

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

PRINTED: 11/16/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185145	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 11/03/2011
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  CEDAR RIDGE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1217 US HIGHWAY 62 E CYNTHIANA, KY 41031
---	--

(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	<p>This Plan of Correction constitutes our written allegation of compliance for the deficiency cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by State and Federal law, F371.</p> <p>It is the policy of this campus to ensure proper storing/preparing and serving of food.</p> <p>1. The staff identified as providing deficient practice were counseled by the Dietary Manager as to the proper standards with regards to food sanitation, proper food temperatures, handwashing and changing gloves at the appropriate time. The dietary staff were educated to the handwashing policy and procedure that the campus does have in place.</p> <p>2. The Director of Food Services conducted an in-service with dietary staff to address proper procedures with regards to hand washing/changing gloves at the appropriate time/serving food at proper food temperature/taking temperature of food at the proper time prior to serving food. The In-service was completed by 11/8/11. A kitchen sanitation audit was conducted by ED and Director of Food Services and Dietary Support Services on 11/9/11 with no deficient practice identified.</p> <p>3. The Director of Food Services and/or the Executive Director will conduct monthly audits utilizing audit forms to observe for proper dietary sanitation procedures. Additionally, when Home Office support staff visit monthly, they will complete a Dietary Sanitation Audit. The results of the audits will be discussed as part of the Quality Assurance meeting. Any opportunities for improvement will be addressed immediately with dietary staff education. The audits will continue monthly as part of the QA program.</p>	11/9/11
F 371 SS=F	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>The facility must -</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview and review of the facility's policy it was determined the facility failed to prepare and distribute food in a sanitary manner. The facility failed to ensure staff changed gloves and washed hands between tasks and failed to ensure food was held at the proper temperature. The facility's failure had the potential to effect fifty-one (51) of fifty-one (51) residents in the facility.</p> <p>The findings include:</p> <p>Interview, on 11/03/11 at 11:39 AM, with the facility's Nurse Consultant revealed the facility did</p>	F 371		

RECEIVED  
NOV 24 2011  
BY

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE Executive Director	(X6) DATE 11/23/11
---	-----------------------------	-----------------------

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: 11/16/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  188145	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 11/03/2011
NAME OF PROVIDER OR SUPPLIER  CEDAR RIDGE HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 1217 US HIGHWAY 62 E CYNTHIANA, KY 41031	
(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>not have a policy on handwashing specific to the dietary department.</p> <p>1. Observation of the tray line, during the noon meal on 11/01/11, revealed Cook #6 did not test the holding temperature of the gravy, beef patties, chipped turkey, chicken wings, french fries or hash browns.</p> <p>Interview, on 11/03/2011 at 11:29 AM, with Cook #6 revealed she did not test all the food on the steam table. She explained she had done that when the foods were taken from the cooker and did not retest them when she did the main meal items.</p> <p>Interview, on 11/03/11 at 11:14 AM, with the Dietary Manager revealed the facility tested holding temperatures for the regular foods, pureed foods and mechanically altered foods on the steam table. She stated the alternate foods were tested when they were removed from the cookers, and not after they were placed on the steam table.</p> <p>2. Observation of Dietary Aide (DA) # 5, on 11/01/11 at 12:05 PM, revealed she plugged in the microwave with her gloved hands. Further observation revealed she proceeded to heat some bacon and finished cooking a grilled cheese sandwich. Continued observation revealed she prepared a bacon, lettuce and tomato sandwich and sliced the sandwich in half. Observation revealed DA #5 touched the bread with the gloved hand used to plug in the microwave. Continued observation revealed DA #5 passed the grilled cheese sandwich and bacon sandwich to the cook on the serving line.</p>	F 371		

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

PRINTED: 11/18/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185145	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 11/03/2011
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  CEDAR RIDGE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1217 US HIGHWAY 62 E CYNTHIANA, KY 41031
---	--

(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 2</p> <p>Further observation revealed DA #5 took the skillet, used to cook to the grilled cheese sandwich, to the dirty dish line. DA #5 was observed to proceed to the food preparation counter and begin cleaning the counter. Observation of DA #5 revealed while cleaning the food preparation table she received a bowl of soup from a staff member working in the dining room. Continued observation revealed she obtained blinder parts from the clean sink area, touched the inside of the blinder with gloved hands then pureed the bowl of potato soup and delivered it to the staff in the dining room. Continued observation revealed DA #5 did not change her gloves or wash her hands until all the above task were completed.</p> <p>During interview, on 11/01/11 at 12:18 PM, with DA #5 she stated "you got me, I didn't changes my glove on Tuesday (11/01/11) after plugging in the microwave". The DA explained gloves should be changed and hands washed between each task.</p> <p>3. Observation, on 11/01/2011 between 12:15 PM and 12:21 PM, revealed Cook #6 transferred food from the kitchen steam table onto a cart and then onto the steam table in dining room. Observation revealed during the process of transferring the food to the dining room the cook touched the door with her gloved hand twice. Upon completion of the transfer of food, Cook #6 began serving food without changing her gloves or washing her hands.</p> <p>Interview, on 11/03/11 at 10:59 AM, with Cook #6 revealed she had touched the door when transferring food to the dining room on 11/01/11.</p>	F 371		
-------	--	-------	--	--

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

PRINTED: 11/16/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185145	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 11/03/2011
NAME OF PROVIDER OR SUPPLIER  CEDAR RIDGE HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 1217 US HIGHWAY 82 E CYNTHIANA, KY 41031	
(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 3</p> <p>In further interview Cook #8 stated gloves should be changed and hands washed anytime she left the kitchen and went back in.</p> <p>4. Observation, 11/02/11 between 6:25 AM and 6:44 AM, revealed Cook #7 took a pan of sausage from the steamer using oven mitts. Continued observation revealed the cook removed the oven mitts and her hands were gloved. In further observation, Cook #7 placed sausage in the meat grinder and ground the sausage. The cook left sausage sitting on the food preparation table uncovered and swept the floor by the preparation table. Observation revealed Cook #7 failed to change her gloves or wash her hands.</p> <p>Interview, on 11/03/11 at 10:59 AM, with Cook #7 revealed cooks should change gloves and wash hands after using oven mitts because they "get groddy" inside.</p> <p>5. Observation of DA #5, on 11/03/2011 from 12:02 PM until 12:17 PM, revealed she took a container to the walk-in refrigerator and returned to the food preparation table. Further observation revealed DA #5 entered the walk-in refrigerator and returned with a tray of salads. The DA was observed to then obtain a tray of fruit cups from the walk-in refrigerator without changing gloves or washing her hands. Further observations during this time revealed DA #5 took coffee cups and serving trays to the dining room staff and took clean saucers to the cook on the serving line. DA #5 did not change gloves or wash her hands during this observation period.</p> <p>In interview, on 11/03/11 at 12:18 PM, with DA #5</p>	F 371		

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

PRINTED: 11/16/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185145	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 11/03/2011
NAME OF PROVIDER OR SUPPLIER  CEDAR RIDGE HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 1217 US HIGHWAY 62 E CYNTHIANA, KY 41031		
(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	Continued From page 4 revealed she did not touch food during the observation period on 11/03/11 and therefore did not change her gloves or wash her hands.  Interview, on 11/03/2011 at 11:11 AM, with DA #9 revealed staff should wash hands and change gloves when they start work, when changing from one job to another, when going in and out of the kitchen, when going in and out of the walk-in refrigerator, and after using the oven mitts.  Interview, on 11/03/2011 at 11:14 AM, with the Dietary Manager revealed staff was to wear gloves and wash hands when working with food, when they go outside of the kitchen and come back in, when they use the oven mitts and when they go from dirty to clean in non food tasks.	F 371			

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

PRINTED: 11/16/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  166146	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - CEDAR RIDGE HEALTH C. B. WING _____	(X3) DATE SURVEY COMPLETED  11/01/2011
--	--	---	--

NAME OF PROVIDER OR SUPPLIER  CEDAR RIDGE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1217 US HIGHWAY 62 E CYNTHIANA, KY 41031
---	--

(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: 2004 Addition 6/16/2010</p> <p>SURVEY UNDER: 2000 New</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (211) Protected</p> <p>SMOKE COMPARTMENTS: Fourteen (14) smoke compartments.</p> <p>COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM (Original Installation)</p> <p>FULLY SPRINKLED, SUPERVISED (DRY SYSTEM) (Original Installation)</p> <p>EMERGENCY POWER: Type II Diesel Generator. (Original Installation)</p> <p>A life safety code survey was initiated and concluded on 11/01/11. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility was found not in substantial compliance with the Requirements for Participation for Medicare and Medicaid.</p> <p>Deficiencies were cited with the highest deficiency identified at "D" level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p>	K 000	<p>K 000</p> <p>The Exit Sign was ordered on 11/1/11 and placed in the kitchen as of 11/7/11.</p> <p>If at anytime the facility identifies an Exit Sign needing replaced and/or repaired, the campus will complete immediately.</p> <p>The facility alleges compliance as of November 7, 2011.</p>	11/7/2011
K 022 SS=D		K 022		

**RECEIVED**  
NOV 24 2011  
BY: \_\_\_\_\_

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Melissa Brown* TITLE *Executive Director* (X6) DATE *11/23/11*

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 60 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: 11/16/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185145	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - CEDAR RIDGE HEALTH C. B. WING _____		(X3) DATE SURVEY COMPLETED  11/01/2011
NAME OF PROVIDER OR SUPPLIER  CEDAR RIDGE HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 1217 US HIGHWAY 82 E CYNTHIANA, KY 41031		
(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 022	<p>Continued From page 1</p> <p>Access to exits is marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. 7.10.1.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain exits according to NFPA standards. The deficiency had the potential to affect one (1) of fourteen (14) smoke compartments, and all Kitchen personnel.</p> <p>The findings include:</p> <p>Observation, on 11/01/11 at 10:20 AM, with the Maintenance Director revealed the kitchen door, used as exit access, was not identified with an exit sign.</p> <p>Interview, on 11/01/11 at 10:20 AM, with the Maintenance Assistant revealed he was unaware of the door not being marked according to NFPA standards and acknowledged the potential for hazard in the event of an emergency.</p> <p>Reference: NFPA 101 7.10.1.4* Exit Access.</p> <p>Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not readily apparent to the</p>	K 022			

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

PRINTED: 11/16/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185145	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - CEDAR RIDGE HEALTH C. B. WING _____		(X3) DATE SURVEY COMPLETED  11/01/2011
NAME OF PROVIDER OR SUPPLIER  CEDAR RIDGE HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 1217 US HIGHWAY 62 E CYNTHIANA, KY 41031		
(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 022	Continued From page 2 occupants. Sign placement shall be such that no point in an exit access corridor is in excess of 100 ft (30 m) from the nearest externally illuminated sign and is not in excess of the marked rating for internally illuminated signs. Exception: Signs in exit access corridors in existing buildings shall not be required to meet the placement distance requirements.  NFPA 101 7.10.8.1* No Exit. Any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO EXIT Such sign shall have the word NO in letters 2 in. (5 cm) high with a stroke width of 3/8 in. (1 cm) and the word EXIT in letters 1 in. (2.5 cm) high, with the word EXIT below the word NO. Exception: This requirement shall not apply to approve existing signs.	K 022			