

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

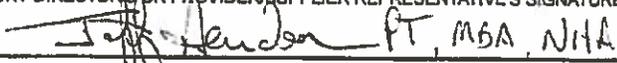
PRINTED: 11/30/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185407	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/12/2015
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NAME OF PROVIDER OR SUPPLIER LAKE CUMBERLAND REGIONAL HOSPITAL SCU	STREET ADDRESS, CITY, STATE, ZIP CODE 305 LANGDON STREET SOMERSET, KY 42502
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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 F 371 SS=D	<p>INITIAL COMMENTS</p> <p>A standard survey was conducted on 11/11-12/15. Deficient practice was identified with the highest scope and severity at "D" level.</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on facility policy, observation, record review, and interview, it was determined the facility failed to maintain the kitchen in a sanitary manner. The facility failed to ensure the grease drip pan underneath the range burners was clean of grease, burned food debris, and liquid spills.</p> <p>The findings include: Review of the facility's policy and procedure, Food and Nutrition - Infection Control Measures, (dated 2015) revealed there was no procedure documentation for thorough cleaning of the range and grease drip pan.</p> <p>Observation of the range at 9:50 AM on 11/11/15</p>	F 000 F 371	<p>I. No residents were noted in the deficiency to have been adversely affected by this practice.</p> <p>II. The range grease drip pan was cleaned on 11/13/2015. To make sure that food products are prepared, distributed, and served under sanitary conditions, a review was completed by the Director of Food and Nutrition Services, or designee, and Nursing Home Administrator of all food preparation areas on 12/3/2015. During the time of the review all equipment and food preparation surfaces were noted to be clean.</p> <p>III. To ensure that the kitchen is consistently maintained in a sanitary manner, the cleaning schedule will be updated to reflect cleaning of the grease drip pan weekly. Dietary team members will complete all cleaning assignments according to established kitchen cleaning schedule. Additionally, all areas within the dietary department will be observed by the Director of Food and Nutrition Services, or designee, to ensure that the kitchen is maintained in a sanitary manner. All dietary team members will be in-serviced regarding this process. Education will be completed for dietary team members by the Director of Food and Nutrition Services. All education will be completed by 12/15/2015.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 12/7/15
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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: 185407	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/12/2015
NAME OF PROVIDER OR SUPPLIER LAKE CUMBERLAND REGIONAL HOSPITAL SCU			STREET ADDRESS, CITY, STATE, ZIP CODE 306 LANGDON STREET SOMERSET, KY 42502		
(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 371	<p>Continued From page 1</p> <p>revealed the grease drip pan had an excessive accumulation of grease, burned food debris, and liquid spills.</p> <p>Review of the cleaning schedules revealed the grease drip pan was not listed on the schedules to be cleaned.</p> <p>An interview conducted with a dietary employee (chef) at 1:05 PM on 11/12/15 revealed he did not know when the grease drip pan had been cleaned. The employee stated it appeared to not have been cleaned "in a while."</p> <p>Interview with the Food Service Director on 11/12/15 at 3:15 PM revealed the range grease drip pan was not specified on the cleaning schedule.</p>	F 371	<p>IV.</p> <p>The food services team will be responsible for maintaining the sanitary condition of the kitchen. This will include reviewing all cleaning logs to ensure that cleaning has been documented. The review will also include a direct observation of the assigned area(s) to be cleaned, as noted on the cleaning schedule log, to ensure that the areas are maintained in sanitary conditions. This review will be completed by the Director of Food and Nutrition Services, or designee, weekly. To validate this process, a kitchen sanitation audit will be completed weekly by the Director of Food and Nutrition Services, or designee, and Nursing Home Administrator weekly for one month. This same review will be continued for an additional two months bi-weekly, and then monthly for three months. The outcome of these audits will be reported to the Quality Assurance Committee for additional review and follow up as indicated.</p>	12/15/15	

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

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185407	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 11/11/2015
NAME OF PROVIDER OR SUPPLIER LAKE CUMBERLAND REGIONAL HOSPITAL SCU			STREET ADDRESS, CITY, STATE, ZIP CODE 305 LANGDON STREET SOMERSET, KY 42502		
(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: 1992</p> <p>SURVEY UNDER: 2000 Existing Short Form</p> <p>FACILITY TYPE: SNF</p> <p>TYPE OF STRUCTURE: 4-story, Type 11 (222)</p> <p>SMOKE COMPARTMENTS: 2</p> <p>FIRE ALARM: Complete automatic fire alarm system</p> <p>SPRINKLER SYSTEM: Complete automatic (wet) sprinkler system</p> <p>GENERATOR: Type I diesel generator</p> <p>A life safety code survey was initiated and concluded on 11/11/15, for compliance with Title 42, Code of Federal Regulations, 483.70(a) and found the facility to be in compliance with NFPA 101 Life Safety Code, 2000 Edition.</p> <p>No deficiencies were identified during this survey.</p>	K 000			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

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