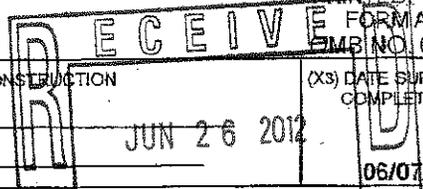


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/19/2012
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185217	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/07/2012
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NAME OF PROVIDER OR SUPPLIER METCALFE HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 701 SKYLINE DRIVE, PO BOX 116 EDMONTON, KY 42129
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
F 253 SS=D	<p>A standard health survey was conducted on 06/05-07/12. Deficient practice was identified with the highest scope and severity at "D" level.</p> <p>483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to provide maintenance services necessary to maintain a sanitary orderly and comfortable interior. Fire doors to the ramp on Station 2 were observed to be chipped and splintered and a hold-open device was observed to be loose.</p> <p>The findings include:</p> <p>A review of the facility policy titled Preventative Maintenance Program (undated) revealed a quarterly checklist to include inspection of fire doors was required to be completed.</p> <p>Observations conducted during an environmental tour on 06/07/12, at 1:20 PM, of double doors on Station 2 leading to the main dining room and the sun porch revealed the edges of the fire doors were chipped and splintered.</p> <p>A review of the facility checklist revealed the fire</p>	F 253	<p>The preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This plan of correction is prepared and executed solely because it is required by federal and state law</p> <ol style="list-style-type: none"> The fire doors at the top of the dining room ramp and the hold-open device have been repaired. The maintenance staff have inspected the facility wood doors and hold-open devices. All issues requiring repair have been addressed. The housekeeping and maintenance staff have received in-service education on the need to inspect facility wood doors and hold-open devices to identify issues requiring repair as provided by the Administrator on 6/29/12 The CQI indicator for the monitoring of the facility interior will be utilized monthly X 2 months and then every 6 months in accordance with the established CQI calendar under the supervision of the Housekeeping Supervisor. 	6/29/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *My Neighbor* TITLE: Administrator (X8) DATE: 6/25/12

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 METCALFE HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 701 SKYLINE DRIVE, PO BOX 115 EDMONTON, KY 42129		
(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 253	Continued From page 1 doors had been inspected by Maintenance on 05/24/12, and no concerns were identified. An interview conducted with the facility Maintenance Director on 06/07/12, at 1:30 PM, revealed the doors were inspected quarterly to ensure the hold-open devices worked and the doors closed properly but the condition of the door was not checked for splintering and chipping. Additional interview revealed the Maintenance Director was not aware the door edges were chipped and splintered or that the hold-open device was loose, and was not aware how long these doors had been in disrepair.	F 253			
F 364 SS=D	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy review, it was determined the facility failed to provide foods/liquids that were palatable and at the proper temperature during the evening meal on 06/05/12, and during the breakfast meal on 06/06/12. The findings include: A review of the Minimum Temperature at Point of Service to the Resident policy (no date) revealed food would be delivered to residents at the	F 364	1. Facility has purchased insulated bases and lids that, according to manufacturer's description, has a holding time of up to 40 minutes. 2. Facility has purchased insulated bases and lids that, according to manufacturer's description, has a holding time of up to 40 minutes. 3. Timing devices have been implemented on the meal tray carts to alert the staff to trays that have remained on the cart longer than the allowed 20 minute time. Trays remaining after the timing device alarm sounds will be returned to the kitchen and replaced with fresh trays. Nursing staff have received in-service education by the DM/DON/ADON on the need to return trays to the kitchen for replacement when the timing device alarm sounds. Insulated bases and domes have been purchased and are being utilized for trays delivered to resident rooms. 4. The CQI indicator for the monitoring of food temperatures will be utilized monthly X 2 months and then monthly as per the established CQI calendar under the supervision of the Dietary Manager.	6/28/12	

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NAME OF PROVIDER OR SUPPLIER METCALFE HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 701 SKYLINE DRIVE, PO BOX 115 EDMONTON, KY 42129		
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F 364	<p>Continued From page 2</p> <p>minimum temperatures at the point of service. The policy identified the minimum point of service temperature for meat, vegetables, and gravy to be 115-125 degrees Fahrenheit and milk was to be less than 45 degrees Fahrenheit. The policy did not include specific timeframes for the resident meal trays to be distributed.</p> <p>Observation conducted of the evening meal service on 06/05/12, revealed trays were transported in an open cart from the kitchen to the Station 2 hallway at 5:45 PM. During tray delivery, one Certified Nurse Aide (CNA) was observed to deliver trays to the residents' rooms, to go back to the kitchen for individual resident requests, and to answer resident call lights. The last tray was removed from the food cart at 6:13 PM (28 minutes later), and a test tray was obtained for food temperatures and palatability. The food temperatures were: rice - 120 degrees Fahrenheit, squash - 108 degrees Fahrenheit, and baked chicken - 86 degrees Fahrenheit. Palatability testing revealed the rice tasted warm, the squash tasted lukewarm and bland, and the chicken tasted cold and bland.</p> <p>Interview with CNA #1 on 06/05/12, at 5:25 PM, revealed tray delivery usually took approximately 30 minutes to complete due to the CNA having to answer resident call lights and go back and forth to the kitchen for substitutes or special requests. The CNA stated one CNA passed the trays until another CNA was "freed up" to help deliver the trays.</p> <p>A resident group meeting was conducted on 06/06/12, at 4:00 PM. Residents #11 and #16 reported breakfast foods were frequently cold.</p>	F 364		

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NAME OF PROVIDER OR SUPPLIER METCALFE HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 701 SKYLINE DRIVE, PO BOX 115 EDMONTON, KY 42129		
(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 364	Continued From page 3 Observations conducted during the breakfast meal on 06/07/12, revealed 13 trays were transported on an open cart from the kitchen to the Station 2 hallway at 7:38 AM. The last tray was removed from the food cart at 6:13 PM (12 minutes later), and a test tray was obtained for food temperatures and palatability. The food temperatures were: scrambled eggs - 98 degrees Fahrenheit, gravy with biscuits - 94 degrees Fahrenheit, milk - 50 degrees Fahrenheit, and the bacon was cold to touch. Palatability testing revealed the eggs were lukewarm to taste and the bacon, gravy with biscuits, and milk were cool to taste. An interview conducted with the Dietary Manager (DM) on 06/07/12, at 1:15 PM, revealed temperatures were checked in the kitchen at the beginning of each meal and at mid-point of the meal service. The DM stated test trays for temperature and palatability were conducted monthly by the Registered Dietitian, usually during the lunch meal, and no problems had been identified. The DM also stated she was not aware of residents' complaints of cold foods. In addition, the DM stated onions had been omitted from the recipe for the squash prepared for the evening meal on 06/05/12. The DM stated she usually tasted all the foods served, but did not taste the chicken or squash on 06/05/12. Interview with the dietary cook on 06/07/12, at 3:00 PM, revealed onions had been omitted from the recipe for the squash prepared on 06/05/12 for the evening meal. The cook stated the onions were available, but she forgot to add them to the recipe.	F 364			

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NAME OF PROVIDER OR SUPPLIER METCALFE HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 701 SKYLINE DRIVE, PO BOX 115 EDMONTON, KY 42129		
(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 364	Continued From page 4	F 364			
F 371 SS=D	<p>483.35(j) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>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</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy review, the facility failed to store and serve food under sanitary conditions during the breakfast meal on 06/07/12. Three trays were observed to contain banana halves uncovered during transport from the kitchen to the Station 2 hallway.</p> <p>The findings include: Review of the Dietary Food Handling policy (no</p>	F 371	<p>1. Bananas will be served whole and unpeeled.</p> <p>2. Meal tray delivery observations were performed by the Dietary Manager and RD on 6/21/12 to determine that all food items are covered appropriately for meal tray delivery.</p> <p>3. The dietary staff have received in-service education on the requirement to serve bananas whole and unpeeled by the Dietary Manager on 6/25/12.</p> <p>4. The CQI indicator for the monitoring of dietary sanitation will be utilized monthly as per the established CQI calendar under the supervision of the Dietary Manager.</p>	6/25/12	

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NAME OF PROVIDER OR SUPPLIER METCALFE HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 701 SKYLINE DRIVE, PO BOX 115 EDMONTON, KY 42129	
(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 371	Continued From page 5 date) revealed prepared foods should be transported to other areas in closed food carts or covered by a facility approved method. During the breakfast meal on 06/07/12, 13 trays were observed to be transported from the kitchen in an open cart to the Station 2 hallway at 6:38 AM. Three of the trays were observed to contain banana halves that were not covered. The facility staff was observed to transport the trays from the kitchen to the Station 2 hallway and up and down the hallway during tray delivery. Interview with the Dietary Manager (DM) on 06/07/12, at 1:15 PM, revealed the dietary staff was responsible to cover all food items to be transported to the different hallways in the facility. The DM stated the tray line should be double checked by the kitchen staff to ensure foods were covered appropriately during transport.	F 371		
F.468 SS=D	483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS The facility must equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to ensure handrails were firmly secured to the wall. A hand rail in the main dining room was observed loose from the wall. The findings include: A review of the facility policy titled Preventative	F 468	1. The hand rail by the main dining room has been secured. 2. All handrails in the facility have been inspected by the Environmental Services Director and maintenance staff to determine that they are secure. 3. Facility staff have received in-service education by the Administrator on 6/28/12 on the need to report all repair issues that they identify in a timely manner. 4. The CQI indicator for the monitoring of secure facility hand rails will be utilized monthly X 2 months and then every 6 months as per the established CQI calendar under the supervision of the Environmental Services Director.	6/28/12

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NAME OF PROVIDER OR SUPPLIER METCALFE HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 701 SKYLINE DRIVE, PO BOX 115 EDMONTON, KY 42129	
(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 468	<p>Continued From page 6</p> <p>Maintenance Program (undated) revealed the preventative maintenance was completed daily, weekly, monthly, and quarterly to ensure facility equipment was safe and in good, operable condition. However, a review of the facility Preventative Maintenance Checklist revealed no provisions to check facility handrails to ensure the handrails were firmly secured to the wall.</p> <p>Observations conducted on 06/05/12, at 12:15 PM and 6:00 PM, and during an environmental tour conducted on 06/07/12, at 1:20 PM, revealed a handrail in the main dining room was loose from the wall.</p> <p>A review of the maintenance log revealed the loose handrail in the dining room had been tightened by Maintenance on 05/21/12. However, the handrail had become loose from the wall again.</p> <p>An interview conducted with the Maintenance Director revealed the handrails were randomly checked each day to ensure they were firmly attached to the wall. Additional interview revealed the preventative maintenance checks did not include the handrails nor did the facility have a system to ensure all handrails were routinely checked. According to the Maintenance Director, she was not aware the handrail had become loose again.</p>	F 468		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185217	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 06/06/2012
NAME OF PROVIDER OR SUPPLIER METCALFE HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 701 SKYLINE DRIVE EDMONTON, KY 42129		
(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	
K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1991</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One story, Type 111 (211)</p> <p>SMOKE COMPARTMENTS: 5</p> <p>FIRE ALARM: Complete automatic fire alarm system.</p> <p>SPRINKLER SYSTEM: Complete automatic (dry) sprinkler system.</p> <p>GENERATOR: Type II diesel generator.</p> <p>A life safety code survey was initiated and concluded on 06/06/12, for compliance with Title 42, Code of Federal Regulations, 483.70(a) and found the facility to be in compliance with NFPA 101 Life Safety Code, 2000 Edition.</p> <p>No deficiencies were identified during this survey.</p>	K 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.