



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

PRINTED: 12/27/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185440	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  12/08/2011
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NAME OF PROVIDER OR SUPPLIER  VILLAGE CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2980 RIGGS AVENUE ERLANGER, KY 41018
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F 281	<p>Continued From page 1</p> <p>medications per physician orders. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 11/01/11 revealed the resident was frequently incontinent of urine.</p> <p>Review of the Physician's Order, dated 11/29/11, revealed Resident #12 was to have a urinalysis (UA) and urine culture and sensitivity (C&amp;S). Review of the Nurse's Note, dated 11/29/11 at 6:00 PM, revealed the nurse had received an order for a UA and C&amp;S. Continued review of the Nurses' Notes revealed the next entry was dated 12/01/11 at 8:00 AM. Documentation indicated a urine specimen had been collected that day for the ordered laboratory tests, two (2) days after the order was received.</p> <p>Review of laboratory reports revealed the UA result, positive for a UTI, was received on 12/02/11. Continued review revealed the nurse documented on the report the Physician had been notified and had given an order for "Bactrim DS times 5 days". Bactrim is an antibiotic commonly prescribed to treat UTIs. Review of the December 2011 Medication Administration Record (MAR) revealed the medication was not initiated until 12/06/11, four (4) days after the order was received.</p> <p>Interview with the Unit Manager, on 12/08/11 at 12:15 PM, revealed she had identified the oversight on 12/06/11. She stated the nurse who notified the Physician of the laboratory results had written the order on the report, but failed to write an order and transcribe it onto the MAR. She further stated she had the nurse phone the Physician in notification of the error and to receive an additional order.</p>	F 281	<p>serviced by the in-service / education coordinator, a registered nurse, related to the policy and procedure for physicians orders, including transcription of new orders to the physician order form and MAR / TAR as indicated. Lab and/or pharmacy notification with nurses notes will reflect the new orders and also to be noted on the 24 hour report to monitor the resident throughout the duration of the therapy. Any PRN staff who have not been in-serviced will not be scheduled for any further shifts until in-servicing has been completed.</p> <p>As part of our ongoing quality assurance program all new orders are being monitored daily. This monitoring is completed Monday through Friday by the Unit Managers or charge nurse. The house supervisor will complete the monitoring on the weekends. In addition all lab results are compared to the new orders or nurses notes (If there are no new orders, this will be reflected in the nurses notes.) to assure all physicians orders are transcribed and followed. (See Exhibit #1 Attached)</p> <p>Compliance with this policy will be reviewed by our Unit Managers at least weekly and addressed accordingly. The results of this review process shall be included in the regular quality assurance process and reviewed in the quarterly meetings.</p>	

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NAME OF PROVIDER OR SUPPLIER  VILLAGE CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2990 RIGGS AVENUE ERLANGER, KY 41018
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F 281	<p>Continued From page 2</p> <p>Subsequent interview with the Unit Manager, on 12/08/11 at 2:10 PM, revealed she had interviewed all nursing staff who took care of Resident #12 between 11/29/11 when the order for UA and C&amp;S was received, and 12/01/11 when the specimen was actually collected. She reported staff had been unable to collect a specimen sooner because the resident had either been incontinent or the urine was contaminated with fecal matter. During continued interview, she stated the delay was unacceptable and staff should have reported to the Physician they had been unable to get the specimen and receive further instructions.</p> <p>Interview with the attending Physician, on 12/08/11 at 6:00 PM, revealed he was also the facility's Medical Director. He stated he had been made aware of the delay in initiating treatment and had given a repeat order for the antibiotic therapy. He stated one (1) week was a long time to process the order for the laboratory tests and initiate treatment.</p>	F 281	<p>Completion Date: Dec. 15, 2011 Persons responsible: Cindy Dempsey, RNC, DON Rita Cahill, LPN, ADON and Director of Quality and Reporting Pat Feldhaus, RN, In-service Director, Unit Coordinators and House Supervisors</p> <p>Preparation or execution of this plan of correction does not constitute admission or agreement to any alleged deficiencies cited in this document. This plan of correction is prepared and executed, as required by the provision of federal and state law.</p>	
F 333 SS=D	<p>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS</p> <p>The facility must ensure that residents are free of any significant medication errors.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to ensure residents were free of significant medication errors for one (1) of nineteen (19) sampled residents, (Resident #12). Resident #12 was ordered antibiotic therapy</p>	F 333	<p>F 333 SS = D 483.25(m)(2) RESIDENT FREE OF SIGNIFICANT MED ERRORS</p> <p>This facility has a policy of assuring all residents are free of significant med errors. Every attempt is made to assure each resident receives their physician prescribed medications as ordered.</p> <p>The Unit Manager identified the oversight of the physician order for resident #12, while following the Monday, Wednesday, Friday, QA process the facility requires for all physician orders.</p>	

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F 333	<p>Continued From page 3 for a Urinary Tract Infection on 12/02/11. However, the nurse failed to transcribe the order. The error was identified on 12/06/11 and the antibiotic was initiated, four (4) days after the original order was received.</p> <p>The findings include:</p> <p>Review of the clinical record revealed Resident #12 was admitted by the facility on 03/26/09 with diagnoses which included Alzheimer's Disease and Urinary Incontinence. Review of the Comprehensive Care Plan, renewed on 10/13/11, revealed interventions related to prevention and/or early detection of a Urinary Tract Infection (UTI). Continued review revealed the intervention to administer medications per Physician's orders.</p> <p>Review of laboratory reports revealed the UA result, positive for a UTI, was received on 12/02/11. Continued review of the report revealed a note by the nurse indicated the Physician had been notified and had given an order for "Bactrim DS times 5 days". (Bactrim is an antibiotic commonly prescribed to treat UTIs.) Review of the December 2011 Medication Administration Record (MAR) revealed the medication was not initiated until four (4) days later, on 12/06/11.</p> <p>Interview with the Unit Manager, on 12/08/11 at 12:15 PM, revealed she had identified the oversight on 12/06/11. She stated the nurse who notified the Physician of the laboratory results had written the note on the laboratory report, but failed to write an official order and transcribe it onto the MAR.</p>	F 333	<p>On 12-6-2011 all nurses involved were immediately in-serviced by the Unit Manager related to the facility policy for correct procedure and documentation of physician orders, including transcription of new orders to the physician order form and MAR / TAR as indicated, lab and/or pharmacy notification with nurses notes to reflect the new orders and also to be noted on the nursing 24 hour report to monitor the resident throughout the duration of the therapy.</p> <p>Effective 12-15-2011, all regular &amp; part time licensed nursing staff have been in-serviced by the in-service / education coordinator, a registered nurse, related to the policy and procedure for physicians orders, including transcription of new orders to the physician order form and MAR / TAR as indicated. Lab and/or pharmacy notification with nurses notes will reflect the new orders and also to be noted on the 24 hour report to monitor the resident throughout the duration of the therapy. Any PRN staff who have not been in-serviced will not be scheduled for any further shifts until in-servicing has been completed.</p> <p>As part of our ongoing quality assurance program all new orders are being monitored daily. This monitoring is completed Monday through Friday by the Unit Managers or charge nurse and the house supervisor will complete the monitoring on</p>	

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F 333	Continued From page 4 Interview with the attending Physician, on 12/08/11 at 6:00 PM, revealed he was also the facility's Medical Director. He stated he had been made aware of the delay in initiating treatment and had given a repeat order for the antibiotic therapy. Continued interview revealed the delay in treatment could have made a difference. He further stated four (4) days between the lab results and the initiation of an order was too long.	F 333	the weekends. In addition all lab results are compared to the new orders or nurses notes (If there are no new orders, this will be reflected in the nurses notes.) to assure all physicians orders are transcribed and followed. (See Exhibit #1 Attached)	
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 record review, it was determined the facility failed to prepare and serve food under sanitary conditions. Observation during supper meal service, on 12/05/11 from 6:20 PM through 6:30 PM, revealed a dietary aide picked up plates she had dropped on the floor, returned the plates to the service area, adjusted her glasses on her face and continued serving resident meals without washing her hands and changing gloves.  The findings include:	F 371	Compliance with this policy shall be reviewed by our Unit Managers at least weekly and addressed accordingly. The results of this review process shall be included in the regular quality assurance process and reviewed in the quarterly meetings.  Completion Date: Dec. 15, 2011 Persons responsible: Cindy Dempsey, RNC, DON Rita Cahill, LPN, ADON and Director of Quality and Reporting Pat Feldhaus, RN, In-service Director, Unit Coordinators and House Supervisors  Preparation or execution of This plan of correction does not constitute admission or agreement to any alleged deficiencies cited in this document. This plan of correction is prepared and executed, as required by the provision of federal and state law.	

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F 371	<p>Continued From page 5</p> <p>Review of the facility's Sanitation and Food Handling Policy, no date, revealed employees were to wash hands when going from a soiled job to a clean job and after touching parts of the body. Additional review of the policy revealed employees must change gloves and wash hands before putting new ones on to be sure not to cross contaminate foods with the gloved hands.</p> <p>Observation during the supper meal service, on 12/05/11 at 6:20 PM, revealed Dietary Aide #1 dropped plastic divided plates onto the floor. Further observation revealed Dietary Aide #1 picked the plates up off the floor with her gloved hands by touching the bottom of the plates that had been on the floor. Dietary Aide #1 placed the plates on the wooden edge of the steamtable and continued plating resident's meals with out washing her hands and changing her gloves. Continued observation, at 6:24 PM, revealed Dietary Aide #1 adjusted her reading glasses on her face with her gloved hand and continued plating resident's without washing her hands and changing her gloves.</p> <p>Interview with Dietary Aide #1, on 12/05/11 at 6:30 PM, revealed she should have washed her hands and changed her gloves after picking the plates up off the floor and again after adjusting her glasses.</p> <p>Interview with the Dietary Manager, on 12/07/11 at 2:30 PM, revealed kitchen sanitation was covered upon hire and through out the year. Inservice's and attendance were documented. Further interview revealed dietary sanitation was a daily, self monitoring event, if in doubt, wash hands and change gloves.</p>	F 371	<p>F 371 483.35(i) Food Procure, Store/Prepare/Serve-Sanitary SS=E</p> <p>The facility must- Procure food from sources approved or considered satisfactory by Federal, state or local authorities; and store, prepare, distribute and serve food under sanitary conditions.</p> <p>1. All dietary staff have been re-educated related to hand washing and glove use and the need to remove gloves and wash hands between serving food and handling other items while serving meals. In addition, staff were re-educated on sanitary conditions related to dropping plates on the floor and then placing them back in the service area and on changing gloves and hand washing after touching face, hair or glasses. These inservices were completed between 12/6 &amp; 12/12/2011 by Matt Knollman Food Service Director and Pat Feldhaus RN, Inservice Education Coordinator. This process will be monitored by the charge nurse in the dining room at each meal and random audits by the Food Service Coordinator using Exhibit #2. The monitoring sheets will be forwarded to the QA coordinator weekly and will be reported on Quarterly and as needed as part of the QA process.</p> <p>Note: Although there was not a date of</p>	

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F 441 SS=E	<p><b>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</b></p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p>	F 441	<p>review on the hand washing policy, this policy as well as all policies the facility utilizes are reviewed and updated annually and as needed. This process was last completed on 2/3/2011. See Addendum #1 attached.</p> <p>Date of Completion: 12/12/2011 Persons responsible: Matt Knollman Food Service Director, Rita Cahill LPN, Director of Quality and Reporting, Unit Managers &amp; Pat Feldhaus, RN Inservice Education Director</p> <p>Preparation or execution of This plan of correction does not constitute admission or agreement to any alleged deficiencies cited in this document. This plan of correction is prepared and executed, as required by the provision of federal and state law.</p> <p>F 441 483.65 Infection Control Prevent spread, linens SS=E The facility must establish and maintain an Infection Control Program designed to provide safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p>	

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F 441	<p>Continued From page 7</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>Observation, on 12/07/11 of a skin assessment for Resident #4, revealed staff used improper hand hygiene.</p> <p>Further observation, on 12/07/11 of incontinence care for Resident #2, revealed staff provided incontinence care by cleansing stool from the perineal area, removed the soiled gloves, and without washing hands opened a closet door to obtain a brief.</p> <p>In addition, observation on 12/08/11 at lunch meal service revealed staff opened the trash can lid with their hands and then without washing hands went on to serve coffee and plates from the tray line.</p> <p>The findings include:</p> <p>Review of the facility "Hand Washing Policy", undated, revealed hand washing was the single most important procedure for preventing nosocomial infections. Indications for Handwashing included; after situations during which microbial contamination of hands was likely to occur, especially those involving contact with</p>	F 441	<p>(a) Infection Control Program The facility must establish an Infection Control Program under which it-</p> <ol style="list-style-type: none"> <li>(1) Investigates, controls, and prevents infections in the facility;</li> <li>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</li> <li>(3) Maintains a record of incidents and corrective actions related to infections.</li> </ol> <p>(b) Preventing Spread of Infection</p> <ol style="list-style-type: none"> <li>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</li> <li>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</li> <li>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.             <ol style="list-style-type: none"> <li>1. All Licensed staff involved in skin assessments including LPN #1 were re-educated on 12/8/11 through 12/15/2011 by Pat Feldhaus RN, Inservice Education Director on gloves and hand washing procedures during skin assessments to include: handwashing and applying new gloves after exam of head, torso and again after peri area and removing gloves and washing hands when skin assessment is completed. All nurses will be monitored by Wound Care Nurse or another nurse</li> </ol> </li> </ol>	

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F 441	<p>Continued From page 8</p> <p>mucous membranes, blood or body fluids, secretions, or excretions, after touching inanimate sources that were likely to be soiled, between care of different anatomical sites on the same resident, after removing gloves.</p> <p>1. Observation, on 12/07/11 at 10:00 AM, revealed Licensed Practical Nurse (LPN) #1 performed a skin assessment for Resident #4 using improper hand hygiene. The nurse picked up each foot with her gloved hands and checked for skin breakdown, and then without washing her hands and changing her gloves, checked the genital area touching the vagina. Further observation revealed the nurse again did not wash her hands and change her gloves and proceeded to lift the breast and check for skin breakdown. She then removed her gloves and washed her hands.</p> <p>Interview, on 12/07/11 at 10:30 AM with LPN #1, revealed she should have done a head to toe skin assessment which would have included checking the head first, then the breast and upper torso. She stated she would then need to wash hands and change gloves and check the genitalia, wash hands and change gloves and check the lower extremities and feet.</p> <p>2. Observation, on 12/07/11 at 10:50 AM, revealed Certified Nursing Assistant (CNA) #2 performed peri-neal care for Resident #2. She cleansed stool from the rectal area, removed her soiled gloves, and without washing her hands, opened a cabinet door and obtained a brief.</p> <p>Interview, on 12/07/11 at 11:00 AM with CNA #2, revealed she had been observed performing</p>	F 441	<p>designated and trained by her using exhibit #3 to assure they are washing hands when needed during skin assessments. After the initial monitoring, as part of our ongoing QA process the Wound Care Nurse or designee will monitor at least 3 nurses doing skin assessments per quarter and log the information on Exhibit #3 re-educating nurses if needed when problems are noted during the process. This information will be reported as part of the Quarterly QA process.</p> <p>2. All Nursing Assistants including CNA #2 were re-educated on 12/8/11 through 12/12/11 by Pat Feldhaus, RN, Inservice Education Director on proper peri care and handwashing after removing gloves and before opening cabinet door to obtain clean briefs. Staff development will continue to monitor Nursing Assistants performing peri care using Exhibit #4 as part of our on going QA monitoring. Any area of noncompliance will be addressed when noted during this monitoring. Problems identified will be reported by Inservice Education coordinator as part of our Quarterly QA process.</p> <p>3. All Nursing and Dietary staff including CNA #3 were re-educated on using the step pedal on the trash cans in the dining room and not to open cans with their hands. They were also re-educated on proper handwashing during the dining process. These inservices occurred between 12/8 &amp; 12/12/2011 by Pat Feldhaus, RN, Inservice</p>	

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F 441	<p>Continued From page 9</p> <p>perl-care by the staff development in the past with no concerns. Continued interview, revealed she usually washed her hands after removing her gloves; however, may have been nervous.</p> <p>3. Observation, on 12/06/11 at 12:00 PM, of the noon meal service revealed CNA #3 used her hands to raise the trash can lid, then without washing her hands, poured a package of coffee in a cup, again raised the trash can lid with her hands to discard the package and then poured hot water in the cup from the coffee maker. She then washed her hands and again opened the trash can lid with her hands to discard the paper towel in which she dried her hands. Further observation revealed she then went to the tray line to serve plates to the residents.</p> <p>Interview, on 12/06/11 at 1:25 PM with CNA #3, revealed she acknowledged she did touch the trash can lid with her hands and should have used the foot pedal after washing her hands.</p> <p>Interview, on 12/08/11 at 2:00 PM, with the Infection Control Nurse, revealed staff should use the trash can pedals and not open the trash can lid with their hands. She stated the dining room meal service was audited on a regular basis by the dietary manager using an audit sheet; however, the audit did not include watching staff with hand hygiene. Continued interview revealed the charge nurses needed to monitor hand hygiene since they were responsible for overseeing the dining room meal service. She further stated staff needed to stop and wash their hands after performing perineal care and prior to touching other objects in the room.</p>	F 441	<p>Education Director. As part of our on going QA process, the charge nurse monitoring the dining room at each meal will complete the Quality Improvement form (see Exhibit #2) related to Infection Control &amp; Sanitary Conditions. Any problems noted during the monitoring will be addressed by the nurse immediately. These forms will be turned in to QA coordinator weekly.</p> <p>Note: Although there was not a date of review on the hand washing policy, this policy as well as all policies the facility utilizes are reviewed and updated annually and as needed. This process was last completed on 2/3/2011. See Addendum #1 attached.</p> <p>Date of Completion: Dec 15, 2011 Persons responsible: Rita Cahill LPN Director of Quality and Reporting, Pat Feldhaus RN Inservice Education Director, Unit Managers, Charge Nurses</p>	

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

PRINTED: 12/27/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  165440	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  12/06/2011
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NAME OF PROVIDER OR SUPPLIER  VILLAGE CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2890 RIGGS AVENUE ERLANGER, KY 41018
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K 000	<p><b>INITIAL COMMENTS</b></p> <p>CFR: 42 CFR §483.70 (a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 8/12/99 Construction Date</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: Three (3) stories, Type II (222) Protected</p> <p>SMOKE COMPARTMENTS: Eight (8) smoke compartments.</p> <p>COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM</p> <p>FULLY SPRINKLED, SUPERVISED (Dry SYSTEM)</p> <p>EMERGENCY POWER: Type II Diesel Generator.</p> <p>A life safety code survey was initiated and concluded on 12/06/11. 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. The facility is licensed for one hundred (100) beds and the census was ninety-three (93) the day of the survey.</p>	K 000	<p style="text-align: center;">RECEIVED JAN - 6 2012</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <i>Tony Zubrowski</i>	TITLE  <i>Administrator</i>	(X6) DATE  1/5/12
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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  VILLAGE CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2080 RIGGS AVENUE ERLANGER, KY 41018
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K 000  K 147 88=F	<p>Continued From page 1</p> <p>Deficiencies were cited with the highest deficiency identified at "F" level.</p> <p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained according to NFPA standards. The deficiency had the potential to affect six (6) of eight (8) smoke compartments, all residents, staff, and visitors. The facility is licensed for one hundred (100) beds with a census of ninety-three (93) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 12/08/11 between 10:00 AM and 2:00 PM, with the Maintenance Supervisor revealed beds and bed alarms plugged into power strips in rooms # 112, #103, #104, #105, #207, #210, #214, #316, #317. Power strips were observed in all resident rooms being used as permanent wiring, NFPA 99 requires a sufficient number of receptacles in rooms to avoid the need for extension cords or multiple outlet adapters.</p> <p>Interview, on 12/08/11 between 10:00 AM and 2:00 PM, with the Maintenance Supervisor</p>	K 000  K 147	<p>Preparation or execution of this plan of correction does not constitute admission or agreement to any alleged deficiencies cited in this document. This plan of correction is prepared and executed, as required by the provision of federal and state law.</p> <p>K 147 NFPA 101 Life Safety Code Standard SS=F</p> <p>This Standard is not met as evidence by: based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained according to NFPA standards. No residents, staff or visitors were affected by this potentially deficient practice. During the walk through with the Life Safety Inspector, it was Observed that the electrical equipment could be rearranged so that all medical equipment could be plugged into the wall outlets. Maintenance personal went through all resident rooms and rearranged all electrical equipment and plugged all medical equipment into the wall outlets. All staff were re-educated on 12/6/2011 by Pat Feldhaus RN, Inservice Education Director related to medical equipment being plugged directly into wall outlets. As part of our ongoing Quality Assurance &amp; Safety process, the checking of medical equipment being plugged into wall outlets has been added to the Adaptive Equipment Rounds Monitoring (See addendum 2 attached) that is completed three times a week by our interdisciplinary team. Any problems identified during these</p>	

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K 147	<p>Continued From page 2</p> <p>revealed he was aware medical equipment could not be plugged into power strips and the nursing staff had been educated on this issue also.</p> <p>Reference: NFPA 99 (1999 edition)</p> <p>3-3.2.1.2 D</p> <p>Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.</p>	K 147	<p>rounds will be addressed and corrected immediately. Review of this process will become part of the Monthly safety and Quarterly Quality Assurance meetings.</p> <p>Date of Completion: Dec. 9, 2011 Persons responsible: Rodney Kannady, Executive Director of Maintenance, Brian Blair, Safety Committee Chairperson, Rita Cahill LPN, Director of Quality &amp; Reporting, Unit Managers, Pat Feldhaus RN Inservice Education Director &amp; Tony Zubrowski, Administrator</p>	