

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

PRINTED: 12/27/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185315	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 12/18/2013
NAME OF PROVIDER OR SUPPLIER CLINTON COUNTY CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 404 NORTH WASHINGTON STREET ALBANY, KY 42602		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{F 000}	INITIAL COMMENTS Based upon implementation of the acceptable POC, the facility was deemed to be in compliance 12/17/13 as alleged.	{F 000}			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PROVIDER OR SUPPLIER CLINTON COUNTY CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 404 NORTH WASHINGTON STREET ALBANY, KY 42602	
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F 000	INITIAL COMMENTS A Recertification survey was conducted on 11/05/13 through 11/07/13 to determine the facility's compliance with Federal requirements. The facility failed to meet the minimum requirements for recertification with the highest scope and severity at a "E".	F 000	Clinton County Care and Rehabilitation does not believe and does not admit any deficiencies existed before, during or after the survey. The facility reserves all rights to contest the survey findings through informal dispute resolution, formal appeal proceedings, or any administrative or legal proceedings. The plan of correction is not meant to establish any standard of care contract obligation or position, and the facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in the plan of correction should be considered as a waiver of any potentially applicable peer review, quality assurance or self-critical examination privilege which the facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The facility offers its response, credible allegations of compliance, and plan of corrections as part of its ongoing efforts to provide quality of care to its residents.	
F 366 SS=D	483.35(d)(4) SUBSTITUTES OF SIMILAR NUTRITIVE VALUE Each resident receives and the facility provides substitutes offered of similar nutritive value to residents who refuse food served. This REQUIREMENT is not met as evidenced by: The facility failed to honor food preferences and/or dislikes for one (1) of five (5) residents (Resident #5). The findings include: Observation of the noon meal, on 11/06/13 at 12:02 PM, revealed Resident #5's meal card listed green beans as a dislike, however, observation of the resident's meal tray revealed the resident received mixed vegetables that contained green beans. Interview with Resident #5, on 11/06/13 at 12:05 PM, revealed he/she disliked green beans but often received them on his/her meal tray. Interview with State Registered Nurse Aide (SRNA) #1, on 11/06/13 at 12:25 PM, revealed the procedure when passing meal trays included making sure the meal provided matched the meal	F 366		

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

TITLE

(X6) DATE

Donna Bee

Administrator

12/18/13

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F 000	INITIAL COMMENTS	F 000		
F 366 SS=D	<p>483.35(d)(4) SUBSTITUTES OF SIMILAR NUTRITIVE VALUE</p> <p>Each resident receives and the facility provides substitutes offered of similar nutritive value to residents who refuse food served.</p> <p>This REQUIREMENT is not met as evidenced by: The facility failed to honor food preferences and/or dislikes for one (1) of five (5) residents (Resident #5).</p> <p>The findings include:</p> <p>Observation of the noon meal, on 11/06/13 at 12:02 PM, revealed Resident #5's meal card listed green beans as a dislike, however, observation of the resident's meal tray revealed the resident received mixed vegetables that contained green beans.</p> <p>Interview with Resident #5, on 11/06/13 at 12:05 PM, revealed he/she disliked green beans but often received them on his/her meal tray.</p> <p>Interview with State Registered Nurse Aide (SRNA) #1, on 11/06/13 at 12:25 PM, revealed the procedure when passing meal trays included making sure the meal provided matched the meal</p>	F 366	<p>1. Resident #5 was offered a substitute for the mixed vegetables on noon meal pass of 11/6/2013. An interview was completed with resident #5 on 11/6/2013 by Nancy Gilbert, Dietary Manager to discuss the resident's food preferences.</p> <p>2. Residents were interviewed on 12/17/2013 by Nancy Gilbert, Dietary Manager and Owen Kleffer, Dietary Manager regarding their food likes and dislikes to ensure that their food preferences are honored. No other concerns were identified.</p> <p>3. Dietary staff were in-serviced on 11/8/2013 by Nancy Gilbert, Dietary Manager on importance of reading tray cards during meal service to ensure that no resident receives a food they dislike.</p> <p>To prevent reoccurrence, meal services were audited by Nancy Gilbert, Dietary Manager for a period of 7 days. Nancy Gilbert, Dietary Manager or Designee will randomly audit meal service weekly for a period of 3 months to ensure resident's preferences are honored.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Honma Kee TITLE: Administrator (X6) DATE: 12/18/13

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F 366	Continued From page 1 card. Interview with the Certified Dietary Manager, on 11/07/13 at 2:25 PM, revealed Resident #5 should not have received the mixed vegetables since they contained green beans, which was listed as a food dislike.	F 366	Continued from page 1 4. Findings of audits will be reported to the Administrator and will be reviewed by the Quality Assurance Committee monthly for 3 months for recommendations and further follow-up as indicated.	12/17/13
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and facility policy review, it was determined the facility failed to store, prepare, distribute and serve food under sanitary conditions. Observations of the kitchen, revealed undated food items stored in the refrigerator; rust colored substances and debris on the range hood; a sanitizer bucket with the improper level of sanitizer; and food served below the acceptable range for hot food temperatures. A review of the facility's census and condition, dated 11/05/13, revealed there were 50 residents in the facility and five of those residents were tube feeders and did not eat food from the kitchen area.	F 371	1. Food items identified were disposed of on 11/5/2013 by Nancy Gilbert, Dietary Manager. The range hood vents were immediately cleaned by Nancy Gilbert, Dietary Manager on 11/5/2013. The sanitizing bucket was emptied on 11/6/2013 and refilled with the appropriate level of sanitizer by Nancy Gilbert, Dietary Manager. A solution guide was posted in dietary by Nancy Gilbert, Dietary Manager on 11/6/2013. The dietary cook heated the pureed food in the microwave to bring to correct temperature before serving the food on 11/5/2013. 2. All other food items were checked by Nancy Gilbert, Dietary Manager on 11/5/2013 to ensure all food items were dated. No other concerns were identified. All vents were checked on 11/5/2013 by Nancy Gilbert, Dietary Manager to ensure they were clean. No other concerns were identified.	

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F 371	<p>Continued From page 2</p> <p>The findings include:</p> <p>A review of the facility "Infection Control" Policy, undated, revealed leftover food items should be stored in covered containers and clearly labeled and dated, before being refrigerated. All foods on the steam table should be held at around 160 degrees Fahrenheit (F), in order to ensure hot foods remained above 140 degrees F, up to the time when the residents begins to eat his/her meal.</p> <ol style="list-style-type: none"> 1. An observation of the refrigerators, on 11/05/13 at 9:25 AM, revealed three large bags of lettuce, four Lemon Meringue Pies, 75 cartons of vanilla shakes, 75 cartons of prune juice and four-16 ounce jars of spices with no dates, to include Garlic Powder, Chives, Sage and Cloves. 2. An observation of the kitchen, on 11/05/13 at 9:45 AM, revealed rust- colored dust and debris in the vents of the range hood, over the stove. 3. A check of the sanitizer bucket, used to wipe the counters, on 11/06/13 at 11:45 AM, revealed the sanitizer level at 200 parts per million (PPM.) An interview with the Dietary Manager revealed the recommended level was 100 PPM. An interview with the Cook revealed she used three capfuls of bleach for the sanitizer bucket, but there were no posted recommendations to follow. 4. An observation of the tray line, on 11/05/13 at 11:40 AM, revealed the temperature of pureed peas and carrots was 130 degrees F; pureed salmon was 120 degrees F and pureed broccoli and cheese was 108 degrees F and was not reheated, prior to placing in the food cart. 	F 371	<p>Continued from page 2</p> <p>All other sanitizing buckets were checked for proper solution PPM's by Nancy Gilbert, Dietary Manager on 11/6/2013. No other Concerns were identified.</p> <p>A pureed test tray was checked for proper temperature by Nancy Gilbert, Dietary Manager on 11/5/2013 with no other concerns noted.</p> <p>3. Dietary staff were in-serviced on proper storage and dating of food items on 11/8/2013 by Nancy Gilbert, Dietary Manager. A 7 day audit was completed by Nancy Gilbert, Dietary Manager to ensure food items were being properly stored and dated. Random weekly audits will be completed by Nancy Gilbert, Dietary Manager or Designee to ensure all food items are properly stored and dated for a period of 3 months.</p> <p>Nancy Gilbert, Dietary Manager immediately cleaned the range hood vents on 11/5/2013. Dietary staff were in-serviced on 11/8/2013 regarding cleaning schedule and cleaning of the range hood vents. Nancy Gilbert, Dietary Manager or Designee will complete random weekly audits to ensure the range hood vents are clean and free of debris for a period of 3 months.</p>	
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F 371	Continued From page 3 An interview with the Cook, on 11/05/13 at 11:45 AM, revealed she stated the proper temperature should have been 130 degrees F and she had a hard time keeping pureed foods at that temperature and should have placed the food back in the microwave to reach the proper temperature, prior to the food leaving the steam table. An interview with the Dietary Manager, on 11/05/13 at 12:00 PM, revealed she was the one who checked the refrigerator for outdated and undated food items and was not aware these items were not dated. She also stated she was aware of issues with the range hood, as it had just been cleaned, or that staff were unaware of the proper temperature of food leaving the tray line. An interview with the Dietician, on 11/07/13 at 2:25 PM, revealed she contracts with the facility to work two days a month and checks the steam tables and does a test tray, at those times. She was not aware of any food complaints or undated food items in the refrigerator.	F 371	Continued from page 3 Dietary staff was in-serviced on 11/6/2013 on proper solution percentage for sanitizing buckets. A notice with recommended sanitizing solution PPM's was posted in the dietary department by Nancy Gilbert, Dietary Manager. Nancy Gilbert, Dietary Manager completed a 7 day audit to ensure proper solution PPM's. Random weekly audits of the sanitizing buckets will be completed by Nancy Gilbert, Dietary Manager or Designee for a period of 3 months. Nancy Gilbert, Dietary Manager in-serviced dietary staff on proper food temperatures and ensuring that no food was served from the dietary department that was below acceptable temperature range on 11/8/2013. A 7 day audit was completed by Nancy Gilbert, Dietary Manager to ensure that food was being held and served at the proper temperatures. Nancy Gilbert, Dietary Manager or Designee will complete random weekly audits for a period of 3 months to ensure food is being held and served at appropriate temperature. 4. Findings of all audits will be reported to the Administrator and will be reviewed by the Quality Assurance Committee monthly for 3 months for recommendations and further follow-up as indicated.	11/8/13	

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{K 000}	INITIAL COMMENTS Based upon implementation of the acceptable POC, the facility was deemed to be in compliance 11/18/13 as alleged.	{K 000}			

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

TITLE

(X6) DATE

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K 000	INITIAL COMMENTS CFR: 42 CFR 483.70(a) Building: 01 Survey under: NFPA 101 (2000 Edition) Facility type: SNF/NF Type of structure: Type V (000) Smoke Compartments: 4 Fire Alarm: Fire alarm installed 1985 Sprinkler System: Sprinkler System installed 1985 Generator: Type II. Diesel A standard Life Safety Code survey was conducted on 11/06/13. Clinton County Care and Rehabilitation Center was found not to be in compliance with the requirements for participation in Medicare and Medicaid.	K 000	Clinton County Care and Rehabilitation does not believe and does not admit any deficiencies existed before, during or after the survey. The facility reserves all rights to contest the survey findings through informal dispute resolution, formal appeal proceedings, or any administrative or legal proceedings. The plan of correction is not meant to establish any standard of care contract obligation or position, and the facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in the plan of correction should be considered as a waiver of any potentially applicable peer review, quality assurance or self-critical examination privilege which the facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The facility offers its response, credible allegations of compliance, and plan of corrections as part of its ongoing efforts to provide quality of care to its residents.	
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4	K 052	1. An additional phone line was installed on the fire alarm dialer panel on 11/18/2013 by Fasco Fire Suppression Equipment. The two exit doors were found to need new relays. New relays for both doors was installed on 11/8/2013.	

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

TITLE

(X6) DATE

Wonna Ru

Administrator

12/18/13

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K 052	Continued From page 1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure the building fire alarm system was installed and maintained as required by NFPA standards. This deficient practice affected four (4) of four (4) smoke compartments, staff and all the residents. The facility has the capacity for 52 beds with a census of 49 the day of the survey. The findings include: During the Life Safety Code tour on 11/06/13, at 11:03 AM, with the Director of Maintenance (DOM), it was observed that the fire alarm dialer panel located in the front lobby contained one (1) phone line when two (2) phone lines were required for additional safety purposes. During the test of the fire alarm system two (2) of the four (4) exit doors that are magnetically locked failed to release. The locks should not reengage until the fire alarm system is reset and showing normal conditions. The two (2) exit doors that did not release would release when utilizing the delayed egress system adjacent to the exit doors during this test. An interview on 11/06/13, at 11:14 AM, with the DOM revealed he was not aware the dialer panel required two (2) phone lines. The DOM was not aware the exit doors were not operating correctly.	K 052	2. Donna Lee, Administrator contacted the representative for phone line installation, and set an appointment for the additional phone line to be installed on the fire alarm dialer panel on 11/6/2013. The additional line was installed on 11/18/13. Steve Hardin, Plant Director obtained new relays for both doors and they were installed on 11/8/2013. 3. The phone lines on the fire alarm dialer panel will be inspected on a quarterly basis by Fasco Fire Suppression Equipment and any issues will be immediately addressed. The exit doors will be inspected on a monthly basis, during the facility fire drill, by Steve Hardin, Plant Director or Designee to ensure that all exit doors are in proper operation. The exit doors will also be inspected on a quarterly basis by Fasco Fire Suppression Equipment. Any concerns will be immediately corrected. 4. Inspection results will be reported to the Administrator and the Quality Assurance Committee for a period of 3 months for recommendations and further follow-up as indicated.	11/18/13

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K 052	Continued From page 2 The findings were revealed to the Administrator on exit. Reference: NFPA 72 1999 edition 3-9.6.3 All door hold-open release and integral door release and closure devices used for release service shall be monitored for integrity in accordance with 3-9.2. 5-5.3.2.1.6.1 A DACT shall employ one of the following combinations of transmission channels: (1) Two telephone lines (numbers) (2) One telephone line (number) and one cellular telephone connection (3) One telephone line (number) and a one-way radio system (4) One telephone line (number) equipped with a derived local channel (5) One telephone line (number) and a one-way private radio alarm system (6) One telephone line (number) and a private microwave radio system (7) One telephone line (number) and a two-way RF multiplex system (8) *A single integrated services digital network (ISDN) telephone line using a terminal adapter specifically listed for supervising station fire alarm service, where the path between the transmitter and the switched telephone network serving central office is monitored for integrity so that the occurrence of an adverse condition in the path shall be annunciated at the supervising station within 200 seconds	K 052			