5.  Findings include:  Review of the facility policy titled, Oxygen Therapy and cated 9/31/12, revealed procedure #1 "Verify physician order or implement per approved facility protocol".  A record review revealed Resident #5 was admitted to the facility with diagnoses to include Senile Dementia, Glaucoma, Psychosis and Depression.  Review of the quarterly Minimum Data Set (rkiDS) assessment, dated 05/03/13, revealed tine facility had assessed Resident #5 as cognitively impaired and required extensive assistance with all activities of daily living.  Review of the Physician's orders, dated 06/01/13 through 06/30/13, revealed Resident #5 was to have Q2 at two (2) liters per minute (line) per meast cannula continuous and foam ear	KINDRE	D TRANSITIONAL CA	RE AND REHABILITATION - HIL		3	5740 OLD HARTFORD RD		
and a review of the facility policy, it was determined the facility failed to ensure services maset professional standards of quality related to the failure to carry out the physician orders for one (1) resident (#5), in the selected sample of twenty four (24) residents. The facility failed to follow the physician's orders for foam ear padding around the oxygen (O2) nasal cannula tubing for Resident #5.  Findings include:  Review of the facility policy titled, Oxygen 1 herapy and oated 8/31/12, revealed procedure #1 'Verity physician order or implement per approved facility protocol'.  A record review revealed Resident #5 was admitted to the facility with diagnoses to include Senile Dementia, Glaucoma, Psychosis and Depression.  Review of the quarterly Minimum Data Set (MDS) assessment, dated 05/03/13, revealed the facility hed assessed Resident #5 as cognitively impaired and required extensive assistance with all activities of daily living.  Review of the Physician's orders, dated 05/03/13, revealed Resident #5 was to have O2 at two (2) liters pen minute (Vin) per nasal cannula continuous and foam ear	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD OROSS REFERENCES TO THE APPROPT	θE	COMPLETION
Observations on 06/19/13 at 8.30 AM revealed Resident #5 was in a wheelchair in the lobby area with O2 per nasal cannula from a portable oxygen with O2 per nasal cannula from a portable oxygen with O2 per nasal cannula from a portable oxygen with O2 per nasal cannula from a portable oxygen with O2 per nasal cannula from a portable oxygen with O2 per nasal cannula from a portable oxygen with O2 per nasal cannula from a portable oxygen with O2 per nasal cannula from a portable oxygen with O2 per nasal cannula from a portable oxygen with O2 per nasal cannula from a portable oxygen with O2 per nasal cannula from a portable oxygen with O2 per nasal cannula from a portable oxygen with O2 per nasal cannula from a portable oxygen with O2 per nasal cannula from a portable oxygen with		and a review of the determined the facilimeet professional si the failure to carry one (1) resident (#5 twenty four (24) resident follow the physician around the oxygen around the oxygen Resident #5.  Findings include:  Review of the facility I herapy and dated if 1 "Verity physician approved facility produced in the facility of the profession.  Review of the quarte assessment, dated in activities of daily Review of the Physician all activities of daily Review O2 at two (2) in masal cannula continuous of the physician cannula continuous of the Physician activities of daily Review O2 at two (2) in masal cannula continuous of the Physician cannula continuous of the Physician of t	facility policy, it was lity failed to ensure services standards of quality related to put the physician orders for ), in the selected sample of idents. The facility failed to 's orders for foam ear padding (O2) nasal cannula tubing for y policy titled, Oxygen 8/31/12, revealed procedure order or implement per order or implement per order or implement per order or implement per order. Psychosis and eaucoma, Psychosis and eaucoma, Psychosis and early Minimum Data Set (MDS) 05/03/13, revealed the facility ident #5 as cognitively ed extensive assistance with living.  Clan's orders, dated 06/01/13 evealed Resident #5 was to ters per minute (I/m) per nuous and foam ear in tubing.	Fi	The second secon	All residents on oxygen were checked nursing management to ensure they he protectors for their tubing and that the in place on 6/20/13.  Any residents with identified behavior picking at their ear protectors will have noted by the interdisciplinary team on behavior sheets, aide assignment shee included in their care plan as of July 1 2013.  3. Systemic changes to ensure the defin practice will not recur:  New orders for oxygen will be reviewed daily (M-F) at standup meetings. Weel Supervisor will reviewed MD orders on weekend for any new orders to ensure oxygen foam ear protectors are on the Treatment Administration Record (TA All nursing staff will be in serviced by Staff Development RN or DNS on importance of placement of ear protect all-staff meetings the week of July 15th nursing staff that have not received the education prior to 8/2/13 will be remo from the schedule and not allowed to we until the education has been provided.  Weekly audits of tubing changes and a of all residents with oxygen will be done	hy ad car y were of of e this their is and 9, cient ed kend the R). the cors at cors a	

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IOENTIFICATION NUMBER: A. BUILDING \_\_\_ B, WING 06/20/2013 185120 -STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3740 OLD HARTFORD RD KINDRED TRANSITIONAL CARE AND REHABILITATION - HIL OWENSBORO, KY 42303 PROVIDER'S PLAY OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) 4. How the facility will monitor performance F 281 | Continued From page 7 to ensure solutions are sustained: Additional observations at 9:30 AM, 10:30 AM, 12:00 PM, 1:00 PM, 2:00 PM and 3:15 PM on TARS will be monitored monthly by the 06/19/13 revealed Resident #5 in the lobby area Unit Managers during changeover to ensure with peers with O2 per nasal cannula and no that each resident has their oxygen tubing on foam ear protectors in place. the TAR. Observation, on 06/20/13 at 9:25 AM during a skin assessment being provided by Registered Results of the weekly audits by the Unit Nurse (RN) #1 and Licensed Practical Nurse Managers will be forwarded to the DNS to (LPN) #1, revealed Resident #5 with O2 per nasal be tracked and trended and reviewed at the cannula but no foam ear protectors were in place monthly PI meeting for three months on the oxygen tubing. RN #1 and LPN #1 verified or until compliance is achieved. there were no foam ear protectors in place on the oxygen tubing. Observation on 06/20/13 at 12:55 PM revealed Resident #5 resting in bed with O2 per nasal cannula and there was still no foam ear protectors in place. interviews on 06/20/13 with RN #1, LPN #1 and the Corporate Compliance Officer at 1:00 PM, 1:05 PM and 1:15 PM respectively, revealed foam ear protectors come with the O2 tubing and Resident #5 often picks them off. They additionally stated nurses were to check every day to ensure the foam ear protectors were in place and were to document on the Medication Administration Record (MAR). Interviews with the Director of Nursing and the Assistant Director of Nursing, on 06/20/13 at 1:20 PM and 2:30 PM respectively, revealed they expected the nurse to ensure Resident #5 was

SS=D | PERSONS/PER CARE PLAN

the physician.

provided the foam ear protectors as prescribed by

F 282 483,20(k)(3)(ii) SERVICES BY QUALIFIED

Care Plan

F 282 F282 - Services by Qualified Persons/Per

8/2/13

PRINTED: 07/05/2013

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED	
1	:	185120	B. WING	s		06/	20/2013
	PROVIDER OR SUPPLIER D TRANSITIONAL CA	RE AND REHABILITATION - HIL	•	3	REET ADDRESS, CITY, STATE, ZIP CODE 1740 OLD HARTFORD RD DWENSBORO, KY 42303		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	must be provided by	ge 8 led or arranged by the facility y qualified persons in ch resident's written plan of	F	282	1. Corrective action for those resident to have been affected:  Resident #8's care plan was immediate reviewed by the Interdisciplinary Teat updated on 6/20/13 to reflect that ther no longer a need for a bed sensor alarmatically.  Corrective action for those with position of the sensor with the sensor wit	tely m and e was m.	
	This REQUIREMENT is not met as evided by: Based on observation, interview, record and facility policy/procedure review it was determined the facility failed to ensure call provided in accordance to the resident's of for one (1) resident (#8), in the selected sof twenty four (24) residents. Resident #6 safety alarm in place as per the care plan				to be affected:  House wide audit was conducted by n management on residents that were readmitted within the last three month ensure physician orders, care plans an SRNA assignment sheets were correct will be completed by July 26. Any corwill be corrected at that time.	ursing s to d . Audit	
	Review of the facility policy titled "Care Plans, lated 01/07/12, revealed documentation under Rationale: "Plan of care is developed on the patient's individual needs as identified by assessments. The care plan includes a reatment plan, patient's preferences, patient goals that are measurable and contain a schedule to evaluate the patient's progress of ack of progress toward his/her goals".  Record review revealed Resident #8 was admitted to the facility on 02/28/13 with diagnoses of include Chronic Pancreatitis, Congenital Anomaly of the Heart, and Congested Heart Fallure. A review of the quarterly Minimum Data Set (MDS) assessment, dated 05/17/13, revealed the facility assessed the resident as cognitively			***************************************	3. Systemic changes to ensure the define practice will not recur:  MDS nurses will close the care plan withey are doing the discharge assessment when a resident is re-admitted they with open the care plan and ensure orders multiple or the care plan intervention and the assignment sheet and are being implemented. Any identified concerns the immediately addressed.	hen  It.  Il  natch.  Its per	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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1	PROVIDER OR SUPPLIER D TRANSITIONAL CA	RE AND REHABILITATION - HIL	:	REET AODRESS, CITY, STATE, 2IP CODE 1740 OLD HARTFORD RD DWENSBORO, KY 42303		
(X4) fo PRÉFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID FREFIX TAG	PROVIDER'S FLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIES (DEFICIENCY)	85	(XS) COMPLETION DATE
F 282	ambulation. A review dated 06/02/13, 06/ the resident sustain without assistance.  A review of the Physio6/06/13, revealed all times due to decreview of the State (SRNA) assignment and the Risk for Fall 08/07/13, verified the Observations, on 06 12:00 PM, 3:10 PM, revealed Resident # sensor alarm visuali 06/20/13 at 10:15 Ai	lent with transfer and w of the Fall Evaluations, 04/13, and 06/06/13, revealed ed a fall while ambulating sician's Orders, dated an order for a sensor pad at reased safety awareness. A Registered Nurse Aide t sheet, updated 06/16/13, is Care Plan, revised e sensor pad at all times.  6/19/13 at 8:40 AM, 10:20 AM, and 06/20/13 at 9:30 AM, and 06/20/13 at 9:30 AM, was in the bed with no zed. Observation, on M, revealed the resident throom without assistance	F 282	4. How the facility will monitor perfoto ensure solutions are sustained:  MDS team will fill out a log with disc and re-admitted residents which will burned in to the DNS/Designee weekly log and the results of the DNS/ADNS weekly observation rounds will be revat the PI Meeting monthly for three moor until compliance is achieved.	harged e 7. This	
The state of the s	3:10 PM, revealed h assistance and did n Interview with SRNA PM, revealed she wa on 06/19/13. She revealed the bathroom withou an alarm to the bed. assignment sheet inhowever, she revealed 19/13.  Interview with SRNA AM, revealed she was	rsident #8, on 06/19/13 at e/she gets up without not have an alarm to the bed.  #4, on 06/20/13 at 12:55 as the aide for Resident #8, realed the resident went to a sasistance and did not have. She verified the SRNA dicated a sensor alarm; ed it was not noticed on #3, on 06/20/13 at 10:40 as the aide for Resident #8, rified the resident did not				

	T OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER D TRANSITIONAL CA	RE AND REHABILITATION - HIL	S	TREET ADDRESS, CITY, STATE, ZIP CODE 3740 OLD HARTFORD RD OWENSBORO, KY 42303		
(X4) ID PREFIX TÁG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES *MUST DE PREGEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S FLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-PEFERENCED TO THE APPROPT DEFICIENCY)	BE	(X5) CCHPLETION DATE
	assignment sheet in times, and revealed the assignment sheet interview with the D C6/20/13 at 2:15 PM to follow the SRNA: 483.25(c) TREATM! PREVENT/HEAL PI Based on the compresident, the facility who enters the facility who enters the facility who enters the facility who enters the secular services to promote pressure sores recesservices to promote prevent new sores for this REQUIREMENT by:  Based on observation review it was determated to pressure sores for one selected sample of the facility falled to place on Resident for pressure sores.  Findings include:  Resident #5 was addiagnoses to include	ne bed. She verified the SRNA indicated a sensor alarm at all she was supposed to check et prior to providing care.  Irrector of Nursing (DON), on it, revealed she expected staff assignment sheets.  ENT/SVCS TO RESSURE SORES  rehensive assessment of a must ensure that a resident ty without pressure sores essure sores unless the condition demonstrates that ole; and a resident having lives necessary treatment and healing, prevent infection and from developing.  IT is not met as evidenced on, interview and record sined the facility failed to ent the care plan to prevent ne resident (#5) in the wenty four (24) residents, ensure ear protectors were in 15's oxygen tubing to prevent mitted to the facility with	F 314	F314 - Treatment/Sucs to prevent/hea	s found tectors re plan ntial ential by d ear y were e this their s and 9,	8/2/13

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 07/05/2013 FORM APPROVED

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	TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1		LE CONSTRUCTION		E SURVEY PLETED
		185120	B. WINC	·		06/	20/2013
NAME OF F	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
KINDRE	D TRANSITIONAL CA	RE AND REHABILITATION - HIL		•	740 OLD HARTFORD RD DWENSBORO, KY 42303		
		YELLEVY OF OCCUPANION	· · · · · · · · · · · · · · · · · · ·	<u> </u>	<del></del>		
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F 314	Centinued From particles of the quarterly Minimos/03/13, revealed Resident #5 as cogextensive assistance living.  Review of Physician through 06/30/13, rehave oxygen at 2/L continuous and foar tubing.  Review of Resident of breath, dated 06/10 use foam ear proof to use foam ear proof the time.  Observation on 06/2 assessment with Relicensed Practical Mesident #5 had oxythere were no foam oxygen tubing. Review of foam ear prooxygen tubing. Furt at 12:55 PM revealed and there was sthe resident's oxygen.	ge 11 imum Data Set (MDS), dated the facility had assessed nitively impaired and required e with all activities of daily  I's Orders, dated 06/01/13 evealed Resident #5 was to per minute per nasai cannula n ear protectors on oxygen  #5's care plan for shortness 2013, revealed an intervention tectors on line of tubing.  [19/13 at 8:30 AM, 9:30 AM, ], 1:00 PM, 2:00 PM and 3:15 ent #5 with oxygen per nasal n ear protectors in place at  [20/13 at 9:25 AM during a skin registered Nurse (RN) #1 and lurse (LPN) #1 revealed regen per nasal cannula but ear protectors in place on the lurse (LPN #1 verified there rotectors in place on the her observation on 06/20/13 d Resident #5 was resting in still no foam ear protectors on n tubing.		314	plan with interventions to prevent presores implemented.  3. Systemic changes to ensure the definition practice will not recur: New orders for oxygen will be review daily at standup meetings (M-F). We supervisor will review MD orders or weekend for any new orders to ensure oxygen foam ear protectors are on the All nursing staff will be in serviced by Staff Development RN or DNS on importance of placement of ear protect all-staff meetings the week of July 15 nursing staff that have not received the education prior to 8/2/13 will be remefrom the schedule and not allowed to until the education has been provided.  Weekly audits of tubing changes and a of all residents with oxygen will be dotthe Unit Managers.  DNS/ADNS will conduct weekly observation rounds of at least 5 reside hall to validate that care plan intervent reduce pressure sores match the assign sheet and are being implemented. An identified concerns will be immediated addressed.  4. How the facility will monitor perfort to ensure solutions are sustained:	icient  yed ekend the the TAR.  y the  ctors at  h. Any e oved work  audits one by  must per ions to ument  y y mance	
	the Corporate Comp 1:05 PM and 1:15 P	13 with RN #1, LPN #1 and blance Officer at 1:00 PM, ' M respectively, revealed foam with the oxygen tubing and			TARS will be monitored monthly by the Unit Managers during changeover to a that each resident has their oxygen tub the TAR.	ensure	

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:	1		PLE CONSTRUCTION		TE SURVEY MPLETED
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F 332 SS≈D	had a care plan interprotectors to prevent additionally stated in day to ensure the for place and were to discovered the following the following the place and were to discovered the following the physician and percent of the physician and percent of the physician and percent of the facility must ensure the physician and percent of the facility must ensure the physician and percent of the facility must ensure the physician of the facility must ensure the facility must ensure the facility must ensure the facility medication error rate of the facility medication administration opportudication errors, for error rate of 16 percent medication dose, a result food and two ministration of the facility medication dose, a result food and two ministration dose, a result food and two ministration administration dose, a result food and two ministration and two ministration dose, a result food and two ministration administration dose, a result food and two ministration and the facility of t	licks them off. Resident #5 ervention for foam ear at skin breakdown. They burses were to check every bar ear protectors were in bocument on the Medication bord (MAR).  Director of Nursing and the f Nursing, on 06/20/13 at 1:20 spectively, revealed they to ensure Resident #5 was ear protectors as prescribed by ear the resident's plan of care.  OF MEDICATION ERROR MORE  sure that it is free of es of five percent or greater.  It is not met as evidenced on, interview, record review facility policy, it was by failed to ensure the retion rate was less than five			Results of the weekly audits by the U Managers will be forwarded to the Dibe tracked and trended and reviewed monthly PI meeting for three months.  DNS/ADNS will conduct weekly observation rounds of at least 5 reside hall to validate that care plan interven match the assignment sheet and are be implemented. Any identified concern be immediately addressed. Results of weekly observation rounds will be revat the monthly PI meeting for three mor until compliance is achieved.  F332 – Free of Medication Error Rate 5% or More  1. Corrective action for those resident found to have been affected:  Resident #17 and #25 had a medication documented with the Medical Director notified.  Resident #25's order for enteric coated aspirin was discontinued.  2. Corrective action for those with pot to be affected:  A house wide audit of residents with diabetes will be done by nursing management by July 19 to ensure timin oral medications is being done according manufacturer's recommendation.	NS to at the ents per tions eing is will riewed onths s of its an error	8/2/13

PRINTED: 07/05/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION   DRIFFER SUPPLIER   AND PLAN OF CORRECTION   A BUILDING   DRIFFER SUPPLIER	CENTE	RS FOR MEDICARE	& MITHICAIN SEKAICES	<del>,</del>	U	MR NO	<u>. 0938-0391</u>
NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHABILITATION - HIL  SUMMARY STATEMENT OF DEFICIENCIES (FREERING MAD PREHABILITATION - HIL  SUMMARY STATEMENT OF DEFICIENCIES (FREERING MAD PREHABILITATION - HIL  FOR PROVIDER OR SLAY 22303  Continued From page 13  A review of the facility policy, "Medication Administration," dated 067/5/12, revealed medications were to be administered within 60 minutes of the schedules time of administrations were to have been prepared using the five rights of medication and strength, the right time of administration, the right frequency and route of administration pass, on 067/9/13 at 845 AM, revealed Amaryl, a Diabetic medication, was administration Records (MARS.) dated 06/2013 and the Admission Orders Record, revealed the Amaryl was scheduled to have been administered at 7:00 AM, "Verfore breakfast."  An Interview with Certified Medication Assistant (CMA) #1, on 06/19/13 at 8:50 AM, revealed the Amaryl should have been administered at 2:00 AM, "Verfore breakfast."  An Interview with Certified Medication Assistant (CMA) #1, on 06/19/13 at 8:50 AM, revealed the Amaryl should have been administered at 2:00 AM, "Verfore breakfast meal, which was delivered at approximately 7:20 AM.  2. An observation of a medication administration pass, on 06/19/13 at 8:50 AM, revealed the Amaryl should have been administered with the breakfast meal, which was delivered at approximately 7:20 AM.  2. An observation of a medication administration pass, on 06/19/13 at 8:50 AM, revealed the Amaryl should have been administered with the breakfast meal, which was delivered at approximately 7:20 AM.  2. An observation of a medication administration pass, on 06/19/13 at 9:06 AM, revealed CMA #1 administered Careled Aspirin and Lanoxin that were crushed and placed in appleasuce to Resident #2. In addition, one tablet of Calcium 500 may administered.  F 332 A med cart to medication record/MD orders and twill be done by Nursing managers and CMT's by August 2**. To ensure correct medications will	STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION		}			
STAGE OLD HARTFORD RD   STAGE NOT RECEIVED BY EVERY   SUMMARY STATEMENT OF DEFICIENCES   PRECEDENCY MUST BE PRECEDED BY FULL   TAGE   PRECEDED BY FULL			185120	B. WING	and the same of th	06/	20/2013
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OWENSHORD, KY 42303  FREGILATORY OR LSC IDENTIFYING INFORMATION  TAG IN CARCIL CORRECTION CARDIOUS INFORMATION  A review of the Eacility pools, "IMEGICALION IN EXCEPTION IN EXPONENTIAL EXPON	MNODE	n toanoitional ea	OF AND BYLLAND ITATION I III		3740 OLD HARTFORD RD		
F 332  Continued From page 13  A review of the facility policy, "Medication Administration pass, on 66/19/13 at 8-45 AM, revealed Amministration Records (MARs.) dated 66/2013 and the Administor do have been administered at 7:00 AM, "before breakfast."  A review of the Medication Administration Records (MARs.) dated 66/2013 and the Administration Records (MARs.) dated 66/2013 and the Administration Records (MARs.) dated 66/2013 and the Administered with the breakfast."  An Interview with Certified Medication Assistant (CMA) #1, on 06/19/13 at 8:50 AM, revealed the Amaryl was scheduled have been administration pass, on 06/19/13 at 8:00 AM, revealed the Amaryl administered. 2. An observation of a medication administration pass, on 06/19/13 at 8:00 AM, revealed the Amaryl administered to Records (RARs.) dated 6/2013 and the Administration Pass, on 06/19/13 at 8:00 AM, revealed the Amaryl was scheduled to have been administered at 7:00 AM, "before breakfast."  An Interview with Certified Medication Assistant (CMA) #1, on 06/19/13 at 8:00 AM, revealed the Amaryl should have been administered with the breakfast meal, which was delivered at approximately 7:20 AM.  2. An observation of a medication administration pass, on 06/19/13 at 9:05 AM, revealed CMA #1 administered at administered with the breakfast meal, which was delivered at approximately 7:20 AM.  2. An observation of a medication administration pass, on 06/19/13 at 9:05 AM, revealed the Amaryl administered with the breakfast meal, which was delivered at approximately 7:20 AM.  2. An observation of a medication administration pass, on 06/19/13 at 9:05 AM, revealed to the monthly report will be done monthly. The monthly report will be done monthly. The monthly procommittee for review of crushed medications will be done monthly. The monthly procommittee for review of the monthly Procommittee for review of the mext three	VINDKE	D TRANSITIONAL CA	RE AND REHABILITATION - HIL		OWENSBORO, KY 42303		
A review of the facility policy, "Medication Administration," dated 06/15/12, revealed medications were to be administered within 60 minutes of the schedules time of administration, except for before and after meals, which are based on scheduled meal itmes and administered within 30 minutes of the meal. The medications were to have been prepared using the five rights of medication administration: The right resident, right medication and strength, the right time of administration, the right frequency and route of administration.  1. An observation of a medication administration pass, on 06/19/13 at 8:45 AM, revealed Amaryl, a Diabetic medication, was administered to Resident #17.  A review of the Medication Administration Records (MARs,) dated 06/2013 and the Admission Orders Record, revealed the Amaryl was scheduled to have been administered at 7:00 AM, "before breakfast."  An interview with Certified Medication Assistant (CMA) #1, on 06/19/13 at 8:50 AM, revealed the Amaryl should have been administered with the breakfast meal, which was delivered at approximately 7:20 AM.  2. An observation of a medication administration pass, on 06/19/13 at 9:06 AM, revealed the Amaryl should have been administered with the breakfast meal, which was delivered at approximately 7:20 AM.  2. An observation of a medication administration pass, on 06/19/13 at 9:06 AM, revealed CMA #1 administored tenteric Coated Aspirin and Lanoxin that were crushed and placed in applesauce to Resident #25. In addition, one tablet of Calcium 500 mg was administered.	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	(X5) COMPLETION DATE
A review of the MARs and physician orders, for		A review of the facilial Administration," data medications were to minutes of the sche except for before are based on scheduler within 30 minutes of were to have been portion of medication administration administration.  1. An observation of pass, on 06/19/13 and Diabetic medication Resident #17.  A review of the Mad Records (MARs.) da Admission Orders Resident #17.  A review of the Mad Records (MARs.) da Admission Orders Resident #17.  An Interview with Ce (CMA) #1, on 06/19/13 and Maryl should have breakfast meal, while approximately 7:20 and observation of pass, on 06/19/13 and administered Enteric that were crushed at Resident #25. In ad 500 mg was administered for a base of the school of	illy policy, "Medication ed 06/15/12, revealed be administered within 60 edules time of administration, and after meals, which are I meal times and administered if the meal. The medications prepared using the five rights histration: The right resident, distrength, the right time of right frequency and route of a medication administration at 8:45 AM, revealed Amaryl, a was administered to dication Administration at 8:45 AM, revealed the Amaryl are been administered at 7:00 ist."  Pertified Medication Assistant (13 at 8:50 AM, revealed the been administered with the child was delivered at AM.  If a medication administration at 9:05 AM, revealed CMA #1 coated Aspirin and Lanoxin and placed in applesauce to lidition, one tablet of Calcium stered.	F 3:	audit will be done by Nursing manage CMTs by August 2 <sup>nd</sup> . to ensure corremedications are on hand as ordered by physician.  Residents with orders for crushed medications will be reviewed by the pharmacist to determine appropriate medication has been ordered.  Medication pass times will be reviewed the DNS/ADNS for each hall to ensure appropriate time frames by July 19 <sup>th</sup> .  Education to be completed for all CM and licensed nurses regarding med painclude timing of diabetic medications crushing meds per DO NOT CRUSH guidelines. Education scheduled for aper pharmacy consultant/ DNS. Any linursing staff that have not received the education prior to 8/2/13 will be remotifrom the schedule and not allowed to vanied the education has been provided.  3. Systemic changes to ensure the defining for medication will be reviewed during daily standup meeting with ord changes.  Pharmacy review of crushed medication will be done monthly. The monthly rewill be forwarded to the monthly PI	ers and ect y the ed by re  ET's ss to s and July 25 icensed e eved work ere  cient ed er ens port	

· Other Other Foot for dall a telefore Actaches Andricia

STATEMEN	T OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i ' '			(X3) DATE SURVEY COMPLETED	
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F 441 SS=D	crushable meds." To MARs of what may However, a review of Not To Be Crushed the Enteric Coated in to be crushed. I milligrams was order 1000 milligrams.  An interview with CMAM, revealed she she facility's "Medication prior to crushing the administered two of An interview with the 06/20/13 at 2:40 PM have been administed 483.65 INFECTION SPREAD, LINENS  The facility must estable for the right of disease and infection Control Prosafe, sanilary and coto help prevent the dof disease and infection Control The facility must estable for the facility must estable for the facility must estable for the facility; (2) Decides what proshould be applied to	in order "May crush all here was no indication on the for may not be crushed. If the facility's "Medications List," dated 12/2010, revealed Aspirin and the Lanoxin were in addition, the Calcium 500 red for two tablets, to equal and the Calcium 500 red for two tablets, to equal and the Calcium 500 red for two tablets, to equal and the Calcium tablets.  If DON and the ADON, on a revealed the Amaryl should in meals and the physician losage of the Calcium, should be control.  CONTROL, PREVENT replies and maintain and gram designed to provide a sumfortable environment and evelopment and transmission ison.  Program replies to program replies and infection Control			Med Pass observations will be done by	of li wed at ree d. found	8/2/13

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/SLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 441	1 Continued From page 15 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.		F441	2.0		
	by: Based on observation the facility's policy/p the facility failed to exact washing when Indicapractice for one resistant of twenty-for the facility failed to ecleansed after use. Findings include:  1. Review of the Hapolicy/procedure, da	on, interview, and review of rocedure, it was determined ansure appropriate hand ated by accepted professional dent (#1) in the selected ar (24) residents. In addition, ensure a glucometer was and Hyglene/Handwashing ated 08/31/11, revealed hand performed in the following		infection control rounds. All nursing s will be reinserviced quarterly at all-sta meetings  A spot was designated for each med ca where bleach wipes are to be kept on J 20 <sup>th</sup> . Extra wipes will be in Central Su with 24 hour access by nursing staff.  4. How the facility will monitor perfort to ensure solutions are sustained:	ff rt une pply	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	[ (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACTION SI		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	situations:  4. After touching secretions, excretions whether or not glove 2. Between task same patient when to prevent contamin 3. Intermittently between patient continuicated to avoid traditionally, the progrows during patient contaminated body of the patients or end Additionally, the progrows during patient contaminated body of the patients of Resident's perineal at the buttocks and approare, both SRNA's resident's perineal at the buttocks and approare, both SRNA's resident's perineal at the buttocks and approare, both SRNA's resident with a blank from the resident's bed and placed a wearing soiled glove her gloves; however resident with a blank from the resident's besoiled gloves. SRNA gloves and left the redirty linen. She did not leaving the resident's the soiled utility room hand sanitizer in the linterview with SRNA revealed she should gloves immediately at the soiled gl	a blood, body fluids, and conteminated items, as and procedures on the contaminated with body fluids ation of different body sites. after gloves were removed, tacts, and when otherwise ansfer of microorganisms to vironments. Cedure revealed to change to care if moving from a site to a clean body site.  I care if moving from a site to a clean body site.  I care if moving from a site to a clean body site.  I care if moving from a site to a clean body site.  I cleansed and rinsed the erformed incontinent care on the cleansed and rinsed the rea, then SRNA#2 cleansed olied a barrier cream. After epositioned the resident in edge behind him/her while s. SRNA#1 then removed, SRNA#2 covered the et and gathered supplies edside table wearing the #2 removed the soiled esident's room with a bag of ot wash her hands prior to soom. She took the bag to n, then came out and used	F 4		Availability of bleach wipes will be che through infection control rounds by the and reported at the weekly Infection Comeeting.  SDC will conduct observations of at least employees weekly to validate correct infection control techniques with residuare and hand washing. Any identified concerns will be addressed immediated Results of SDC employee observations Infection Control rounds will be tracked trended and reported to the monthly PI meeting for the next three months or until compliance is achieved.	e SDC ontrol east 3 ent i y.	

	T OF DEFICIENCIES OF CORRECTION	(XI) PROVIOER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING				(X3) DATE SURVEY COMPLETED	
		185120	B. WING			06.	/20/2013	
	PROVIDER OR SUPPLIER D TRANSITIONAL CA	RE AND REHABILITATION - HIL		3	REET ADDRESS, CITY, STATE, ZIP CODE 1740 OLD HARTFORD RD DWENSBORO, KY 42303			
(X4) IO PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIATE OF THE APPR	BE	(X5) COMPLETION DATE	
F 441	donned a new pair resident.  Interview with SRN/revealed she should gloves on after provided not wash her har resident's room as sher hand, SRNA #2 washed her hands to follow the policy rexpected staff to take their hands after proshould also wash the resident's room.  2. A review of the policy in the policy in the policy in the policy of the policy in the policy	A #2, no 06/18/13 at 2:50 PM, It have put a new pair of iding incontinent care. She nods prior to leaving the she had soiled linen bags in revealed she should have before leaving the room.  Irector of Nursing (DON), on a revealed she expected staff elated to handwashing. She are off soiled gloves and wash oviding incontinent care. Staff elir hands before exiting a colicy for "Blood Glucose Glucometer," dated 08/31/12, ning the glucometer reading est strip, the glucometer was a 10 percent (%) bleach ened wipe, between each cood glucose level monitoring 106/19/13 at 3:20 PM, Practical Nurse (LPN) #3 a glucometer after obtaining the glucometer on the top of inistering medications to two	F	144				

<u> </u>	TO TOT MEDIOTIVE	C MILENOVIO OF 17A1OFO			<u></u>	110 110	. 0330-030 1
	T OF DEFICIENCIES DE CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185120	B, WING			06/	/20/2013
	PROVIDER OR SUPPLIER  D TRANSITIONAL CA	RE AND REHABILITATION - HIL		3	REETADORESS, CITY, STATE, ZIP CODE 1740 OLD HARTFORD RD DWENSBORO, KY 42303		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SCIDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	8E	(X5) COMPLETION DATE
F 441	and had "Just forgot However, there wer and the LPN had to locked shower roon An interview with the and the Assistant D 06/20/13 at 2: 40 Pt	" to clean the glucometer. e no bleach wipes on the cart go and obtain these from a  n. e Director of Nursing (DON) irector of Nursing (ADON,) on M, revealed they would have neter to have been cleaned,	F	7.1			

PRINTED: 07/03/2013 FORM APPROVED OMB NO. 0938-0391

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER  185120			E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED 06/19/2013	
	ROVIDER OR SUPPLIER D TRANSITIONAL C		STF 3 C	1 00/	19/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENT	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE	COMPLETION DATE
K 000	SMOKE COMPAR- compartments  FIRE ALARM: Conheat detectors . SPRINKLER SYS and dry sprinkler s GENERATOR: Tyldiesel.  A standard Life Saconducted on 06/1 Center-Owensbord compliance with the in Medicare and M for one hundred fill of one hundred this survey.  The findings that for noncompliance with the noncompliance with	23.70(a)  2: 1964 2: 2000 Existing  SNF/NF  TURE: One (1) story, Type I  RTMENTS: Seven (7) smoke  Implete fire alarm system with  TEM: Complete automatic wet system.  The II generator. Fuel source is  If ty Code survey was  9/13. Kindred Transitional Care or was found not to be in the requirements for participation ledicaid. The facility is licensed ity six (156) beds with a census rty three (133) on the day of the	K 000	This Plan of Correction is the center's creditallegation of compliance.  Preparation and/or execution of this plan of does not constitute admission or agreement provider of the truth of the facts alleged or cest forth in the statement of deficiencies. The correction is prepared and/or executed solel it is required by the provisions of federal and the provisions of	correction by the onclusions e plan of y because	

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be oxcused from correcting providing it is determined that other safeguards provide sufficient protection to the pallents. (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.

FORM CMS-2687(02-99) Previous Versions Obsolete

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER/BEPRESENTATIVE'S SIGNATURE

Event ID: MPTU21

Facility ID: 100090

TITLE

(X6) DATE

CENTE	49 LOV MICDIONIC	& MEDICAID SERVICES				MD NO.	<u>.                                    </u>	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION 01 - MAIN BUILDING 01		E SURVEY IPLETED	
		185120	B, WING	<u> </u>		06/	19/2013	
	PROVIDER OR SUPPLIER D TRANSITIONAL CA	RE AND REHABILITATION - HIL	3		REET ADDRESS, CITY, STATE, ZIP GODE 740 OLD HARTFORD RD DWENSBORO, KY 42303			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)		X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
K 000	Continued From pa	ge 1	К	000				
K 018 SS=D	deficiency identified NFPA 101 LIFE SA  Doors protecting correquired enclosures hazardous areas ar those constructed owood, or capable ominutes. Doors in required to resist the no impediment to the are provided with a the door closed. Do are permitted.	Deficiencies were cited with the highest deficiency identified at "F" level. NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1½ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3,6,3,6		218	I. Corrections to doors on rooms #11, and 68 have been corrected as of 7/12 2. All other doors were audited to enscompliance. 3. Weekly door audits will be conducted and documented with corrections mad immediately to ensure compliance. 4. Door audits will be reported to mor PI committee for three months to ensure continued compliance.	/13. ted e	7/13/13	
	Based on observat determined the facili- protecting corridor of resist the passage of NFPA standards. T potential to affect the	s not met as evidenced by: ion and interview, it was lity failed to ensure doors openings were constructed to of smoke in accordance with he deficiency had the ree (3) of seven (7) smoke dents, staff and visitors. The						

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION JNG 01 - MAIN BÜILDING 01	(X3) DATE SURVEY COMPLETED	
,		185120	B. WING		06	/19/2013
	ROVIDER OR SUPPLIER D TRANSITIONAL CA	RE AND REHABILITATION - HIL		STREET ADDRESS, CITY, STATE, ZIP CODE 3740 OLD HARTFORD RD OWENSBORO, KY 42303		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		DBE	(X6) COMPLETION DATE
	beds with a census (133) on the day of The findings Includ Observation, on 06 3:00 PM, with the Drevealed the corridor and 68 would not la Interview, on 06/19 PM, with the Direct was not aware the Reference: NFPA 1 18.3.6.3.1* Doors protecting constructed to resis Compliance with Ni Doors and Fire Win Clearance between the floor covering metall be permitted for Exception: Doors to shower rooms, sink spaces that do not combustible materials.3.6.3.2 Doors shall be proving her proving the proving	or one hundred fifty six (156) of one hundred thirty three is of one hundred thirty three is the survey.  e:  /19/13 between 9:30 AM and Director of Maintenance or doors to room's #11, 52, 58, atch when tested.  /13 between 9:30 AM and 3:00 or of Maintenance revealed he doors would not latch.  01 (2000 edition)  orridor openings shall be set the passage of smoke. FPA 80, Standard for Fire adows, shall not be required. In the bottom of the door and ot exceeding 1 in. (2.5 cm) or corridor doors, to tollet rooms, bathrooms, a closets, and similar auxiliary contain flammable or	KC			
ŀ	combustible materia	contain flammable or als. that release when the door is				

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	FIPLE CONSTRUCTION NG 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		185120	B. WING		06/	19/2013
	PROVIDER OR SUPPLIER  D TRANSITIONAL CA	RE AND REHABILITATION - HIL		STREET ADDRESS, CITY, STATE, ZIP CODE 3740 OLD HARTFORD RD OWENSBORO, KY 42303		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCEO TO THE APPROP DEFICIENCY)	BE	(XS) COMPLETION DATE
K 018 K 029 SS=D	pushed or pulled shapped fire-rated doors) or extinguishing system and/or 19.3.5.4 profite approved auton option is used, the approved system of the approved system of the approved auton option is used, the approved system of the approved auton option is used, the approved auton option is used, the approved auton option is used, the approved is a system of the approved is a system of the approved in the approved in the approved is a system of the approved in the approximation in the appro	all be permitted. FETY CODE STANDARD  construction (with ¾ hour an approved automatic fire m in accordance with 8.4.1 lects hazardous areas. When natic fire extinguishing system areas are separated from oke resisting partitions and elf-closing and non-rated or live plates that do not exceed bottom of the door are	К 0 <sup>2</sup>		oser ce on ure k of ons	7/12/13
	Based on observat determined the facili requirements of Pro accordance with NF deficiency had the p seven (7) smoke co and visitors. The fahundred fifty six (15 hundred thirty three survey. The facility devices for doors pro The findings included Observation, on 06/3:00 PM, with the D revealed rooms required.	s not met as evidenced by: ion and interview, it was iity falled to meet the otection of Hazards in PA Standards. The otential to affect two (2) of impartments, patients, staff cility is certified for one 6) beds with a census of one (133) on the day of the failed to provide self-closing otecting hazardous areas.  :  19/13 between 9:00 AM and irector of Maintenance uired being self-closing or ous amount of combustibles				

STATEMENT OF DEFICIENCIES (X1) PROVIDENSUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 .		E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED		
		185120	B. WING			   06	/19/2013	
	ROVIDER OR SUPPLIER D TRANSITIONAL CA	RE AND REHABILITATION - HIL		37	EET ADDRESS, CITY, STATE, ZIP CODE 140 OLD HARTFORO RD WENSBORO, KY 42303			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	IO PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	COMPLETION DATE	
K 029	did not have self-cloclosed. The rooms requiring a rated do were located in the  1) The Housekeep opened outward into greater than seven fully opened.  2) The Nutritional hazardous amounts did not have a self-content in the process of the process	osing device to keep the door identified as hazardous or with a self-closing device following areas:  sing Closet located in Unit 6, o the egress path and was inches from the wall when services Office had of combustibles and the door closing device.  13 between 9:00 AM and 3:00 or of Maintenance revealed he loors to these rooms did not not for protection from	KC	29				
	resistance rating sha protection rating and automatic-closing in	all have a 3/4-hour fire I shall be self-closing or accordance with 7,2,1.8.						
	Reference:		•					
	NFPA 101 (2000 Ed	tion).	•					
To The Call Superpose of the Call Superpose	shall be safeguarded 1-hour fire resistance	Areas. Any hazardous areas d by a fire barrier having a e rating or shall be provided xtinguishing system in						

STATEMENT OF DEFICIENCIES (XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1		E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED		
		185120	B. WING	·		06/	19/2013
	PROVIDER OR SUPPLIER  D TRANSITIONAL CA	RE AND REHABILITATION - HIL	•	37	EET ADDRESS, CITY, STATE, ZIP COOE 740 OLD HARTFORD RD WENSBORO, KY 42303		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	θE	(X5) COMPLETION DATE
K 029	accordance with 19 option is used, the a from other spaces is and doors. The doo automatic-closing. It include, but shall not following:  (1) Boiler and fuel-fit (2) Central/bulk laur (9.3 m2)  (3) Paint shops (4) Repair shops (5) Soiled linen roor (6) Trash collection (7) Rooms or space including repair shop combustible supplies and equipment in quiby the authority havid (8) Laboratories em combustible material those that would be exception: Doors in permitted to have in field-applied protective plates ex 48 in. (122 cm) about 18.3.2 Protection from 18.3.2.1* Hazardous Any hazardous area accordance with Sec.	be permitted to be in .3.5.4. Where the sprinkler areas shall be separated by smoke-resisting partitions in shall be self-closing or lazardous areas shall be to be restricted to, the ared heater rooms indries larger than 100 ft2 in self-closing of self-closing in quantities deemed hazardous in glurisdiction ploying flammable or alse in quantities less than considered a severe hazard, rated enclosures shall be onrated, factory or attending not more than are the bottom of the door.	K	029			

STATEMENT AND PLAN (	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A BUILDING 01 - MAIN BUILDING 01				(X3) OATE SURVEY COMPLETED	
		185120	B. WING	i		Of	3/19/2013	
	PROVIDER OR SUPPLIER  D TRANSITIONAL CA	RE AND REHABILITATION - HIL		3740	ET ADDRESS, CITY, STATE, ZIP COOE DOLD HARTFORD RO ENSBORO, KY 42303			
(X4) ID PREFIX TAG			ID PREF TAG		(EACH CORRECTIVE ACTION S)	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
K 029	Table 18.3.2.1 Hazardous Area De Separation/Prol Boiler and fuel-fired Central/bulk laundri m2)1 hour Laboratories employ combustible material those that would be hazard See 18.3.6. Laboratories that us would be classified accordance with NF Care Facilities 1 he Paint shops employ and materials in qua would be classified accordance with NF Care Facilities 1 he Paint shops employ and materials in qua would be classified Physical plant maint Soiled linen rooms Storage rooms large exceeding 100 ft2 (9.3 m2) storage rooms large storing combustible material 1 hour Trash collection room NFPA 101 LIFE SAF If there is an automa installed in accordar for the Installation of provide complete cobuilding. The syster accordance with NF	scription scription heater rooms 1 hour les larger than 100 ft2 (9.3 lying flammable or lass in quantities less than considered a severe 3.4 le hazardous materials that las a severe hazard in PA 99, Standard for Health our ling hazardous substances soluties less than those that las a severe hazard 1 hour lenance shops 1 hour 1 hour ler than 50 ft2 (4.6 m2) but not ling ling See 18.3.6.3.4 ler than 100 ft2 (9.3 m2) less than those less than those that less a severe hazard 1 hour lenance shops 1 hour 1 hour ler than 50 ft2 (4.6 m2) but not length See 18.3.6.3.4 ler than 100 ft2 (9.3 m2) length See 18.3.6.3.4 ler than 100 ft2 (9.3 m2) length See 18.3.6.3.4 ler than 100 ft2 (9.3 m2) length See 18.3.6.3.4 ler than 100 ft2 (9.3 m2) length See 18.3.6.3.4 ler than 100 ft2 (9.3 m2)		56 K	The 155 degree sprinkle located in the dining roof 5 conference room have replaced with new 165 coidewall sprinkler heads	m and Unit been legree . The work	1	
i i	Paint shops employ and materials in qua would be classified. Physical plant maint Soiled linen rooms. Storage rooms large exceeding. 100 ft2 (9.3 m2) storage rooms large storing combustible material. Thour Trash collection room NFPA 101 LIFE SAF if there is an automainstalled in accordant for the Installation of provide complete cobuilding. The system accordance with NF Inspection, Testing,	ing hazardous substances antities less than those that as a severe hazard 1 hour enance shops 1 hour 1 hour er than 50 ft2 (4.6 m2) but not ring all See 18.3.6.3.4 er than 100 ft2 (9.3 m2) er than 100 ft2 (9.3 m2) ms 1 hour ETY CODE STANDARD alic sprinkler system, it is not with NFPA 13, Standard of Sprinkler Systems, to verage for all portlons of the in is properly maintained in	Κ 0	56 K	The 155 degree sprinkle located in the dining roo 5 conference room have replaced with new 165 or	m and Unit been legree . The work	A STEAM OF THE PROPERTY OF THE	

OC111C	CENTERS FOR MEDICARE & MEDICAID SERVICES				OWR NO. 0838-038.		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		LE CONSTRUCTION 01 - MAIN BUILDING 01		E SURVEY IPLETED
	-	185120	B. WING			06/19/2013	
NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHABILITATION - HIL		,	) 3	REET ADDRESS, CITY, STATE, ZIP CODE 1740 OLD HARTFORD RD DWENSBORO, KY 42303			
(X4) ID PREFIX TAG	(EACH DEFICIENCY		PROVIDER'S PLAN OF CORRECTIC PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPR		D BE	(XS) COMPLETION DATE	
K 056	Continued From page 7 supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5  This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure the building had a complete sprinkler system installed, in accordance with NFPA Standards. The deficiency had the potential to affect two (2) of seven (7) smoke compartments, residents, staff and visitors. The facility is certified for one hundred fifty six (156) beds with a census of one hundred thirty three (133) on the day of the survey. The facility failed to ensure the facility sprinkler heads were of the same temperature rating in a compartment.  The findings include:  Observation, on 06/19/13 between 9:30 AM and 3:00 PM, with the Director of Maintenance revealed sprinkler heads were installed within the same compartment that were not of the same temperature rating. The sprinkler heads were mixed ratings of 155 degree F, and 165 degree F. The mixed rating sprinkler heads were located in the Dining Room, and the Unit 5 Conference Room.  Interview, on 06/19/13 between 9:00 AM and 3:00 PM, with the Director of Maintenance revealed they were not aware of the mixed sprinkler heads		K	056		II be with ely to corted to hree	
						,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '		LE CONSTRUCTION 01 - MAIN BUILDING 01		TE SURVEY MPLETED
		185120	B. WING	<u></u>	06	/19/2013	
NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHABILITATION - HIL				3	REET ADDRESS, CITY, STATE, ZIP CODE 1740 OLD HARTFORD RD DWENSBORO, KY 42303		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOU TAG CROSS-REFERENCED TO THE APPRI DEFICIENCY)			(X5) COMPLETION DATE
K 056	Continued From page 8 located within the same compartment.			<b>)</b> 56			
	Reference: NFPA 1	3 (1999 Edition) 5-13 8.1					
	Reference: NFPA 13 (1999 Edition) 5-13 8.1  Actual NFPA Standard: NFPA 101, Table 19.1.6.2 and 19.3.5.1, Existing healthcare facilities with construction Type V (111) require complete sprinkler coverage for all parts of a facility. Actual NFPA Standard: NFPA 101, 19.3.5.1.  Where required by 19.1.6, health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7.  Actual NFPA Standard: NFPA 101, 9.7.1.1. Each automatic sprinkler system required by another section of this Code shall be in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems.  Actual NFPA Standard: NFPA 13, 5-1.1. The requirements for spacing, location, and position of sprinklers shall be based on the following principles:  (1) Sprinklers installed throughout the premises (2) Sprinklers located so as not to exceed maximum protection area per sprinkler (3) Sprinklers positioned and located so as to provide satisfactory performance with respect to activation time and distribution.						
to the second se	accordance with the minimum distant Sections 5-6	3 (1999 ed.) shall be positioned in ces and special exceptions of they are located sufficiently					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ER/SUPPLIER/CLIA	(X2) MU		(X3) DATE SURVEY COMPLETED				
	185120		B. WING			06/19/2013			
NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHABILITATION - HIL			STREET ADDRESS, CITY, STATE, ZIP CODE 3740 OLD HARTFORD RD OWENSBORO, KY 42303						
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC) REGULATORY OR L	Y MUST BE PR	ECEDED BY FULL	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE	
K 056	obstructions such a pipes, columns, and fixtures. Table 5-6.5.1.2 Pos Obstructions to Dis  Distance from Spring above Bottom of Side of Obstruction (B  Less than 1 ft 1 ft to less than 1 ft 1 ft to less than 2 ft 2 ft to less than 2 ft 2 ft 6 in. to less than 3 ft 3 ft 6 in. to less than 4 ft to less than 4 ft 4 ft 6 in. to less than 5 ft and greater  For SI units, 1 in. =	sitioning of scharge (SS Maximum nklers to (A)  6 in. n 2 ft 6 in. n 3 ft 6 in. n 4 ft 6 in. n 5 ft  25.4 mm; B), refer to 3 (1999 ed istance from ninimum of 3 (1999 Ed ted quick-rem or portion asis, the systems.	Sprinklers to Avoid (U/SSP)  Allowable Distance of Deflector  Obstruction (in.)  0 21/2 31/2 51/2 71/2 91/2 12 14 161/2 18  If t = 0.3048 m. Figure 5-6.5.1.2(a)) In Walls. Sprinklers 4 in. (102 mm)  esponse sprinklers of a system  tem area of	K	056				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		185120	B. WING			06	/19/2013
NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHABILITATION - HIL				37	EET ADDRESS, CITY, STATE, ZIP CODE 740 OLD HARTFORD RD WENSBORO, KY 42303		·
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)			(X5) COMPLETION DATE
K 056	Continued From page 10 density as indicated in Figure 7-2.3.2.4 when all of the following conditions are satisfied: (1) Wet pipe system (2) Light hazard or ordinary hazard occupancy (3) 20-ft (6.1-m) maximum ceiling height The number of sprinklers in the design area shall never be less than five. Where quick-response sprinklers are used on a sloped ceiling, the maximum ceiling height shall be used for determining the percent reduction in design area. Where quick-response sprinklers are installed, all sprinklers within a compartment shall be of the quick response type. Exception: Where circumstances require the use of other than ordinary temperature-rated sprinklers, standard response sprinklers shall be permitted to be used.		TAG				
	Reference: NFPA 10	01 (2000 edition)					
	to the types of building construct (See 8.2.1.)	e occupancies shall be limited tion shown in Table 19.1.6.2. Iding of Type I(443), Type					
	or Type II(111) cons include roofing syste	truction shall be permitted to ems le supports, decking, or					
	(a) The roof coverin						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			1''	ITIPLE C	(X3) D/	(X3) DATE SURVEY COMPLETED	
		185120	B, WING			6/19/2013	
	ROVIDER OR SUPPLIER  D TRANSITIONAL CA	RE AND REHABILITATION - HIL		3740	TAGORESS, CITY, STATE, 2IP CODE OLD HARTFORD RD ENSBORO, KY 42303		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
K 056 K 104 SS=F	of Roof Coverings. (b) The roof is sepa portions of the build by a noncombustibl not less than 21/2 ir (6.4 cm) of concrete (c) The attic or other or protected throughout by an apsystem.  NFPA 101 LIFE SAIP Penetrations of smooprotected in accordance with NF had the potential to smoke compartmen visitors. The facility fifty six (166) beds withing three (133) on facility failed to provisions (4) years.  The findings include	rated from all occupied ing e floor assembly that includes h. or gypsum fill. r space is either unoccupied aproved automatic sprinkler eTY CODE STANDARD oke barriers by ducts are ance with 8.3.6.  In not met as evidenced by: per testing record review, and ermined the facility falled to ampers were maintained in PA standards. The deficiency affect seven (7) of seven (7) ts, residents, staff and is certifled for one hundred with a census of one hundred the day of the survey. The ide documentation that the were tested within the last		04 K	1. Fire Damper testing is so week of 7/15/13 by Vang Evarsville. 2. A survey of entire building done to ensure all fire da were identified, tested an documented on 7/19/13. 3. Monthly fire damper and conducted and document corrections made immediansure compliance. 4. Fire Damper audits will be to monthly PI committee months or until compliance reached.	guard of ng was mpers d its will be ed with ntely to e reported for three	
,	Fire damper testing	record review, on 06/19/13 at					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	(X2) MULTIPLE CONSTRUCTION (X3) DA A. BUILDING 01 - MAIN BUILDING 01			
		185120	B. WING	B		08	/19/2013
	NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHABILITATION - HIL			3740 O	ADORESS, CITY, STATE, ZIP CODE DILD HARTFORD RD NSBORO, KY 42303		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF OFFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC (DENTIFYING INFORMATION)			10 PROVIDER'S PLAN OF CORRECTIC PREFIX (EACH CORRECTIVE ACTION SHOUL) TAG CROSS-REFERENCED TO THE APPROP			(X6) COMPLETION DATE
K 104	Continued From page 12 10:30 AM, with the Director of Maintenance revealed the facility did not have documentation that fire/smoke dampers had been tested within the last four (4) years.  Interview, on 06/19/13 at 10:30 AM, with the Director of Maintenance revealed he was not aware of the requirements for fire/smoke damper testing.  Reference: NFPA 90A (1999 edition)  3-4.7 Maintenance. At least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify that they fully close; the latch, if provided, shall be checked; and moving parts shall be lubricated as			K 104			
K 147 SS=D	Electrical wiring and with NFPA 70, National NAT	equipment is in accordance onal Electrical Code. 9.1.2  not met as evidenced by: on and interview, it was ty falled to ensure electrical ed in accordance with NFPA ciency had the potential to en (7) smoke compartments, visitors. The facility is dred fifty six (156) beds with	K1		<ol> <li>Power strip was removed an hardwired receptacle was in Stat strips are plugged into permanent hired wired rece of 7/1/13.</li> <li>An audit of entire building with done on 7/1/13 to ensure compliance.</li> <li>All areas will be monitored through monthly room audit forwarded to the monthly PI committee for the next three months to ensure compliance.</li> </ol>	stalled, ptacle as vas s. be	7/2/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DAT	E SURVEY APLETED	
	185120		B. WING			06/19/2013		
NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHABILITATION - HIL			STREET ADDRESS, CITY, STATE, ZIP CODE 3740 OLD HARTFORD RD OWENSBORO, KY 42303					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTI PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPARED TO THE APPROPRICE OF			(X5) COMPLETION DATE	
K 147			K	147				