

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

PRINTED: 09/05/2014  
FORM APPROVED  
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185326	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  08/21/2014
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NAME OF PROVIDER OR SUPPLIER  CLINTON-HICKMAN COUNTY NURSING FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 366 S. WASHINGTON ST. CLINTON, KY 42031
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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 Recertification Survey was conducted on 08/19/14 through 08/21/14 to determine the facility's compliance with Federal requirements. The facility failed to meet minimum requirements for recertification with deficiencies cited at the highest scope and severity of an "E".	F 000	This plan of correction does not constitute admission or agreement by the provider of the truth or the facts alleged or conclusions set forth in the Statement of Deficiencies.  The Plan of Correction is submitted solely because it is required by the provision of federal and state law.	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  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  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy/procedure, it was determined the facility failed to ensure food was served in a sanitary manner related to observations of residents' bread being served by three (3) Certified Nurse Aides (CNAs) using his or her bare hands during the meal service on 08/19/14 and 08/20/14.  The findings include:  Review of the facility's policy/procedure, "Proper Food Handling" (no date), revealed food should be prepared and served with clean and sanitized tongs, scoops, forks, spoons, spatulas, or other	F 371	This plan of correction serves as Clinton-Hickman Nursing Facility credible allegation of compliance  <u>F371:</u>  The facility must store, prepare, distribute, and serve food under sanitary conditions; bare hand contact with food is prohibited.  What corrective action will be accomplished for those residents found to have been affected by the deficient practice;  <i>No resident was found to have been injured by the deficient practice.</i>  For residents having the potential to be affected by same deficient practice:  <i>The DON and Dietary manage reviewed residents diets and currently all residents have the potential to be affected.</i>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Rae BOE</i>	TITLE <i>Administrator</i>	(X6) DATE <i>9/19/14</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.

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NAME OF PROVIDER OR SUPPLIER  CLINTON-HICKMAN COUNTY NURSING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 366 S. WASHINGTON ST. CLINTON, KY 42031	
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F 371	Continued From page 1  suitable implements so as to avoid manual contact of prepared foods. Fingers were to be kept out of food and to use tongs when serving rolls, pickles, etc. The policy was not specific as to the procedure of serving bread from the prepared food trays to the residents.  Observation in the Dining Room, on 08/19/14 at 11:30 AM, revealed CNA #1 took a slice of bread out of a plastic bag with her bare hands, from Resident A's tray, and buttered his/her bread.  Observation in Resident C's room, on 08/19/14 at 11:40 AM, revealed CNA #2 took a slice of bread out of a plastic bag with her bare hands, from Resident C's tray, and buttered his/her bread.  Observation in the Dining Room, on 08/20/14 at 11:30 AM, revealed CNA #2 took a slice of bread out of a plastic bag, from Resident B's tray. She buttered the resident's bread, and also handled his/her cookie with her bare hands.  Interview with CNA #1 and CNA #2, on 08/20/14 at 1:13 PM and 1:28 PM, respectively, revealed they usually took the bread out of the plastic bag and buttered it for the residents who could not do it for himself/herself. CNA #1 stated "we should not touch the resident's bread with our bare hands".  Observation in the Dining Room, on 08/20/14 at 11:33 AM, revealed CNA #3 took a slice of bread out of a plastic bag with her bare hands, from Resident D's tray, and buttered his/her bread.  Interview with CNA #3, on 08/20/14 at 1:30 PM, revealed staff should take bread out of the plastic bag and butter it, but not with his or her bare	F 371	Measures taken by the facility to ensure that the deficient practice does not recur:  <i>Nursing staff were in-serviced on proper procedure for handling food during meal service by the DON on September 2, 2014</i>  <i>Facility staff received training on proper food handling by the consultant dietician on 09/09/2014 with return demonstration by staff on proper technique for handling bread products.</i>  <b>Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and are permanent:</b>  <i>Unannounced audits through observation of meal service will be performed by the DON or ADON weekly x4 then monthly x1year.</i>  <i>A meal pass observation form has been created for documenting audits, First audit was done on 9/4/14</i>  <i>QA committee will monitor facility performance quarterly to ensure ongoing compliance and that corrections are permanent.</i>  QA Committee members include but not limited to Director of Nursing, Medical Director, Administrator, Social Services Director Dietary Manager	F371: 9/10/14

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F 371	Continued From page 2 hands.  Interview with the Dietary Manager, on 08/20/14 at 1:35 PM, revealed she expected the staff not to handle residents' bread with his or her bare hands. She stated there was no policy/procedure available.	F 371		

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NAME OF PROVIDER OR SUPPLIER  CLINTON-HICKMAN COUNTY NURSING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 366 S. WASHINGTON ST. CLINTON, KY 42031	
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01.</p> <p>PLAN APPROVAL: 1967.</p> <p>SURVEY UNDER: 2000 Existing.</p> <p>FACILITY TYPE: SNF/NF.</p> <p>TYPE OF STRUCTURE: One (1) story, Type II (222).</p> <p>SMOKE COMPARTMENTS: Six (6) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system with 62 smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic wet sprinkler system.</p> <p>GENERATOR: Type II generator. Fuel source is Diesel.</p> <p>A standard Life Safety Code survey was initiated on 08/19/14 and concluded on 08/20/14. The facility was found in non-compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for forty six (46) beds with a census of forty one (41) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire).</p>	K 000		



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Koe [Signature] TITLE: Administrator (X6) DATE: 9/12/14

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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K 000	Continued From page 1  Deficiencies were cited with the highest deficiency identified at "D" level.	K 000	This plan of correction does not constitute admission or agreement by the provider of the truth or the facts alleged or conclusions set forth in the Statement of Deficiencies.		
K 017 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure corridors are separated from use areas in accordance with the National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of six (6) smoke compartments, residents in the dining room, staff and visitors. The facility has the capacity for forty six (46) beds and the census was forty one (41) on the day of the survey.	K 017	The Plan of Correction is submitted solely because it is required by the provision of federal and state law.  This plan of correction serves as Clinton-Hickman County ICF credible allegation of compliance effective, September 11, 2014.  <b>K017:</b> NFPA 101 Life Safety Code Standard  What corrective action will be accomplished for those residents found to have been affected by the deficient practice;  <i>No residents were found to have been affected by the deficient practice.</i>  For residents having the potential to be affected by same deficient practice:  <i>Any resident who may enter the employee dining area has the potential to be affected.</i>		

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K 017	Continued From page 2  The findings include:  Observation, on 08/20/14 at 9:39 AM, with the Maintenance Supervisor revealed two (2) roll down type service doors located in the Kitchen wall to the egress. The roll down type doors were not self-closing or connected to the fire alarm to close in the event of an emergency.  Interview, on 08/20/14 at 9:40 AM, with the Maintenance Supervisor revealed he was not aware of the requirements for corridor walls.  The census of forty one (41) was verified by the Administrator on 08/20/14. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 08/20/14.  Reference: NFPA 101 (2000 edition)  19.3.6.3 Corridor Doors. 19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and	K 017	Measures taken by the facility to ensure that the deficient practice does not recur:  <i>The manufacturer of the current door has gone out of business, and no parts are available to allow us to connect our current doors to the fire alarm system. Therefore, we are having to special order new doors.</i>  <i>on 9/10/14 Two new roll down shutter service Doors were ordered from Supply Services, Inc. to replace the old doors located in the wall between the kitchen and employee dining area. We were given an estimated delivery of 4 or more weeks.</i>  <i>Once the doors have been delivered, an additional week is needed for the installation of the doors.</i>  <i>On 9/10/14 we contracted with Premier Fire &amp; Security, Inc. to connect the doors to our fire alarm system to self-close in the event of an emergency.</i>  Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and are permanent:  <i>Once the doors have been installed the fire drill evaluation form will be updated adding monitoring of these two new roll down shutter service doors. The doors will be checked during fire drills and included in the monthly fire drill report to be discussed at QA meetings to ensure ongoing compliance.</i>	K017: 9/11/14

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K 017	Continued From page 3 similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke. 19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with 19.3.5.2. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: Existing roller latches demonstrated to keep the door closed against a force of 5 lbf (22 N) shall be permitted to be kept in service. 19.3.6.3.3* Hold-open devices that release when the door is pushed or pulled shall be permitted. 19.3.6.3.4 Door-closing devices shall not be required on doors in corridor wall openings other than those serving required exits, smoke barriers, or enclosures of vertical openings and hazardous areas.	K 017		