

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

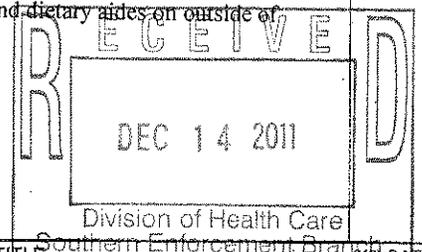
PRINTED: 12/05/2011
FORM APPROVED
OMB NO. 0938-0391

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 11/17/2011
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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 000	<p>INITIAL COMMENTS</p> <p>A standard health survey was conducted on 11/15-17/11. Deficient practice was identified at 'E' level.</p>	F 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.</p>	
F 363 SS=E	<p>483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED</p> <p>Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure nutritional needs were met in accordance with the recommended dietary allowance for twenty-five of fifty-one residents. Facility staff failed to use the correct scoop size when serving the evening meal on 11/15/11 and, as a result, the portion size of ground meat, pureed broccoli, and pureed corn was not in accordance with the facility's planned menu.</p> <p>The findings include:</p> <p>A review of the portion control policy (dated 01/2004) revealed uniform size or amounts of food served could be obtained by utilizing appropriate utensils. An equivalent sheet dated 01/2004 revealed the appropriate size scoops and serving sizes to be utilized in the kitchen.</p> <p>A review of a list of residents on an altered</p>	F 363	<p>The plan of correction is not meant to establish any standard of care contract obligation or position, and the facility reserves all right 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 residents.</p> <p>1. The #16 scoop was immediately removed and replaced with the #12 scoop on 11/15/11. The Dietary manager conducted an immediate in-service on 11/15/11 for the dietary staff regarding appropriate scoop/portion size. The correct scoop size, per ordered portion was posted in clear view of the cook and dietary aides on outside of cabinet door.</p>	11/22/11



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE <u>NHA</u> DATE <u>12/12/11</u>
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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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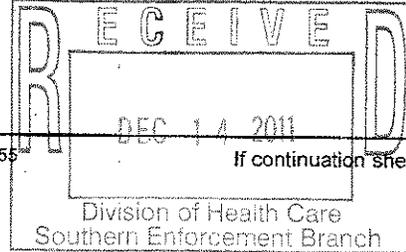
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NAME OF PROVIDER OR SUPPLIER CLINTON COUNTY CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 404 NORTH WASHINGTON STREET ALBANY, KY 42602
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F 363	<p>Continued From page 1</p> <p>consistency diet revealed 10 residents received pureed meat, corn, and broccoli, and 15 residents received ground meat.</p> <p>Observation of the tray line for the evening meal was conducted at 4:44 PM on 11/15/11. Observations revealed the cook used a number 16 scoop (2 ounces) for the ground meat, and a number 12 scoop (3 ounces) for the pureed corn and pureed broccoli. However, a review of the planned menu revealed a serving size of ground meat was 3 ounces and the serving size for the pureed corn and pureed broccoli was 4 ounces.</p> <p>An interview was conducted at 5:30 PM on 11/15/11, with the cook that had served the hot foods from the steam table. The cook stated she used 4 ounces of regular food to blend for the residents on a pureed consistency diet, and she served the amount of food produced from the 4 ounces of regular food (prior to blending). The cook further stated she did not know she was supposed to serve the specified amounts listed on the planned menu.</p> <p>Review of a dietary employee in-service training dated 10/11/11 revealed the cook had attended an in-service training on portion control and diets on 10/11/11.</p>	F 363	<p>2. A 100% audit of residents who received a mechanically-altered diet was conducted by Dietary Manager and Director of Nursing. The audit revealed 10 residents who received pureed diets and 15 residents who received ground meats. Of these residents receiving these diets for this one meal, none were indicated with actual weight loss.</p> <p>3. On 11/17/11 the Dietary Manager in-serviced the dietary staff on how to pre-select the appropriate sized scoops in accordance with the menu and how to pre-set the scoops prior to tray preparation. During orientation, new employees will be in-serviced by the Dietary Manager on selecting appropriate scoop size and then a return demonstration will be utilized to ensure understanding and compliance. The Dietary Manager will conduct yearly in-services with dietary staff on correct scoop/portion sizes. The Dietary Manager conducted daily audits of utilization of correct scoop size on 11/17/11 – 11/22/11, and weekly audits on 11/28/11 and will continue audits weekly thereafter. These findings will be forwarded to the Administrator weekly to ensure appropriate follow-up.</p> <p>4. Findings of the above stated audits will be reviewed by the Quality Assurance Committee monthly for 3 months for further recommendations and follow-up as indicated.</p>	
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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 11/15/2011
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 11/15/11. 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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