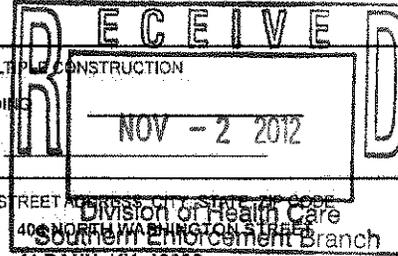


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/25/2012  
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  10/11/2012
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NAME OF PROVIDER OR SUPPLIER  CLINTON COUNTY CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 405 NORTH WASHINGTON STREET Southern Enforcement Branch 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)	ID 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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F 000	INITIAL COMMENTS  A standard health survey was conducted on 10/09-11/12. Deficient practice was identified with the highest scope and severity at "D" level.	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=D	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 review of the facility's policy, it was determined the facility failed to provide maintenance services to maintain a sanitary, orderly, and comfortable interior. Doors to rooms C107 and C110, and the B Hall entrance doors were splintered with sharp edges. In addition, a metal pipe, with sharp edges, was protruding from the base of a dining room wall.  The findings include:  The Maintenance Service policy (dated January 2005) revealed, "The maintenance department was responsible for maintaining the building, grounds, and equipment in a safe and operable manner at all times."  During the environmental tour on 10/09/12, 10/10/12, and 10/11/12, entrance doors to rooms C107 and C110, and the B Hall entrance doors were noted to be splintered with sharp edges. A metal pipe was protruding from the wall above the floorboard on a dining room wall. The metal pipe	F 253		

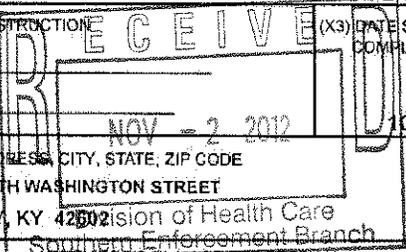
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Norman Lee</i>	TITLE <i>Administrator</i>	(X6) DATE <i>11/8/12</i>
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused 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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CENTERS FOR MEDICARE & MEDICAID SERVICES

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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  10/11/2012
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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 42002
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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
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F 000	INITIAL COMMENTS	F 000		
F 253 SS=D	<p>483.15(h)(2) HOUSEKEEPING &amp; 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 review of the facility's policy, it was determined the facility failed to provide maintenance services to maintain a sanitary, orderly, and comfortable interior. Doors to rooms C107 and C110, and the B Hall entrance doors were splintered with sharp edges. In addition, a metal pipe, with sharp edges, was protruding from the base of a dining room wall.</p> <p>The findings include:</p> <p>The Maintenance Service policy (dated January 2005) revealed, "The maintenance department was responsible for maintaining the building, grounds, and equipment in a safe and operable manner at all times."</p> <p>During the environmental tour on 10/09/12, 10/10/12, and 10/11/12, entrance doors to rooms C107 and C110, and the B Hall entrance doors were noted to be splintered with sharp edges. A metal pipe was protruding from the wall above the floorboard on a dining room wall. The metal pipe</p>	F 253	<p>1.The doors of C107 and C110 were immediately repaired by the Plant Director on 10/10/12 and B Hall entrance doors were repaired by the Plant Director on 10/11/12 and replaced with new doors on 10/29/12. The metal pipe was immediately covered with a safety cover on 10/11/12 by the Plant Director and was completely removed on 10/16/12.</p> <p>2.A 100% audit of all facility doors was completed by the Plant Director on 10/12/12.</p> <p>3.The facility doors have been added to the maintenance audit schedule and will be assessed weekly for splintering or marring by the Plant Director or Designee. Any doors found to be defective will be repaired immediately. The Plant Director or Designee will complete monthly plumbing inspections/audits of the facility and any issues found will be addressed immediately.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Alanna Poe</i>	TITLE <i>Administrator</i>	(X6) DATE <i>11/2/12</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.

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

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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  10/11/2012	
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>was approximately 4-5 inches long and had sharp edges.</p> <p>A review of a logbook maintained by the Maintenance Department of areas in the facility that needed to be assessed and/or repaired revealed the hinges and handles of the interior/exterior doors had been assessed in January to September 2012. Further review of the maintenance section logs revealed the common areas (bathrooms and dining room) were checked for walls, floors, handrails, and baseboards being in good condition on 01/25/12, 02/15/12, 03/20/12, and 04/25/12.</p> <p>Interview with the Maintenance Supervisor on 10/10/12, at 4:20 PM, revealed the doors for rooms C107 and C110, the B Hall entrance doors, and the dining room had been checked and he had not noticed the doors were splintered; however, the Maintenance Supervisor stated he had contacted a plumber regarding the metal pipe in the dining room but the plumber had been unable to come to the facility because of another job in the community.</p> <p>Interview with the Administrator on 10/11/12, at 10:00 AM, revealed supervisory staff conducted rounds of the facility, including environmental rounds, on a daily basis. According to the Administrator, anything observed to be broken or in need of repair was addressed at that time and repairs made. The Administrator stated the splintered doors had not been identified during the rounds. The Administrator also stated a plumber had been contacted by the Maintenance Supervisor to make repairs to the metal pipe in the dining room but, due to other obligations, the</p>	F 253	<p>Continued from page 1</p> <p>4. Findings of the audits will be forwarded to the Administrator weekly to ensure appropriate follow-up. Findings of the maintenance audits will be reviewed by the Quality Assurance Committee monthly for 3 months for recommendations and further follow-up as indicated.</p>	10/29/12

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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	Continued From page 2 plumber would not be available to complete the repairs until a later date.	F 253			
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective 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	F 441	1.The wound care nurse was in-serviced by the Director of Nursing on 10/11/12 regarding hand-washing and re-gloving post irrigation of wounds. The licensed nursing staff were in-serviced by the Director of Nursing on 10/11/12 regarding hand-washing and re-gloving post irrigation of wounds.  2.No other residents were found to be affected by the deficient practice.  3.The facility policy was revised by the Director of Nursing on 10/18/12 to include hand-washing and re-gloving post irrigation of any wound. A 7 day audit was completed by the Director of Nursing of dressing changes for Resident #4. Random monthly audits will be completed for a period of 3 months by the Director of Nursing or Designee to ensure proper procedures are followed.  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.	10/18/12	

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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 441	<p>Continued From page 3 infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility policy, the facility failed to use appropriate hand washing technique during wound care treatment for one of thirteen sampled residents (Resident #4). Staff was observed to omit hand washing and/or glove changes prior to placing a clean dressing over an open wound on the resident's right heel.</p> <p>The findings include:</p> <p>Review of the facility Hand washing policy (dated December 2012) revealed hand washing should be performed before and after caring for each resident. A review of the policy regarding application of a Clean Dressing (revision date August 2007) revealed staff should perform hand washing and change gloves prior to wound irrigation. The policy did not include guidelines for hand washing and glove changes prior to application of a clean dressing.</p> <p>A review of the Recommendations from the Centers for Disease Control (CDC) guideline for Hand Hygiene in Healthcare Settings revealed hands should be decontaminated if moving from a contaminated body site to a clean body site during care and after contact with nonintact skin.</p> <p>Review of the medical record revealed the facility admitted Resident #4 on 04/28/09 with diagnoses to include Senile Dementia, Congestive Heart</p>	F 441			

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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)	ID 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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F 441	<p>Continued From page 4</p> <p>Failure, Peripheral Vascular Disease, and Chronic Ischemic Heart Disease. Further record review revealed Resident #4 was readmitted to the facility from the hospital on 07/19/12 with an unstageable wound of the right heel which required surgical debridement on 09/04/12.</p> <p>A review of the physician's order dated 09/29/12 revealed the physician ordered a Culture and Sensitivity (C&amp;S) to be conducted of the right heel wound. Review of the C&amp;S results obtained on 09/29/12 revealed a growth of Staphylococcus aureus present in the right heel wound. Further review of the physician's orders dated 09/29/12 revealed the physician prescribed Bactrim DS (antibiotic) twice a day for 14 days for treatment.</p> <p>Observation of wound care treatment conducted on 10/09/12, at 3:50 PM, revealed an open wound measuring approximately 2.5 centimeters (cm) by 2.8 cm by 1 cm in depth was present on Resident #4's right heel. The wound was also noted to have yellow slough tissue with reddened surrounding tissue. The nurse was observed to wash her hands, put on clean gloves, and irrigate the wound with a syringe filled with normal saline solution. The nurse then picked up non-sterile 4 x 4 gauze with the gloved hand and patted the heel wound dry. The nurse was observed to pick up medicated gauze with the same gloved hand used to pat the heel dry, place the gauze into the open wound, and then cover the wound with a 4 x 4 gauze and an abdominal pad dressing. However, the nurse failed to perform hand washing or change gloves after irrigating the wound, patting the wound dry using the gloved hand and 4 x 4, and prior to applying the clean packing and dressing to the resident's open</p>	F 441		
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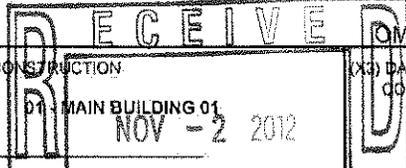
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NAME OF PROVIDER OR SUPPLIER  CLINTON COUNTY CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 404 NORTH WASHINGTON STREET ALBANY, KY 42602		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 441	Continued From page 5 wound.  Interview conducted with RN #1 on 10/10/12, at 10:55 AM, revealed she was the facility wound care nurse. RN #1 stated she had been trained to perform hand washing and glove change when going from a dirty site to a clean site during wound care. RN #1 stated she should have changed gloves and performed hand washing after irrigating the resident's wound.  Interview with the Director of Nurses (DON) on 10/10/12, at 2:00 PM, revealed hand washing and glove change should be performed when going from a dirty to clean site when wound care was provided. The DON also stated random observations were conducted of staff performance during wound care and no problems had been identified.	F 441			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185315	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED  10/09/2012
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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)	ID 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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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 10/09/12. 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 a "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 038 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p>	K 038		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Donna Kue</i>	TITLE <i>Administrator</i>	(X6) DATE <i>11/2/12</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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185315	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 MAIN BUILDING #1 B. WING _____	(X3) DATE SURVEY COMPLETED  10/09/2012
NAME OF PROVIDER OR SUPPLIER  CLINTON COUNTY CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 404 NORTH WASHINGTON STREET ALBANY, KY 40002 Division of Health Care Sourthern Baptist Hospital	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(X5) COMPLETION DATE	
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 10/09/12. Clinton County Care and Rehabilitation Center was found not to be in compliance with the requirements for participation in Medicare and Medicaid.  Deficiencies were cited at a "D" level.	K 000		
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1	K 038	1. The nursing staff were immediately in-serviced on 10/9/12 that the door was not to be key locked by the Plant Director. The code for the front gate was immediately posted by the gate on 10/9/12 by the Plant Director.  2. A 15 second delayed egress will be installed on the front entrance door.	

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

TITLE

(X8) DATE

*Alonna Bee*

*Administrator*

*11/2/12*

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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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  10/09/2012
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 038	Continued From page 1  This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that exits were readily accessible to the public way. This deficient practice affected one of four smoke compartments, staff, residents, and visitors. The facility has the capacity for 52 beds with a census of 49 on the day of the survey.  The findings include:  During the Life Safety Code tour on 10/09/12, at 9:00 AM, an interview with the Director of Nursing revealed the front doors of the facility were locked with a key at 9:00 PM nightly. Exits must remain accessible to the public way in case of fire or other emergency. An interview with the Director of Maintenance (DOM) on 10/09/12, at 12:25 PM, revealed he was not aware the doors were key locked at night. A canopied walkway from the front doors led to a gate with a keypad operation without a posted combination. The DOM was also unaware the combination must be posted.  Reference: NFPA 101 (2000 Edition).  19.2.2.2.4 Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side.  Exception No. 2*: Delayed-egress locks complying with 7.2.1.6.1 shall be permitted, provided that not more than one such device is located in any egress path.	K 038	Continued from page 1  3.The Plant Director or Designee will complete daily audits for all facility exit doors to ensure proper operation.  4.Audit findings 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.	11/7/12	

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

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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 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED  10/09/2012
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 038	Continued From page 2 Exception No. 3: Access-controlled egress doors complying with 7.2.1.6.2 shall be permitted.	K 038			