

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

PRINTED: 03/08/2013  
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  02/22/2013
NAME OF PROVIDER OR SUPPLIER  VILLAGE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2990 RIGGS AVENUE ERLANGER, KY 41018		
(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	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.		
F 282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy it was determined the facility failed to ensure qualified staff provided care and services, per the plan of care for one (1) of nineteen (19) sampled residents (Resident #10). The facility assessed Resident #10 to be at risk for falls and care planned the resident not to be left unattended in the bathroom. Record review revealed, on 11/18/12 at 6:20 AM, Resident #10 was left unattended in the bathroom and sustained a fall. The findings include: Review of the facility's policy: "Nursing Comprehensive Care Plan", undated, revealed a resident specific plan of care is written on each person residing at the facility. All key clinical personnel were knowledgeable about the information found on the care plan. Review of the medical record revealed the facility admitted Resident #10, on 09/28/12, with diagnoses which included Abnormal Gait.</p>	F 282	<p>483.20(k)(3)(ii) BE PROVIDED BY QUALIFIED PERSONS IN ACCORDANCE WITH EACH RESIDENT'S WRITTEN PLAN OF CARE.</p> <p>This facility has a policy to ensure that all residents are provided care in accordance with their written plan of care.</p> <p>All residents are comprehensively assessed and care planned accordingly to meet their individual needs. All residents identified at risk for falls have a specific nursing care plan outlining interventions and approaches to reduce the risk of falls. The CNA's care plans. (NACP) note the individualized approaches to care for that resident, including any approaches deemed necessary to prevent falls. Any resident that does sustain a fall is clinically evaluated by the charge nurse at the time of the fall. The charge nurse implements any additional interventions and adds those to the NACP at that time. The findings are noted in the nurse's notes and on the Resident Incident Report and a QA fall investigation form,</p>	MAR 18 2013	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X5) DATE

*[Signature]* Administrator 3/18/13

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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F 282	Continued From page 1 Alzheimer's Dementia, Right Hip Fracture (from a fall), Muscle Weakness and Difficulty Walking. Review of the resident's Minimum Data Set (MDS), dated 12/10/12, revealed the resident was severely cognitively impaired. Further review of the medical record revealed the facility assessed Resident #10 to be at risk for falls related to cognitive impairment, impaired safety awareness, history of falls, unsteady balance and incontinence of bowel. Continued review of the medical record revealed the resident was care planned to be at risk for falls. Review of the plan of care, initiated on 10/19/12, revealed interventions that included a chair alarm to alert staff if the resident attempted to get out of the chair without assistance, extensive assistance with transfer and toileting, and do not leave the resident unattended in the bathroom. Observations, on 02/21/13 at 2:05 PM, revealed the resident was seated in his/her wheelchair and had a fall prevention alarm in place at 2:20 PM. Further review of Resident #10's medical record, under the Comprehensive Resident Assessment section, revealed a fall entry note dated 11/17/12. Review of the note revealed on 11/16/12, at approximately 8:20 AM, the resident attempted to get up from the toilet and fell in the bathroom. Continued review of the note revealed the resident hit his/her head when he/she fell. Review of the Nurses' Notes, dated 11/16/12 at 8:20 AM, revealed the resident was trying to toilet him/herself and fall in the bathroom in the common area. Continued review of the note revealed the resident had hit his/her head during the fall. No injury was noted. Review of the facility's Risk Management Follow-up for Falls, dated 11/17/12, revealed the nursing assistant stated she had put Resident	F 282	(exhibit #1), is completed. The Unit Manager assesses the falls documentation and the resident record and implements any further approaches deemed appropriate, documents the findings in the Comprehensive Resident Assessments notes and up-dates the plan of care to include any new approaches. All residents with repeat falls are added to the Falling Star program. These residents all wear an orange bracelet and have orange stars by their room numbers as well as on the NACP to alert staff to their high risk of falls. All residents who sustain falls are discussed in the daily stand-up meetings Monday thru Friday. Discussion includes specifics of the fall, any new interventions implemented and outcomes. The staff members involved with falls with injuries are required to attend the next scheduled Resident at Risk meeting to discuss the specific fall they were involved with and any measures that could have been taken to prevent the fall. Focus of discussion is what contributed to the fall, whether policies were properly followed, and employee input to prevent further falls. Falls prevention is done every shift, seven days a week, (exhibit # 2). Adaptive equipment rounds are conducted 3 times a week to assure that all equipment, devices, and alarms are present and functioning properly, (exhibit # 3). All newly hired staff, as well as new contract staff, receive in-service education specific to adherence to the NACP and interventions to prevent falls.	

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F 282	Continued From page 2 #10 on the toilet and left to get a brief. Further review revealed upon return to the room, she found the resident on the floor yelling for help. Interview with the Director of Nursing (DON) and Registered Nurse #1/Unit Manager, on 02/22/13 at 4:40 PM, revealed on 11/16/12 the resident was left unattended in the bathroom and fell. Continued interview with the DON revealed the resident was care planned to be assisted to the toilet and was not supposed to be left unattended. Continued interview revealed the facility's protocol was if a resident had an alarm they were not supposed to be unattended. The DON stated when they had conducted their investigation and interviewed the aide, she knew the resident was not to be left unattended, but had gone out of the bathroom to get a brief.	F 282	On 11-16-2012 Resident #10 was admitted to the hospital. Upon his return on 11-27-2012 he was comprehensively re-assessed. The falls risk care plan and NACP were updated to include individualized approaches as deemed appropriate.  On 11-16-2012, staff involved were immediately in-serviced regarding falls and care plan interventions and approaches specific to falls prevention. In-services include strict adherence to the resident care plan and individualized approaches, never leaving any resident assessed to be at risk of falls alone in non-populated areas, such as bathrooms, resident rooms, dining areas and common areas and the importance of a rapid response to all alarms. Staff directly involved received disciplinary action.  Effective 3-15-2013, all staff have been in-serviced in regard to falls and care plan interventions and approaches specific to falls prevention. In-services include strict adherence to the resident care plan and individualized approaches. They are also encourage to never leave any resident assessed to be at risk of falls alone in non-populated areas, such as bathrooms, resident rooms, dining areas and common areas. The need for rapid response to all call lights and alarms are also covered. Any part time or PRN staff who have not received the in-services will not be scheduled for any further shift until in-service has been completed.		
F 323 SS-E	483.26(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy it was determined the facility failed to ensure the environment was free of accident hazards as possible. Observations during the initial tour, on 02/20/13, revealed the soiled utility room on the				

F 282  
Continued

As part of our ongoing quality assurance program, all falls will continue to be investigated and addressed individually at the time of fall and reviewed in the Monday thru Friday Stand-up meeting and the twice monthly Resident at Risk meetings. The monitoring of falls prevention and adaptive equipment rounds will be reviewed daily with the Quality Improvement Review From to assure on-going compliance. (See Exhibit #4).

Compliance with this policy will be reviewed by our Director of Quality and Reporting twice per month in the Resident at Risk meetings 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: March 15, 2013

Persons responsible:

Cindy Dempsey, RNC, DON

Rita Cahill, LPN, ADON and Director of Quality and Reporting

Kristi Hilbert, LPN, In-service Director, Unit Coordinators and House Supervisors

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F 323	Continued From page 3 third floor was unlocked and contained chemicals with the potential to cause harm if ingested or inhaled. In addition, the facility failed to ensure supervision to prevent accidents for one (1) of nineteen (19) sampled residents (Resident #10). The facility assessed Resident #10 as being at risk for falls and was not to be left unattended in the bathroom. However, record review revealed on 11/16/12 at 6:20 AM, Resident #10 was left alone in the bathroom and sustained a fall. The findings include: 1. Review of the facility's policy titled "Storage Area", no date, revealed it is the policy of the facility that storage areas are to be maintained in a clean and safe manner. Under the procedures section, the policy stated cleaning supplies would be stored as instructed on the label of the product. Observations during initial tour, on 02/20/13 at 9:00 AM, revealed the third floor soiled utility room was unlocked and unlatched. The soiled utility room door handle remained in a fixed vertical position, and the latching mechanism was not engaging in the door jam. Upon entering the room, chemicals were discovered in the cabinet under the sink. Inspection of the cabinet revealed a canister of Sanl-Wipes, Powder Dam 8 ounces (an absorbent spill powder), and Red-Z (an absorbent spill powder). Continued observation, on 02/20/13 at 9:15 AM, revealed the soiled utility room was entered by State Registered Nurse Assistant (SRNA) #1, by simply pushing the door. Review of the manufacturer's Material Safety Data Sheet (MSDS) for Red-Z, revealed inhalation of the chemical powder was dangerous and may result in throat and upper respiratory tract irritation. If ingested, the label stated	F 323	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.  F 323 SS = E 483.25(H) THE FACILITY MUST ENSURE THAT 483.25(H)(1) THE RESIDENT'S ENVIRONMENT REMAINS AS FREE OF ACCIDENT HAZARDS AS IS POSSIBLE; AND 483.25(h)(2) EACH RESIDENT RECEIVES ADEQUATE SUPERVISION AND ASSISTANCE DEVICES TO PREVENT ACCIDENTS.  1) This facility has a policy of assuring the resident environment is as free of hazards as possible and each resident receives adequate supervision and assistive devices to prevent injuries.  On each unit, a cabinet in the soiled utility room now has a locked unit for storage of chemicals. All staff are being in-serviced related to hazardous chemicals and proper storage, the locked unit, location of the key and procedure for securing chemicals in a manner consistent with maintaining a safe environment.  The locked cabinets have been added to the adaptive equipments rounds conducted three times a week. (exhibit #3)		

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F 323	<p>Continued From page 4</p> <p>burning of the throat, mouth, esophagus, abdominal distress and moderate irritation may occur. Contact with the eye could result in redness and burning. Under the storage section of the MSDS, it indicated the chemical was to be stored out of reach of children.</p> <p>Review of the manufacturer's MSDS for Powder Dam, revealed the chemical was an irritant to the skin and eyes. In addition, the chemical could result in constipation if ingested as well as other symptoms. In all routes of exposure to the Powder Dam chemical, medical attention was recommended. Further review, under physical properties, revealed the chemical was said to have an apple odor. Lastly, the MSDS instructed to store the chemical out of reach of children for health and safety reasons.</p> <p>Review of the manufacturer's MSDS for Sani-wipes, revealed the chemical was harmful and could be fatal if swallowed. Furthermore, the MSDS stated exposure to the chemical could aggravate preexisting eye and skin disorders. The MSDS also instructed that the chemical be stored out of reach of children.</p> <p>Interview with SRNA #1, on 02/20/13 at 9:15 AM, revealed the soiled utility room was usually unlocked. SRNA #1 also stated she believed residents who wandered could get inside the soiled utility room.</p> <p>Interview with Housekeeper #1, on 02/20/13 at 9:40 AM, revealed she was unaware chemicals were stored in the soiled utility room. She reported the soiled utility room door on the third floor was always unlocked.</p>	F 323	<p>The adaptive equipment rounds are monitored with the quality improvement review form, (exhibit #4) and reported twice per month at the Resident at Risk meeting.</p> <p>Effective 3-22-2013, all regular &amp; part time staff have been in-serviced by the in-service / education coordinator, a Licensed Practical nurse, related to the policy and procedure for assuring the residents environment remains as free as possible of hazards and the residents receive adequate supervision and assistive devices to remain free of injury. Any staff who have not received in-servicing will not be scheduled to work any shifts until the in-service has been completed.</p> <p>As part of our ongoing quality assurance program this process will be monitored three times per week with the adaptive equipment rounds and reviewed twice monthly with Resident at Risk meeting.</p> <p>The results of this review process shall be included in the regular quality assurance process and reviewed in the quarterly meetings.</p> <p>Completion Date: March 22, 2013 Persons responsible: Cindy Dempsey, RNC, DON Rita Cahill, LPN, ADON and Director of Quality and Reporting Kristi Hilbert, LPN, In-service Director, Unit Coordinators and House Supervisors</p>		

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F 323	Continued From page 5  Interview with Central Supply Staff #1, on 02/20/13 at 9:50 AM, revealed she stocks the soiled utility rooms every three (3) days. She reported the door to the soiled utility room remained unlocked.  Interview with the Unit Manager for the third floor, on 02/20/13 at 9:20 AM, revealed she was unaware the soiled utility room door handle was in need of repair. She stated no one had reported to her that the door was not latching. Further interview revealed, the Unit Manager was also unaware chemicals were being stored in the soiled utility room. She further stated that for as long as she could remember, the soiled utility room had been unlocked. However, she was now contacting maintenance to have the door handle repaired, so it would latch. Lastly, she reported there were there (3) confused residents, who wandered on the third floor.  Interview with the Maintenance Director, on 02/21/13 at 2:40 PM, revealed he had not received a maintenance request to repair the soiled utility room door on the third floor, until after surveyor questioning on 02/20/13. He reported the spring in the handle was broken and prevented the door from latching. The Maintenance Director also stated the soiled utility room was always unlocked, and he was unaware of any chemicals being stored under the sink.  Interview with the Director of Nursing (DON), on 02/22/13 at 3:40 PM, revealed the cleaning chemicals should be locked in the Housekeeping Closet. She also stated, Sanit-wipes should be kept locked up on each unit. Due to safety	F 323	2. All residents are comprehensively assessed and care planned appropriately to meet their individual needs. All residents identified at risk for falls have a specific nursing care plan outlining interventions and approaches to reduce the risk of falls. The CNAs' care plans (NACP) note the individualized approaches to care for that resident, including any approaches deemed necessary to prevent falls. Any resident that does sustain a fall is clinically evaluated by the charge nurse at the time of the fall. The charge nurse implements any additional interventions and adds those to the NACP at that time. The findings are noted in the nurse's notes and on the Resident Incident Report and a QA fall investigation form, (exhibit #1), is completed. The Unit Manager assesses the falls documentation and the resident record and implements any further approaches deemed appropriate, documents the findings in the Comprehensive Resident Assessments notes and up-dates the plan of care to include any new approaches. All residents with repeat falls are added to the Falling Star program. These residents all wear an orange bracelet and have orange stars by their room numbers as well as on the NACP to alert staff to their high risk of falls. All residents who sustain falls are discussed in the daily stand-up meetings Monday thru Friday. Discussion includes specifics of the fall, any new interventions implemented and outcomes. The staff members involved with falls with injuries are required to attend the next scheduled Resident at Risk meeting to discuss the		

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F 323	<p>Continued From page 6</p> <p>concerns, the DON stated absorbent powders used for spill clean up such as Red-Z and Powder Dam should be locked in the Housekeeping Closet. In addition, she reported she was unaware the handle to the utility room was not functioning properly. Lastly, she stated daily walk throughs and equipment rounds are conducted on different shifts with various disciplines to ensure the medical equipment and environment is safe and in good operating condition. Thus, she was unsure as to why the concerns in the soiled utility room had been overlooked prior to surveyor questioning.</p> <p>2. Review of the facility's policy: "Falls Policy and Procedure", Revised 09/2008, revealed the facility would assess each resident to determine if they are at risk for falls and would plan their care and implement interventions accordingly. In addition, review of the "Procedure" section revealed the plan of care would be formulated to include interventions to address the prevention of falls. Review of the facility's policy: "Resident Incidents -Assessment and Reporting", revised 10/02/08, revealed all incidents involving residents must be assessed and reported via the Internal Incident tracking form. Further review of the policy revealed if the incident was a fall, a "Fall Q.A. Investigation" form must also be completed by the initiating nurse.</p> <p>Review of the medical record revealed the facility admitted Resident #10, on 09/28/12, with diagnoses which included Abnormal Gait, Alzheimer's Dementia, Right Hip Fracture (from a fall), Muscle Weakness, and Difficulty Walking. Review of the resident's Minimum Data Set (MDS), dated 12/10/12, revealed the resident was severely cognitively impaired.</p>	F 323	<p>specific fall they were involved with and any measures that could have been taken to prevent the fall. Focus of discussion is what contributed to the fall, whether policies were properly followed, and employee input to prevent further falls. Falls prevention is done every shift, seven days a week, (exhibit # 2). Adaptive equipment rounds are conducted 3 times a week to assure that all equipment, devices, and alarms are present and functioning properly, (exhibit # 3). All newly hired staff, as well as new contract staff, receive in-service education specific to adherence to the NACP and interventions to prevent falls.</p> <p>On 11-16-2012 Resident #10 was admitted to the hospital. Upon his return on 11-27-2012 he was comprehensively re-assessed. The falls risk care plan and NACP were updated to include individualized approaches as deemed appropriate.</p> <p>On 11-16-2012, staff involved were immediately in-serviced regarding falls and care plan interventions and approaches specific to falls prevention. In-services include strict adherence to the resident care plan and individualized approaches, never leaving any resident assessed to be at risk of falls alone in non-populated areas, such as bathrooms, resident rooms, dining areas and common areas and the importance of a rapid response to all alarms. Staff directly involved received disciplinary action.</p>		

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F 323	<p>Continued From page 7</p> <p>Review of the medical record revealed the facility assessed the resident to be a fall risk due to cognitive impairment, impaired safety awareness, history of falls, unsteady balance, and incontinence of bowel. Continued review of the medical record revealed the resident was care planned for falls. Review of the plan of care, Initiated 10/19/12, revealed Interventions that included not to leave the resident unattended in the bathroom.</p> <p>Further review of Resident #10 's medical record, under the Comprehensive Resident Assessment section, revealed a fall entry note dated 11/17/12. Review of the note revealed, on 11/16/12 at approximately 6:20 AM the resident attempted to get up from the toilet and fell in the bathroom. Continued review of the note revealed the resident hit his/her head when he/she fell, with no injury noted.</p> <p>Review of the Nurses' Notes, dated 11/16/12 at 6:20 AM, revealed the resident was trying to toilet self and fell in the bathroom in the common area, hitting his/her head.</p> <p>Review of the facility's Risk Management Follow-up for Falls, dated 11/17/12, revealed the aide stated she had put Resident #10 on the toilet and left to get a brief. Further review revealed when the aide returned to the bathroom the resident was on the floor yelling for help.</p> <p>Interview with the Director of Nursing (DON) and Registered Nurse #1/Unit Manager, on 02/22/13 at 4:40 PM, revealed on 11/16/12 the resident had been left unattended in the bathroom and fell. The Unit Manager stated she had been made aware of the fall and the nurse in charge had reported about the fall. She further stated the resident self propelled himself/herself into the bathroom next to the nurses' station and an aide</p>	F 323	<p>Effective 3-15-2013, all staff have been in-serviced in regard to falls and care plan interventions and approaches specific to falls prevention. In-services include strict adherence to the resident care plan and individualized approaches. They are also encourage to never leave any resident assessed to be at risk of falls alone in non-populated areas, such as bathrooms, resident rooms, dining areas and common areas. The need for rapid response to all call lights and alarms are also covered. Any part time or PRN staff who have not received the in-services will not be scheduled for any further shift until in-service has been completed.</p> <p>As part of our ongoing quality assurance program, all falls will continue to be investigated and addressed individually at the time of fall and reviewed in the Monday thru Friday Stand-up meeting and the twice monthly Resident at Risk meetings. The monitoring of falls prevention and adaptive equipment rounds will be reviewed daily with the Quality Improvement Review From to assure on-going compliance. (See Exhibit #4).</p> <p>Compliance with this policy will be reviewed by our Director of Quality and Reporting twice per month in the Resident at Risk meetings 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		
(X4) IO 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 323	Continued From page 8 went into assist the resident to the toilet. The Unit Manager further stated the aide had left the resident on the toilet to get a new brief. The DON stated the resident was supposed to be supervised at all times when in the bathroom. She stated any residents who had fall alarms were not supposed to be left unattended when they were in the bathroom. The DON stated when they had conducted their investigation and interviewed the aide, she (the aide) knew the resident was not to be left unattended, but had gone out of the bathroom to get the brief. The DON also revealed the aide was Inservice and disciplined for her actions. Continued interview with the DON revealed the nurse in charge never completed a QA investigation which was supposed to be completed at the time of the fall. She stated because the nurse never completed the QA investigation form, they did an unusual occurrence form because the nurse did not do an investigation.	F 323	Completion Date: March 15, 2013 Persons responsible: Cindy Dempsey, RNC, DON Rita Cahill, LPN, ADON and Director of Quality and Reporting Kristi Hilbert, LPN, In-service Director, Unit Coordinators and House Supervisors		
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, record review	F 371	F 371 483.35(i) Food Procure, Store/Prepare/Serve-Sanitary SS=E 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.  1.All dietary staff have been re-educated related to utensils being stored in the same direction with the serving side facing up in order to prevent cross contamination when someone reaches in the drawer.		

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F 371	<p>Continued From page 9</p> <p>and review of facility policy it was determined the facility failed to ensure food was stored, prepared and served under sanitary conditions. Observations, of the kitchen on 02/20/13 and 02/21/13, revealed utensils were stored in different directions in a utensil drawer, the top of the knife storage rack had dust and grease build-up and the conduit leading to the light fixture in the middle of the walk-in refrigerator had an accumulation of dust.</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Sanitation and Food Handling", not dated, and policy titled "Cleaning and Sanitizing", not dated, revealed it was the policy of the facility to handle all foods and utensils in a safe and sanitary manner. Further review of the policy revealed the Food Service Director would provide cleaning assignments to indicate time and projects to be carried out by individual employees. Additional policy review revealed all surfaces must be cleaned on a routine basis, as well as whenever necessary even if not scheduled.</p> <p>1. Observation during the initial tour of the kitchen, on 02/20/13 at 8:45 AM, and during the sanitation tour, on 02/21/13 at 3:25 PM, revealed there were two (2) ladles with the serving end facing the right, two (2) scoops with the serving end facing the left and two (2) tongs with the serving end facing down amongst other utensils stored in a utensil drawer.</p> <p>Interview with Dietary Aide #1, on 02/21/13 at 3:25 PM, revealed the utensils are supposed to be stored in the same direction of the serving end</p>	F 371	<p>This inservice was completed on 2/22 &amp; 3/8/2013 by Steve Voskuhl interim Food Service Director and Rita Cahill LPN Director of Quality &amp; Reporting. This process will be monitored weekly by Linda Bidwell Food Service Director with additional random spot checks by Rita Cahill LPN Director of Quality &amp; Reporting &amp; by Colette Truett Registered Dietician. See Exhibit # 5. 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>2. The cleaning schedules Exhibit #6) have been revised and updated to include cleaning &amp; degreasing of knife rack monthly &amp; as needed by the 1<sup>st</sup> cook. Cleaning of dust on conduit in walk in refrigerator will be completed monthly and as needed by 2<sup>nd</sup> cook. These items have been added to the QA checklist (Exhibit # 5) and will be monitored weekly by Linda Bidwell Dietary Manager with additional random spot checks by Rita Cahill LPN Director of Quality &amp; Reporting &amp; by Colette Truett Registered Dietician. If problems are noted during weekly checks they will be addressed immediately. Revisions have also been made to the policies &amp; procedures to include these cleaning schedules. All dietary staff have been re-educated related to cleaning schedules These inservices were completed between 2/22 &amp; 3/8/2013 by Steve Voskuhl interim Food Service Director</p>	
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F 371	<p>Continued From page 10</p> <p>facing up in order to prevent cross contamination when someone reaches in the drawer to get a utensil. Further interview revealed the drawer was too full and needed to be organized to ensure proper storage of the utensils.</p> <p>2. Observation during Initial tour of the kitchen, on 02/20/13 at 8:45 AM and during the sanitation tour, on 02/21/13 at 3:25 PM, revealed a knife storage rack had an accumulation of dust and grease on top of the storage rack where knives were stored.</p> <p>Interview with the Head Cook, on 02/21/13 at 3:30 PM, revealed the knife rack needed to be taken apart and run through the dishwasher. Further interview revealed It was the cook's responsibility to clean the knife rack; however, it was not listed in the cleaning schedule to be cleaned on a regular basis.</p> <p>3. Observation during Initial tour of the kitchen, on 02/20/13 at 8:45 AM and during the sanitation tour, on 02/21/13 at 3:25 PM, revealed approximately a quarter inch of dust on the conduit which leads to the light fixture in the ceiling of the middle walk-in cooler. Further observation revealed the conduit was directly above boxes of various containers of juices.</p> <p>Interview with the Head Cook, on 02/21/13 at 3:30 PM, revealed the dietary director's last day to work was 02/17/13 and he was temporarily in charge. Further interview revealed It was not on the cleaning schedule to clean the conduits; however, he assumed it was dietary's responsibility. Additional interview revealed It looked like it needed to be cleaned, probably had</p>	F 371	<p>and Rita Cahill LPN Director of Quality &amp; Reporting.</p> <p>Date of Completion: 3/15/2013 Persons responsible: Linda Bidewell Food Service Director, Rita Cahill LPN, Director of Quality and Reporting, &amp; Colette Truett Registered Dietician.</p>		

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F 371	Continued From page 11 not been clean in awhile and needed to be added to the cleaning schedule.	F 371		
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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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K 000	<p>INITIAL COMMENTS</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 02/20/2013. The facility was found to be in compliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility is licensed for one hundred (100) beds and the census was ninety-one (91) the day of the survey.</p>	K 000		

RECEIVED  
MAR 18 2013  
BY: \_\_\_\_\_

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

*[Handwritten Signature]*

ADMINISTRATOR

3/18/13

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.