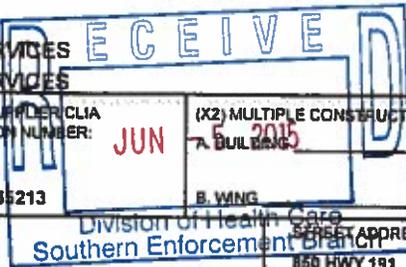


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/29/2015
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: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/14/2015
NAME OF PROVIDER OR SUPPLIER WOLFE COUNTY HEALTH & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 850 HWY 191 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 000	INITIAL COMMENTS	F 000		
F 364 SS=D	<p>A standard health survey was conducted on 05/12-14/15. Deficient practice was identified with the highest scope and severity at "D" level.</p> <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 palatable, attractive, and at the proper temperature.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to ensure foods were palatable and at the proper temperature for residents on the 100 Hall during the lunch meal on 05/13/15. A test tray conducted for a regular, chopped meal tray on 05/13/15 revealed food items were not palatable and not at the appropriate temperature.</p> <p>The findings include:</p> <p>Review of the Meal Pass policy (no date) revealed residents' meals would be delivered timely so that foods would be served to residents with cold food temperatures at 41 degrees Fahrenheit or below and hot foods at 135 degrees Fahrenheit or above.</p> <p>Observation of the lunch meal on 05/13/15 revealed a closed cart containing seven meal trays was transported from the kitchen to the 100 Hall of the facility at 11:53 AM. The last tray was</p>	F 364		

Please see attachment #1

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Amelia Proter, Administrator* TITLE: _____ (X5) DATE: *06/05/15*

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: 185213	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/14/2015
NAME OF PROVIDER OR SUPPLIER WOLFE COUNTY HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 850 HWY 191 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 364	<p>Continued From page 1</p> <p>intercepted at 12:21 PM (28 minutes later) and food temperatures were obtained with facility staff. The temperature of the potatoes was 101 degrees Fahrenheit and they tasted tepid, the steak was 92 degrees Fahrenheit and tasted cold, the seven-layer salad was 47 degrees Fahrenheit and tasted cool, the strawberry salad was 50 degrees Fahrenheit and tasted cool, and the apple juice was 55 degrees Fahrenheit and tasted cool.</p> <p>Interview with Resident #2 on 05/12/15 at 2:30 PM, revealed sometimes his/her food was cool and not at the proper temperature.</p> <p>Interview conducted with the Dietary Manager (DM) on 05/13/15, revealed the hot food temperatures were expected to be 140 degrees Fahrenheit or above at the point of service. The DM further stated that 20 minutes after leaving the kitchen was too long for meal trays to remain on the food tray cart prior to being served to residents. The DM also stated she conducted at least eight test trays monthly from all meals to monitor food temperatures and palatability and no consistent problems had been identified.</p> <p>Interview with the Director of Nurses (DON) on 05/13/15 at 4:00 PM, revealed the food carts were arranged to be delivered in room order and a small number of trays was delivered from the kitchen on each cart to enable staff to deliver the trays in a timely manner. The DON stated she monitored tray delivery service and had not identified any problems with food temperatures or palatability.</p>	F 364			

Attachment #1

Wolfe County Health and Rehabilitation Center

Completion of Annual Survey: May 14, 2015

Plan of Correction

F364

- 1) A replacement tray at lunch with palatable food at proper temperatures was provided for the last tray on the reference cart on Unit 100 on 5/13/15.**
- 2) All three meals have been observed on both units and residents are receiving palatable food in a timely manner with food items at appropriate temperatures.**
- 3) In-services were conducted with all nursing and dietary staff on June 3, 2015 and June 4, 2015 by Dietary Manager, Administrative Nursing Staff, Director of Nursing and the Administrator with a focus on steps to ensure residents receive the meals in a timely manner at appropriate temperatures. An additional measure was put in place that includes timer being placed on each cart to alert staff when time has expired so replacement trays can be obtained. The In-service also included thorough review of the meal-pass process.**
- 4) The Quality Assurance Committee Team will perform two meal pass audits per week, which would include all three meals including using food temperature checks. These audits will be conducted weekly for one month, and then monthly for one quarter. Any irregularities will be corrected immediately and reported to the Quality Assurance Committee for further review and follow-up.**
- 5) Completion Date June 16, 2015.**

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

PRINTED: 11/10/2015
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 05/13/2015
NAME OF PROVIDER OR SUPPLIER WOLFE COUNTY HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 850 HWY 191 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 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>Building: 01</p> <p>Plan Approval: 1990</p> <p>Survey under: NFPA 101 (2000 Edition), Chapter 19 (Existing Health Care) Short Form</p> <p>Facility type: SNF/NF</p> <p>Smoke Compartments: 5</p> <p>Fire Alarm: Complete fire alarm with smoke detectors in corridors and single station smoke detectors in resident rooms</p> <p>Sprinkler System: Complete automatic sprinkler system</p> <p>Generator: Type II, 175 KW Diesel installed 1990; Type II, 150 KW Diesel installed in 2011</p> <p>A standard Life Safety Code survey was conducted on 05/13/15. Wolfe County Health and Rehabilitation Center was found to be in compliance with the requirements for participation in Medicare and Medicaid. The census on the day of the survey was 96. The facility is licensed for 100 beds.</p>	K 000			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

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