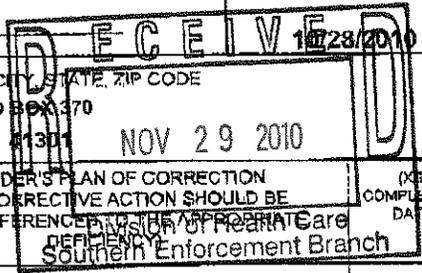


CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-0387

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185213	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  10/28/2010
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NAME OF PROVIDER OR SUPPLIER  WOLFE COUNTY HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 850 HWY 191, PO BOX 370 CAMPTON, KY 41301
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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 October 26-28, 2010. Deficient practice was identified with the highest scope and severity being at "D" level.	F 000		
F 166 SS=B	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES  A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.  This REQUIREMENT is not met as evidenced by: The facility failed to provide prompt efforts to actively seek a resolution and keep the residents appropriately apprised of its progress toward resolution of the grievances for two (2) of twenty-one (21) sampled residents (resident #20 and resident #21). Resident #20 reported missing personal items and resident #21 reported missing money to staff without resolution of the grievance.  The findings include:  The facility's Policy for Reporting Missing Items (no date) states if resident's missing items are not located the Activity/Social Service Director will fill out a Grievance Form.  1. During a group meeting conducted on October 27, 2010, at 10:00 a.m., resident #20 reported he/she had reported missing personal items to the facility staff. Resident #20 revealed approximately one month ago several items were missing which included three tubes of lipstick and	F 166	F/166 - see attached/	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Susan [Signature], Administrator</i>	TITLE <i>Administrator</i>	(X6) DATE <i>11/29/10</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.

Received Time Nov. 29. 2010 8:43AM No. 4546

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185213	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  10/28/2010
NAME OF PROVIDER OR SUPPLIER  WOLFE COUNTY HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 850 HWY 191, PO BOX 370 CAMPTON, KY 41301		
(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 166	Continued From page 1 three to four gowns. Resident #20 stated the missing items were reported to facility staff (unable to recall name of staff). Resident #20 stated one tube of lipstick was found and returned, however, the facility had not informed the resident of progress toward resolution of the missing items.  2. During a group meeting conducted on October 27, 2010, at 10:00 a.m., resident #21 had reported five dollars missing from his/her room to the facility staff (unable to recall name of staff) in July 2010. Resident #21 revealed he/she had not been informed by the facility of the progress toward resolution of the missing five dollars.  In an interview conducted with the Activity Director/Social Service Director (AD/SSD) on October 28, 2010, at 10:00 a.m., revealed resident #21 had reported five dollars missing to him/her. The AD/SSD stated resident #21 did not request a grievance filed, therefore, one was not filed.  An interview conducted on October 28, 2010, at 9:15 a.m., with the AD/SSD and the Administrator revealed when the resident reported personal clothing items missing the staff initially searched for such items. If the items were not found the staff would report the missing clothing items to the laundry staff who would log the missing items and return to the resident. The AD/SSD and the Administrator revealed a grievance form was not completed for the reported missing personal items reported by resident #20 or the reported missing five dollars by resident #21.	F 166			
F 276 SS=D	483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS	F 276	F276 (see attached)		

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F 276	Continued From page 2 A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months.  This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to timely complete a quarterly Minimum Data Set (MDS) assessment for one (1) of twenty-one (21) sampled residents (resident #2).  The findings include:  A record review conducted for resident #2 revealed the resident had an admission MDS assessment completed on July 15, 2010, and was due to have a quarterly assessment completed with an assessment reference date of October 15, 2010. Further record review revealed resident #2 had a 14-day Medicare assessment completed on October 18, 2010. There was no evidence the facility had completed the required assessment.  An interview conducted with the Registered Nurse (RN) responsible for completing the MDS assessment for resident #2 revealed the resident had been out of the facility and had returned. Further interview revealed the RN had completed an assessment but had not coded the assessment correctly and was not aware that resident #2 did not have the required quarterly assessment completed.	F 276		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS	F 281	<i>F281 see attached</i>	

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F 281	<p>Continued From page 3</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide services according to professional standards for one (1) of twenty-one (21) sampled residents. The facility failed to ensure resident #3's physician was aware of the Registered Dietitian's recommendations.</p> <p>The findings include:</p> <p>A review of the medical record for resident #3 revealed the resident was admitted to the facility on October 19, 2010, with diagnoses that included Dementia, Chronic Obstructive Pulmonary Disease, Dysphagia, Severe Malnutrition, and a pressure sore.</p> <p>Further review of the record revealed the Registered Dietitian (RD) had made a recommendation on October 21, 2010, for the resident to receive Certagen Senior and Juven, one packet twice daily for six weeks. The facility was to check the resident's albumin level on October 21, 2010. The facility faxed this recommendation to the physician's office on October 21, 2010. There was no evidence on October 26, 2010, that the physician had responded to the recommendation and no evidence the facility had followed up to ensure the physician was aware of the RD's recommendation.</p> <p>An interview with the Clinical Coordinator (CC) conducted on October 27, 2010, at 3:25 p.m.,</p>	F 281			

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F 281	Continued From page 4 revealed the nurse who received the recommendation was to fax it to the physician and enter it into the daily communication book to ensure the oncoming staff was aware.  There was no evidence in the communication book of the RD's recommendation.  An interview with the Licensed Practical Nurse (LPN) conducted on October 27, 2010, at 3:40 p.m., revealed the LPN did fax the recommendation, but did not make notes in the communication book to follow up. The LPN stated he/she did not usually make any notes, but he/she usually did let the next shift know verbally.	F 281			
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS  A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide the necessary care and services to maintain good hygiene for two (2) of twenty-one (21) sampled residents. Residents #6 and #13 were observed to have long untrimmed/jagged nails.  The findings include:  1. A review of the medical record for resident #6 revealed the resident was admitted to the facility on May 7, 2004, with diagnoses that included	F 312	<i>F 312 see attached</i>		

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NAME OF PROVIDER OR SUPPLIER  WOLFE COUNTY HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 650 HWY 191, PO BOX 370 CAMPTON, KY 41301		
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F 312	<p>Continued From page 5</p> <p>Diabetes, Renal Insufficiency, Chronic Obstructive Pulmonary Disease, Coronary Artery Disease, and Congenital Mental Deficiency.</p> <p>A comprehensive Minimum Data Set (MDS) assessment completed on March 8, 2010, revealed resident #6 was totally dependent upon staff for personal hygiene.</p> <p>A review of the comprehensive plan of care for resident #6 revealed staff was to perform nail care once weekly and as needed.</p> <p>Observations of resident #6 on October 26, 2010, at 3:50 p.m. and 5:20 p.m., and on October 27, 2010, at 9:05 a.m. and 12:00 p.m., revealed the resident's fingernails to be long and jagged.</p> <p>An interview with the Clinical Coordinator (CC) conducted at 3:40 p.m. on October 28, 2010, revealed licensed nurses were required to trim fingernails for all diabetic residents according to the facility policy. The CC further stated Sunday was the designated day for Nursing to trim fingernails for diabetic residents, however, nail care was not included on the treatment record and the nurse was not aware of the requirement. The CC also stated the nail care was not included on the Treatment Administration Record because the CC had failed to include it when the CC was checking monthly orders.</p> <p>2. A review of the medical record for resident #13 revealed the resident was admitted to the facility on November 8, 2001, with diagnoses that included Alzheimer's Dementia, Chronic Renal Failure, Aphasia, Diabetes, and Cerebrovascular Accident.</p>	F 312			

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F 312	<p>Continued From page 6</p> <p>A comprehensive MDS completed on August 22, 2010, revealed resident #13 was totally dependent on staff for personal hygiene.</p> <p>A review of the comprehensive plan of care for resident #6 revealed staff was to perform nail care once weekly and as needed.</p> <p>Observations of resident #13 on October 28, 2010, at 11:35 a.m. and 3:30 p.m., revealed the resident's fingernails were very long.</p> <p>An interview with the Clinical Coordinator (CC) conducted at 3:40 p.m. on October 28, 2010, revealed licensed nurses were required to trim fingernails for all diabetic residents according to the facility policy. The CC further stated Sunday was the designated day for Nursing to trim fingernails for diabetic residents, however, nail care was not included on the treatment record and the nurse was not aware of the requirement. The CC also stated the nail care was not included on the Treatment Administration Record because the CC had failed to include it when the CC was checking monthly orders.</p> <p>An interview with the Director of Nursing (DON) conducted on October 28, 2010, at 2:15 p.m., revealed the nurses and supervisors made rounds on a routine basis to check grooming and fingernails. The DON also stated that they did not check every resident for grooming during every round.</p>	F 312		
F 364 SS=D	<p>483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP</p> <p>Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is</p>	F 364	<p>F 364 see attached</p>	

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NAME OF PROVIDER OR SUPPLIER  WOLFE COUNTY HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 860 HWY 191, PO BOX 370 CAMPTON, KY 41301		
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F 364	<p>Continued From page 7</p> <p>palatable, attractive, and at the proper temperature.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to serve food that was palatable and at the appropriate temperature. Chicken breast, apple juice, and milk were not served at the appropriate temperatures during the noon meal on October 27, 2010.</p> <p>The findings include:</p> <p>A group interview conducted with four alert and oriented residents on October 27, 2010, at 10:00 a.m., revealed that facility food was not palatable and not served at the appropriate temperatures. The residents stated hot foods were not served hot and cold foods were not served cold.</p> <p>Observations of a test tray from the 200 Hall at the noon meal service on October 27, 2010, at 12:40 p.m., revealed the temperature of the chicken breast was 108 degrees Fahrenheit, milk was 48 degrees Fahrenheit, and apple juice was 58 degrees Fahrenheit.</p> <p>An interview conducted with the Dietary Manager on October 27, 2010, at 12:40 p.m., revealed the milk was placed in the freezer before serving but the apple juice was not; further interview revealed it was difficult to maintain the temperature of the chicken breast.</p> <p>A review of the facility meal pass policy, which was without a date, revealed cold food items were</p>	F 364			

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<p>F 364</p> <p>F 444 SS=D</p>	<p>Continued From page 8</p> <p>to be served at 41 degrees or below, and hot foods were to be served at 135 degrees or above.</p> <p>483.65(b)(3) PREVENTING SPREAD OF INFECTION</p> <p>The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that proper infection control practices were maintained for one (1) of twenty-one (21) sampled residents. During wound care for resident #3, the treatment nurse failed to utilize acceptable handwashing technique when performing wound care to wounds on the resident's coccyx.</p> <p>The findings include:</p> <p>A review of the medical record revealed that resident #3 had physician's orders dated October 19, 2010, to clean staged areas to the buttocks/coccyx with normal saline and apply Aquacel and DuoDerm every three days and as necessary.</p> <p>During treatment observation on October 27, 2010, at 2:45 p.m., the treatment nurse was observed to put on gloves and cover a smear of feces with the resident's brief and then change gloves without washing hands. The treatment nurse then poured normal saline on multiple sterile 4x4 gauze pads. The treatment nurse</p>	<p>F 364</p> <p>F 444</p>	<p><i>F 444 see attached</i></p>	
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F 444 Continued From page 9  
cleaned open wound #1 to the resident's coccyx area and changed gloves without washing hands. The treatment nurse cleansed wound area #2 with normal saline-soaked gauze. After changing gloves, but not washing hands, the treatment nurse cleansed open wound area #3 with normal saline. The nurse changed gloves again, but did not wash hands, and applied Aquacel followed by the DuoDerm.

A review of the facility policy, undated, related to handwashing procedures revealed that facility staff was required to perform handwashing or use an alcohol-based sanitizer to decontaminate hands when contact occurred with a resident's intact/non-intact skin, wound dressings, or moving from a contaminated body site to a clean body site during care.

The treatment nurse stated in an interview conducted on October 27, 2010, at 3:00 p.m., that the treatment nurse should have performed handwashing between cleansing the wounds and applying the dressing.

F 444

F 465  
SS=B  
SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON

The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.

This REQUIREMENT is not met as evidenced by:  
Based on observation, interview, and record review, it was determined the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and

F 465

*F 465  
see attached*

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F 465	<p>Continued From page 10</p> <p>the public. Soiled resident equipment, soiled/scarred walls, spider webs, and cracked tile were observed during the survey conducted on October 26-28, 2010.</p> <p>The findings include:</p> <p>Environmental observations during the initial tour conducted on October 26, 2010, at 12:45 p.m., revealed the following:</p> <ul style="list-style-type: none"> <li>-cracked tile was observed on the 200 Hall near the main foyer.</li> <li>-scarred wallpaper was observed near the resident bath on the 100 Hall.</li> <li>-scarred/soiled walls were observed in rooms 213A, 218A, 221A, and 225A.</li> <li>-resident #6's bed frame and feeding tube pole were observed soiled with dried tube feeding residue.</li> <li>-spider webs were observed in the doorway of room 225.</li> </ul> <p>A review of facility maintenance requests provided by the facility Maintenance Director revealed no uncompleted requests had been submitted to repair the walls.</p> <p>An interview conducted with the Maintenance Director on October 28, 2010, at 2:15 p.m., revealed the Maintenance Director had not received any maintenance requests for the wall and tile in need of repair and was not aware of the items in need of repair.</p> <p>A review of the facility housekeeping schedule dated February 16, 2006, revealed rooms were cleaned daily to include checking walls for spots. Further review of the schedule revealed resident</p>	F 465		
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F 465	Continued From page 11 beds and tube feeding poles were to be cleaned daily.  An interview conducted with the Housekeeping Supervisor on October 28, 2010, at 2:30 p.m., revealed the Housekeeping Supervisor checked random rooms on each hall daily to ensure the rooms were clean. However, the Housekeeping Supervisor was not aware of the above noted items in need of cleaning.	F 465			

Wolfe County Health & Rehabilitation Center  
Annual Survey  
October 26-28, 2010

**F166**

1. Resident #20 and Resident #21 were updated on the status of the search for the missing items/money.
2. All residents in the facility will have the opportunity to ensure that prompt efforts will be made to resolve grievances related to missing clothing/items. A meeting was conducted with Resident Council to discuss any unresolved issues and progress toward resolution. All other missing item issues were discussed with appropriate resident/responsible party and responses/updates were given on the progress of resolution.
3. An in-service was conducted with all staff regarding the facility's prompt efforts to resolve grievances, utilizing the Grievance or CQI Referral Form that can be completed for any reason by any staff. The resident/responsible party will receive a response from the facility at the conclusion of the investigation. An in-service with the AD/SSD by the Administrator on November 24, 2010 specifically addressed the use of the form for missing items, the importance of discussing the progress made in resolution of the grievance with the resident/family, and the documentation of the progress on the form and forward to the CQI Committee. Each Department Head has conducted in-service training for their departments.
4. The CQI Committee will review the CQI Referral/Grievance Forms weekly to ensure that issues have been addressed timely and a response to the resident/family from the facility has been given and documented appropriately. These reviews will be done weekly for one month, then monthly for the next quarter. Any irregularity will be corrected and the CQI committee will address further actions as indicated.
5. Completion Date: December 3, 2010

Wolfe County Health & Rehabilitation Center  
Annual Survey  
October 26-28, 2010

**F276**

1. A modification was completed on October 27, 2010 of the MDS Assessment with an ARD of 10-15-10 to include the coding as a Quarterly Assessment.
2. All MDS Assessments were reviewed to ensure coding for the type of assessment was accurate and that assessments were no more than 92 days apart.
3. An in-service was held on November 24 , 2010 by Administrator/DON with all MDS Coordinators to remind them of importance of scheduling and coding MDS within specified timeframes (i.e. no more than 92 days between assessment reference dates). In-service also addressed MDS Coordinator working in correlation with the Medicare Coordinator to discuss upcoming assessments and combine assessments when possible within the guidelines of scheduling.
4. A designated CQI Committee Member will review assessment schedule weekly to ensure that all assessments are being completed within timeframes and that all Medicare assessments are combined with OBRA required assessments when possible. This review will continue on a weekly basis. Any irregularities will be corrected and reported to the CQI Committee for further follow up and review.
5. Completion Date: December 3, 2010

Wolfe County Health & Rehabilitation Center  
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October 26-28, 2010

**F281**

1. The physician was notified of the R.D. recommendation on October 27, 2010 for Resident #3. Orders were obtained and implemented.
2. All other R.D. recommendations have been reviewed by the Unit Supervisor to ensure that the physician has been notified in a timely manner.
3. The Unit Supervisor will retain a list of all residents visited by the R.D. each week. They will use this list to follow up and ensure appropriate action has been taken by the staff nurses. The staff nurses have been instructed to sign off on the list as they complete it. They have also been instructed to document any needed follow-up on the 24 hour report sheet. The Director of Nursing and Nursing supervisors have conducted in services detailing this process to the nursing staff on November 23 and 24, 2010.
4. The QA Committee designee will compare the R.D. list to the resident record to ensure timely physician notification and appropriate follow-up. This review will be conducted weekly for one month and monthly for the next quarter. Any identified concerns will be corrected immediately and reported to the QA Committee for further review.
5. Completion Date: December 3, 2010

Wolfe County Health & Rehabilitation Center  
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October 26-28, 2010

**F312**

1. Resident #6 nails were trimmed on October 27, 2010 and #13 nails were trimmed on October 28, 2010 by the nurses.
2. Resident care rounds have been conducted by nursing supervisors to ensure all residents are receiving necessary services to maintain good grooming. The supervisors specifically checked to ensure that nail care has been provided for all diabetic residents. Treatment records have also been reviewed by nursing supervisors to ensure nail care is included on the treatment record for all diabetic residents.
3. In-Services were conducted by the Director Of Nursing/Nursing Supervisor for the nursing staff on November 23 and 24, 2010, which addressed the facility routine for performing nailcare for those residents diagnosed with diabetes. The in-service addressed the documentation required for nail care and importance of checking treatment records each month to ensure that appropriate transcription has occurred for the diabetic resident.
4. The QA committee will make observations of five diabetic residents per unit to ensure proper grooming is being provided. These observations will be done on a weekly basis for one month, then monthly for one quarter. Any identified concerns will be corrected immediately and reported to the QA committee for further review.
5. Completion Date: December 3, 2010

Wolfe County Health & Rehabilitation Center  
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October 26-28, 2010

**F364**

1. No residents were affected by this test tray.
2. Observations of meal services have been conducted by the dietary manager on both shifts to ensure residents are receiving palatable food trays in a timely manner with food items at appropriate temperatures.
3. In-Services were conducted by the R.D. and Dietary Manager with the dietary staff regarding the requirements for proper food temperatures on November 19, 2010. The In-Service reviewed placing milk and juice in the freezer at least 45 minutes prior to meal service and maintaining hot foods at 165 degrees or above on the steam table.
4. Meal pass audits will be conducted by the QA committee on a weekly basis for the next month and twice a month for the next quarter. These audits will include food temperature checks to ensure food is being served at appropriate temperatures. Rounds will be conducted randomly, including all three meals. Any identified concerns will be corrected immediately and reported to the QA committee for further review.
5. Completion Date: December 3, 2010

Wolfe County Health & Rehabilitation Center  
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October 26-28, 2010

**F444**

1. Resident #3 was discharged home on November 5, 2010.
2. All residents requiring dressing changes are receiving treatment as ordered by the physician with proper guidelines being followed for handwashing during the treatment.
3. In-Services with the nursing staff were conducted by the Director Of Nursing /Nursing Supervisor on November 23 and 24, 2010 regarding proper procedures for providing wound care treatment. The In-Service detailed infection control guidelines for handwashing during dressing change. The nursing supervisors have observed all nurses performing wound care to ensure accepted handwashing practices are being followed.
4. The QA committee designee will conduct observations of nurses performing wound care treatment to ensure proper handwashing standards are being followed. The observations will include observing two nurses weekly for one month and four nurses monthly for one quarter. Any identified concerns will be corrected immediately and reported to the QA committee for further review.
5. Completion Date: December 3, 2010

Wolfe County Health & Rehabilitation Center  
Annual Survey  
October 26-28, 2010

F465

1. The tile in the 200 hallway has been replaced. The wallpaper on the walls near the 100 resident showers has been replaced. The walls in rooms 213, 218, 221 and 225 have been repaired. Resident #6's tube feeding pole and bed frame have been cleaned. The spider webs in doorway of room 225 have been removed.
2. All resident rooms wall, wallpaper, tube feeding poles and bed frames, hallway tile and doorways have been checked for proper cleaning and/or needed repairs.
3. The Administrator conducted an In-Service with the Housekeeping supervisor on November 19, 2010 and the Housekeeping supervisor conducted an in-service with the housekeeping staff regarding prompt cleaning of resident care equipment such as tube feeding poles and bed frames, replacement of torn wallpaper and removal of any spider webs. The Housekeepers were also instructed to fill out maintenance request on any items/areas in need of repair.  
On November 19, 2010 the Administrator In-Serviced the Maintenance Supervisor on regularly making rounds throughout the facility to observe for any needed repairs such as scarred walls and cracked tile.
4. The CQI/QA committee designee will make environmental rounds to observe for any concerns such as items needing repaired and cleaning. The rounds will be conducted weekly for one month, then monthly for one quarter. Any identified concerns will be corrected immediately and referred to QA committee for further review.
5. Completion Date: December 3, 2010

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

PRINTED: 11/15/2010  
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185213	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING 01 B. WING _____	<div style="border: 2px solid black; padding: 5px; text-align: center;"> <b>RECEIVED</b>                  NOV 24 2010                  Division of Health Care Enforcement Branch             </div>	SURVEY COMPLETED 10/26/2010
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NAME OF PROVIDER OR SUPPLIER  WOLFE COUNTY HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 850 HWY 19, PO BOX 100 CAMPTON, KY
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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	INITIAL COMMENTS  A life safety code survey was initiated and concluded on October 26, 2010, for compliance with Title 42, Code of Federal Regulations, §483.70. The facility was found not to be in compliance with NFPA 101 Life Safety Code, 2000 Edition.  Deficiencies were cited with the highest deficiency identified at "D" level.	K 000		
K 025 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4  This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain fire/smoke dampers that penetrated the fire/smoke barrier walls in the attic area. This deficient practice affected two (2) of seven (7) smoke compartments, staff, and approximately sixteen (16) residents. The facility has the capacity for 100 beds with a census of 94 on the day of the survey.  The findings include:	K 025	K025 see attached	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Suse Arnold</i>	TITLE <i>Administrative</i>	DATE 11/24/10
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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

PRINTED: 11/15/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185213	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED  10/26/2010
NAME OF PROVIDER OR SUPPLIER  WOLFE COUNTY HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 860 HWY 191, PO BOX 370 CAMPTON, KY 41301		
(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 025	<p>Continued From page 1</p> <p>During the Life Safety Code survey on October 26, 2010, at 3:15 p.m., with the Director of Maintenance (DOM) a fire/smoke barrier wall above the fire doors on the 100 Wing was observed to have ductwork that contained a fire/smoke damper. A fire/smoke damper closes to prevent fire and hot gases from penetrating the fire/smoke barrier wall and is required to be inspected and maintained every four years. An interview with the DOM on October 26, 2010, at 3:15 p.m., revealed the DOM was unaware of the requirements pertaining to fire/smoke dampers or if there was a record that the dampers had been maintained. Other fire/smoke barrier walls in the facility were not reasonably accessible for inspection purposes.</p> <p>Reference: NFPA 90a (1999 Edition).</p> <p>3-4.7 Maintenance. At least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify that they fully close; the latch, if provided, shall be checked; and moving parts shall be lubricated as necessary.</p>	K 025			

Wolfe County Health & Rehabilitation Center  
Annual Survey  
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**K025**

1. The fire/smoke barriers above Unit 100 have been inspected by an outside fire inspector contractor.
2. All other fire/smoke barriers that penetrate fire/smoke barrier walls in the attic area have been inspected and maintained by an outside contractor.
3. The Corporate Maintenance Supervisor has in-serviced the Maintenance Supervisor on October 29, 2010 regarding the life safety code requirements for inspector/maintenance of fire/smoke dampers that penetrate fire/smoke barrier walls in the attic area of the facility.
4. A log sheet for the Preventative Maintenance of the Fire/Smoke Dampers will be place in the Preventative Maintenance Log Book maintained by the Maintenance Director. The Maintenance Director will be responsible for documenting on the log sheet the date that the independent contractor has provided preventative maintenance to the Fire/Smoke Dampers (once every four years). The CQI will review the Preventative Maintenance Log Book on a yearly basis to ensure that this guidance is being followed. Any identified concerns will be corrected and addressed by the CQI Committee.
5. Completion Date: December 3, 2010