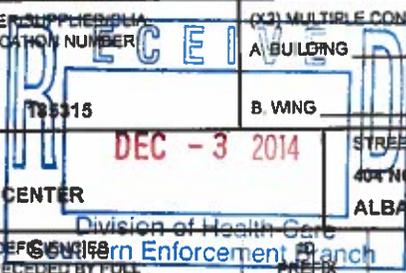


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/21/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 183315	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/06/2014
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	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 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review it was determined that the facility failed to ensure services were provided to maintain a sanitary and comfortable interior related to toilets not being secured to the floor for two (2) of four (4) toilets. Observations on 11/04/14 at 8:18 PM (all times listed are Eastern Standard Time) of the B Hall men's restroom and on 11/05/14 at 8:50 PM of the C Hall restroom revealed the toilets were not secured to the floor and were loose. The findings include: Review of the facility's policy titled "Building Standards Policy," dated January 2005 revealed under the "policy" section that in order to provide and maintain safety and security for the residents, the building structure of the facility would be constructed and maintained according to the requirements as set forth by each state's licensure code. Further review of the "Building Standards Policy" revealed under the "procedure" section that the facility would be constructed, arranged, and maintained to ensure the safety of	F 253		



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

Donna Lu

TITLE

Administrator

(X8) DATE

11/26/14

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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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 11/06/2014
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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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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<p>F 000</p> <p>F 253 SS=E</p>	<p>INITIAL COMMENTS</p> <p>A standard health survey was conducted on 11/04-06/14. Deficient practice was identified with the highest scope and severity at "E" 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 policy review it was determined that the facility failed to ensure services were provided to maintain a sanitary and comfortable interior related to toilets not being secured to the floor for two (2) of four (4) toilets. Observations on 11/04/14 at 6:18 PM (all times listed are Eastern Standard Time) of the B Hall men's restroom and on 11/05/14 at 8:50 PM of the C Hall restroom revealed the toilets were not secured to the floor and were loose.</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Building Standards Policy," dated January 2005 revealed under the "policy" section that in order to provide and maintain safety and security for the residents, the building structure of the facility would be constructed and maintained according to the requirements as set forth by each state's licensure code. Further review of the "Building Standards Policy" revealed under the "procedure" section that the facility would be constructed, arranged, and maintained to ensure the safety of</p>	<p>F 000</p> <p>F 253</p>	<p>1.The toilets on B Hall and C Hall were repaired by Steve Hardin, Maintenance. B Hall was repaired on 11/4/14 and C Hall was repaired on 11/5/14.</p> <p>2.All other toilets in the facility were inspected by Steve Hardin, Maintenance with no other issues or concerns noted on 11/5/14.</p> <p>3.Staff were In-serviced on correct procedure for identifying any maintenance issues and the proper reporting procedures for any items of concern noted or any issues with facility equipment or repairs needed on 11/26/14.</p> <p>Steve Hardin, Maintenance Director or Designee will complete random audits weekly of all bathrooms, to include toilets for any issues or concerns for a period of 3 months.</p> <p>4.Findings of all audits will be reported to the Administrator and will be reviewed by the Quality Assurance Committee monthly for a period of three months.</p>	<p>11/26/14</p>
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Alonna Lu</i>	TITLE <i>Administrator</i>	(X8) DATE <i>11/26/14</i>
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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	
(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	<p>Continued From page 1</p> <p>all residents and that a toilet, lavatory, bath, or shower will be provided according to state/federal requirements.</p> <p>Observations on 11/04/14 at 6:18 PM of the men's restroom on B Hall and on 11/05/14 at 8:50 AM of the restroom on C Hall revealed the toilets in the restrooms were not secured to the floor.</p> <p>Interview with the Facility Plant Operations Director (FPOD) on 11/04/14 at 6:24 PM revealed he was not aware the toilet was loose from the floor on B Hall. Further interview with the Facility Plant Operations Director on 11/05/14 at 9:03 AM revealed he was not aware the toilet was loose from the floor in the restroom on C Hall either. He stated he conducted random room checks but had not identified the concern with the toilets.</p> <p>Interview with the Facility Plant Operations Director on 11/06/14 at 2:53 PM revealed facility staff should complete a repair request when concerns were observed by filling out a repair request form located at the nurses' station and on housekeeping carts. Continued interview with the Facility Plant Operations Director revealed the paper form had three parts. The FPOD stated that he kept two copies of the form and gave one to the Administrator upon receiving the request and once the repair was completed he filed one copy in his records and gave the remaining copy to the Facility Administrator.</p> <p>Interview with the Facility Administrator on 11/06/14 at 2:55 PM revealed she was not aware of any issues with the toilets. She confirmed that facility staff should complete a maintenance repair form and give it to the Plant Operations Director when repairs were needed. Further</p>	F 253		

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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 42802		
(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 2 Interview with the Facility Administrator revealed she used a computer system that generated a weekly report to track and follow up to ensure repairs were made in the facility and that no maintenance repair form had been submitted related to toilets.	F 253			
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility policy, it was determined the facility failed to provide pharmaceutical services to meet the needs of one of thirteen sampled residents (Resident #6). The facility failed to	F 425	1.It was found during observation that Resident #6 was receiving an IV anti-biotic at the correct dose, correct rate and correct rate of time. However, the IV antibiotic was labeled with the wrong resident name. 2.All residents receiving IV antibiotic medications were immediately audited by Tim Pickens, Director of Nursing on 11/7/14 when made aware of the deficient practice to ensure that no other resident had been affected. No other issues or concerns were noted from the audit. 3.The nurse who administered the IV antibiotics was immediately inserviced on facility's policy and procedure for acquiring needed medications and administration of medications by Tim Pickens, Director of Nursing on 11/7/14. All licensed nursing staff were inserviced on the facility's policy and procedure regarding medication administration by Tim Pickens, Director of Nursing on 11/13/14.		

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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 42802
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F 425	<p>Continued From page 3</p> <p>ensure that nursing staff accurately acquired the intravenous (IV) medication Rocephin (antibiotic) for Resident #6.</p> <p>The findings include:</p> <p>Review of the facility policy, "Medication Administration General Guidelines," dated December 2012, revealed medications supplied for one resident should never be administered to another resident.</p> <p>During the initial tour on 11/04/14 at 4:30 PM, observation revealed an empty IV Rocephin 1 gram (gm) bag hanging on the IV pole next to Resident #6. The medication label did not have Resident #6's name on the label and was observed to have a different resident name and date of birth.</p> <p>A review of Resident #6's medical record revealed the facility admitted the resident on 08/29/14 with diagnoses that included chronic Urinary Tract Infections and Weakness. A review of the admission Minimum Data Set (MDS) assessment dated 09/05/14 revealed the resident was cognitively impaired with a Brief Interview for Mental Status (BIMS) score of 3, which indicated the resident was not interviewable.</p> <p>A review of Resident #6's physician orders dated 11/03/14 revealed the resident had an order for Rocephin 1 gm with 100 mL Normal Saline (NS) IV every 24 hours for 10 days related to culture results.</p> <p>A review of the Medication Administration Record (MAR) dated November 2014, revealed the resident received the 5:00 PM dose of Rocephin</p>	F 425	<p>All licensed nursing staff receive a nursing competency check on facility policy and procedure for medication administration during orientation and on yearly competency review thereafter by the Director of Nursing or Designee.</p> <p>An audit of the residents receiving IV medications at the current time was initiated on 11/7/14 and followed through until the IV antibiotic course was completed By Tim Pickens, Director of Nursing.</p> <p>An audit will be performed by Tim Pickens, Director of Nursing or Designee on each resident receiving antibiotic therapy for the next 3 months.</p> <p>The nurse administering the IV medication will complete a competency check on medication administration with the Director of Nursing or Designee at the time the IV medications are administered.</p> <p>4. Audit findings will be reported to the Administrator, Medical Director and Quality Assurance Committee for a period of 3 months.</p>	11/13/14
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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		
(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 425	<p>Continued From page 4 1 gm IV on 11/04/14.</p> <p>An interview conducted with Licensed Practical Nurse (LPN) #2 on 11/06/14 at 1:30 PM revealed she had administered Rocephin 1 gm IV with 100 mL of NS to Resident #8 on 11/04/14 and had "borrowed" the medication from another resident. The LPN continued to state that she had been trained to never borrow medication but "didn't want the resident to have a late dose" while waiting on the pharmacy to bring the said medication. However, observation of the medication room emergency box on 11/06/14 at 1:50 PM revealed four vials of IV Rocephin available for use at the facility.</p> <p>An interview with the facility Pharmacist on 11/06/14 at 1:54 PM revealed the resident's order for the Rocephin medication was received on the evening of 11/03/14 and delivered to the facility on 11/04/14 at 9:45 PM. The pharmacist also stated Rocephin could be found in the facility's emergency kits and was considered a "no wait" medication.</p> <p>An interview with the Assistant Director of Nursing (ADON) on 11/06/14 at 2:17 PM revealed medications should "never be borrowed." The ADON also stated that if the medication was unavailable, it should be pulled from the emergency kit or the pharmacy should be made aware to "stat" the order.</p> <p>An interview with the Director of Nursing on 11/06/14 at 2:34 PM revealed medications could not be substituted or borrowed.</p>	F 425			

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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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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>Building: 01</p> <p>Survey under: NFPA 101 (2000 Edition)</p> <p>Facility type: SNF/NF</p> <p>Type of structure: Type V (000)</p> <p>Smoke Compartments: 4</p> <p>Fire Alarm: Fire alarm installed 1985</p> <p>Sprinkler System: Sprinkler System installed 1985</p> <p>Generator: Type II. Diesel</p> <p>A standard Life Safety Code survey was conducted on 11/05/14. Clinton County Care and Rehabilitation Center was found not to be in compliance with the requirements for participation in Medicare and Medicaid.</p> <p>Deficiencies were cited at "D" level.</p>	K 000	<p>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.</p>	
K 062 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>This STANDARD is not met as evidenced by:</p>	K 062		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Norma Lee</i>	TITLE <i>Administrator</i>	(X6) DATE <i>11/26/14</i>
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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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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>Building: 01</p> <p>Survey under: NFPA 101 (2000 Edition)</p> <p>Facility type: SNF/NF</p> <p>Type of structure: Type V (000)</p> <p>Smoke Compartments: 4</p> <p>Fire Alarm: Fire alarm installed 1985</p> <p>Sprinkler System: Sprinkler System installed 1985</p> <p>Generator: Type II. Diesel</p> <p>A standard Life Safety Code survey was conducted on 11/05/14. Clinton County Care and Rehabilitation Center was found not to be in compliance with the requirements for participation in Medicare and Medicaid.</p> <p>Deficiencies were cited at "D" level.</p>	K 000		
K 062 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>This STANDARD is not met as evidenced by:</p>	K 062	<p>1.Piping for the sprinkler heads for the affected areas was installed on 11/20/14. Sprinkler heads for the affected areas will be installed on or before 12/3/14 by Century Fire Protection.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Donna Lee</i>	TITLE <i>Administrator</i>	(X6) DATE <i>11/26/14</i>
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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	
(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 062	<p>Continued From page 1</p> <p>Based on observation and interview, the facility failed to ensure that sprinkler coverage requirements were maintained. This deficient practice affected one (1) of four (4) smoke compartments, staff, and approximately sixteen (16) residents. The facility has the capacity for 52 beds with a census of 50 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code survey on 11/05/14 at 9:50 AM with the Director of Maintenance (DOM), inadequate sprinkler coverage was observed in two resident restrooms located next to each other in the B Hall of the facility. Walls in the restrooms would obstruct the sprinkler pattern from reaching all areas of the rooms.</p> <p>An interview with the DOM on 11/05/14 at 9:50 AM revealed he thought sprinkler coverage was adequate for these areas.</p> <p>The findings were revealed to the Administrator upon exit.</p> <p>Reference: NFPA 13 (1999 Edition).</p> <p>5-5.5.1* Performance Objective. Sprinklers shall be located so as to minimize obstructions to discharge as defined in 5-5.5.2 and 5-5.5.3, or additional sprinklers shall be provided to ensure adequate coverage of the hazard.</p>	K 062	<p>2. Steve Hardin, Plant Director contacted a representative of Century Fire Protection on 11/5/14 and set an appointment for sprinkler repairs to be made. Century Fire Protection installed piping for the sprinkler heads on 11/20/14 and ordered new sprinkler heads which will be installed on before 12/3/14.</p> <p>3. The sprinklers will be inspected on a quarterly basis by Century Fire Protection and any issues will be immediately addressed.</p> <p>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 needed.</p> <p style="text-align: right;">12/3/14</p>
K 130 SS=D	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2788	K 130	1. All dryers were immediately cleaned of all lint build up by Shawn Shelley, Laundry Director and Steve Hardin, Maintenance Director on 11/5/14.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185315	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 11/05/2014	
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
K 130	<p>Continued From page 2</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain clothes dryers in an approved manner. This deficient practice affected one (1) of four (4) smoke compartments, staff, and other occupants of the building. The facility has the capacity for 52 beds with a census of 50 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code tour on 11/05/14 at 9:10 AM with the Director of Maintenance (DOM), a large amount of lint buildup was observed on top of three dryer lint traps in the lower compartment of the dryers. Some of the temperature sensors located in this area were observed to be covered with lint. The lint may cause the temperature sensors in this area of the dryer not to function as intended and may cause the tumbler to overheat.</p> <p>An interview with the DOM on 11/05/14 at 9:10 AM revealed he was not aware the sensors in this area of the dryers needed to be maintained.</p> <p>The findings were revealed to the Administrator upon exit.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>4.5.7 Maintenance. Whenever or wherever any device, equipment, system, condition, arrangement, level of</p>	K 130	<p>2. A thorough inspection of the laundry area for any issues or concerns to include lint buildup was conducted by Steve Hardin, Maintenance Director on 11/5/14 with no other issues or concerns noted.</p> <p>3. All dryers have been added to a bi-weekly maintenance and cleaning schedule on 11/5/14.</p> <p>Shawn Shelley, Laundry Director or Designee will complete random weekly audits for a period of 3 months to ensure the proper cleaning and maintenance of dryers.</p> <p>4. Audit findings will be reported to the Administrator and Quality Assurance Committee for a period of 3 months for recommendations and further follow-up as indicated.</p>	11/5/14

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

PRINTED: 11/21/2014
FORM APPROVED
OMB NO. 0938-0391

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K 130	Continued From page 3 protection, or any other feature is required for compliance with the provisions of this Code, such device, equipment, system, condition, arrangement, level of protection, or other feature shall thereafter be maintained unless the Code exempts such maintenance.	K 130		