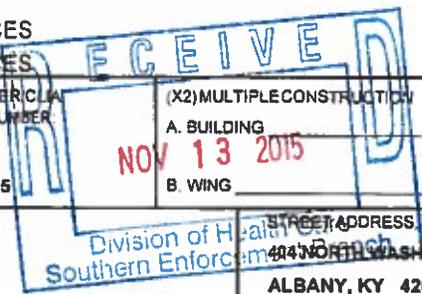


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/29/2015
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 NOV 13 2015 B. WING	(X3) DATE SURVEY COMPLETED C 10/15/2015
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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
F 000	INITIAL COMMENTS A standard health survey was conducted on 10/13-15/15. Deficient practice was identified with the highest scope and severity at "E" level. An abbreviated survey (KY23924) was also conducted at this time. The complaint was unsubstantiated with no deficient practice identified.	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 proceedings. 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 correction as part of its ongoing efforts to provide quality of care to its residents.	
F 441 SS=E	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	F 441	1. Staff were in-serviced on 10/13/15 regarding proper hand washing and meal service tray pass. On 10/15/15 staff were in-serviced on facility's policy regarding meal service delivery, infection control and spread of infection. 2. No residents were found to be affected by the deficient practice. Monitoring for 72 hours was completed for residents for adverse effects related to infection control. No residents were found to have any new onset of signs and symptoms of infections. 3. Meal service delivery audits will be completed 3 times per week for 2 weeks, then 2 times per week for 2 weeks and then weekly for 1 month by the Director of Nursing, Assistant Director of Nursing or Staff Development Coordinator. 4. Findings of the audits will be reported to the	

LABORATORY DIRECTOR OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Wanda Bee TITLE: Administrator (X6) DATE: 11/13/15

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: 186315	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/16/2015
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 1</p> <p>hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, facility policy review, and review of the 2009 United States FDA (Food and Drug Administration) Food Code it was determined the facility failed to establish and maintain an effective infection control program designed to provide a safe and sanitary environment to prevent the transmission of disease and infection for four (4) of 5 (five) unsampled residents (Resident B, Resident C, Resident D, and Resident E). Observation of the dinner meal service on 10/13/15 in the dining room revealed facility staff setting up meal trays for Residents B, C, D, and E. Staff was observed to touch residents' food with bare hands. Further observations on 10/13/15 revealed staff was touching glasses and straws on the lip contact areas with bare skin while serving food.</p> <p>The findings include:</p> <p>Review of the facility's "Infection Control" policy and practices, last revised 08/2012, revealed its purpose was to facilitate maintaining a safe, sanitary, and comfortable environment and to</p>	F 441	Assurance Process Improvement Committee for two months for recommendations and further follow-up as indicated.	11/20/2015

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185316	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/15/2015
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 2 help prevent and manage transmission of diseases and infections.</p> <p>Review of the facility's policy titled "Safe Food Handling," no date, revealed the policy stated "all food purchased, stored and distributed is handled with accepted food-handling practices." Further review of the policy revealed it did not address the handling of clean cups, glasses, or straws.</p> <p>Review of the 2009 FDA Food Code revealed Chapter 4-904.11 stated, "Cleaned and sanitized utensils shall be handled, displayed, and dispensed so that contamination of food- and lip-contact surfaces is prevented."</p> <p>1. Observations during the dinner meal service on 10/13/15 from 4:55 PM to 5:10 PM in the dining room located next to the kitchen revealed CNA (Certified Nursing Assistant) #5 set up the trays for Residents B, C, D, and E. During setup, CNA #5 placed her ungloved hand on top of the residents' sandwiches and cut them in half with a knife.</p> <p>Interview with CNA #5 on 10/13/15 at 5:15 PM revealed that she was not trained to wear gloves when touching residents' food.</p> <p>2. Observations on 10/13/15 at 5:55 PM during the dinner meal service revealed State Registered Nursing Assistant (SRNA) #6 was taking food trays off the food cart and touching the straws on the lip contact area with bare skin.</p> <p>Interview with SRNA #6 on 10/13/15 at 5:59 PM revealed that it was a mistake because she was nervous, but said staff should not touch the lip contact area with bare hands.</p>	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 _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/15/2015
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</p> <p>3. Observation on 10/13/15 at 6:19 PM revealed the Plant Operations Director was touching the lip contact portion of cups and glasses with bare skin while serving food trays to residents.</p> <p>Interview on 10/13/15 at 6:19 PM with the Plant Operations Director revealed a member of Management takes turns passing trays and it was his turn. The Plant Operations Director went on to say he should not have been touching the rim portion of the glasses and that he should have been grabbing them from the bottom portion of the glass.</p> <p>Interview with LPN #6 on 10/15/15 at 3:11 PM revealed that staff should not have been handling glasses and straws by the lip contact areas without gloves. She stated staff is not supposed to touch any contact area with bare hands.</p> <p>Interview with the Dietary Manager (DM) on 10/15/15 at 10:15 AM revealed that staff should not touch residents' food with their bare hands and should not touch a lip contact area of utensils/cups with bare hands when preparing meal trays. The DM stated staff was trained on how to set up a resident's food tray and they should wear gloves any time they might come into contact with residents' food.</p> <p>Interview with the DON (Director of Nursing) on 10/15/15 at 3:56 PM revealed that staff should not be touching residents' food without gloves. The DON stated staff was trained on how to properly handle resident food and that she had not identified a problem with staff touching residents' food without wearing gloves. Furthermore, she stated the facility does not have</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		
(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 4 a policy on proper handling of food.	F 441			

DEPARTMENT OF HEALTH AND HUMAN 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 10/13/2015
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 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 Compartment: Three</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 10/13/15. Clinton County Care and Rehabilitation Center was found to be in compliance with the requirements for participation in Medicare and Medicaid.</p>	K 000			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

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