

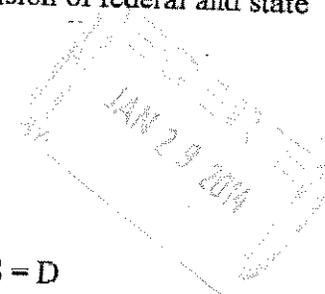
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/08/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 183440	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/19/2013
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
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F 000	INITIAL COMMENTS A Recertification Survey was initiated on 12/17/13 and concluded on 12/19/13. Deficiencies were cited with the highest scope/severity at an "F".	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 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy, it was determined the facility failed to ensure resolution of grievances and failed to ensure residents were informed of the progress towards resolution one (1) of twenty (20) sampled residents (Resident #6). Resident # 6's family reported the resident's beard trimmer was missing to nursing staff. However, there was no documented evidence the grievance or complaint was documented by staff, investigated or resolved. The findings include: Review of the facility's policy titled, "Procedure for Filing and Investigation of a Grievance", revised October 2003, revealed the facility was to respect the right of each resident to voice a grievance or complaint without discrimination or reprisal. "Voiced grievances" were not to be limited to a formal, written grievance process; but, might include a resident's verbalized complaint to facility	F 166	483.10(f)(2) F = 166, SS = D Right To Prompt Efforts To Resolve Grievances. It is the policy of this facility that all residents are entitled to prompt	



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE Administrator DATE 1/29/14

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 required to continued program participation.

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F 166 Continued From page 1
staff. Review revealed the facility was to deal with and make prompt efforts to resolve a resident's complaint or grievance, including acknowledgement of it and actively work towards resolution.

Record review revealed the facility admitted Resident #6 on 01/17/13, and readmitted resident on 07/05/13, with diagnoses which included Cerebrovascular Accident with Right Hemiparesis, Aphasia and Depression. Review of the Quarterly Minimum Data Set (MDS) dated 10/04/13, revealed the facility assessed Resident #6 to be severely cognitively impaired. Further review of Resident #6's record, to include the missing item records/reports, Social Service Notes, and Nursing Notes, revealed no documented evidence of the report of the resident's missing beard trimmer reported by his/her family.

Observation, on 12/17/13 at 4:05 PM, revealed Resident #6 lying on the bed with his/her spouse present by the bed. Interview with Resident #6's spouse at the time of the observation revealed the resident did not speak and staff responded to the resident's needs by reading his/her facial expressions.

Interview, on 12/18/13 at 12:40 PM, with Resident #6's daughter revealed Resident #6's Remington beard trimmer was missing from the resident's room. Resident #6's daughter stated it was an expensive beard trimmer. The daughter stated the resident's beard trimmer had been missing since October. She stated the nurses were notified and a search had taken place on the unit; however, the beard trimmer had not been located. Resident #6's daughter stated she was

F 166 efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.

In the case of Resident #6, it was noted that the Unit Manager discussed with the family that a search had been conducted of this resident's belongings and the unit as a whole but that the trimmer had not been located. This resident's family then purchased a replacement beard trimmer. The family member said that she was not upset regarding the missing trimmer and was happy to replace it.

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F 166	<p>Continued From page 2</p> <p>told her statement had been taken. She indicated she had not been informed of the progress or resolution of the missing beard trimmer.</p> <p>Interview, on 12/19/13 at approximately 2:15 PM, with Licensed Practical Nurse (LPN) #6, revealed she was told by Resident #6's family the resident's beard trimmer was missing. LPN #6 stated she, along with other staff, searched Resident #6's room and other resident rooms on the unit for the missing beard trimmer. She stated, since the missing beard trimmer was reported to her later in the evening, she notified the Social Worker by voicemail of the missing item. LPN #6 further stated she was not certain what happened after a complaint or grievance was reported to Social Services.</p> <p>Interview, on 12/19/13 at approximately 3:15 PM, with Certified Nursing Assistant (CNA) #4, revealed the family reported Resident #6's beard trimmer as "stolen". CNA #4 stated she was educated to view most items as "missing" rather than stolen because of wandering residents. She stated she and other staff searched for the missing beard trimmer in all of the resident rooms on that unit; however, did not locate it. CNA #4 stated LPN #6 normally reported missing items to the Social Worker. She stated a paper form would be filled out, but was not certain who filled out the form for missing items.</p> <p>Interview, on 12/18/13 at 6:00 PM, and 12/19/13 at approximately 3:50 PM, with the Social Service Director (SSD), revealed she did not recall receiving a message on her voicemail from LPN #6 in regards to Resident #6's missing beard trimmer. She stated she was informed of a grievance by staff members and/or family</p>	F 166	<p>It is the practice of this facility to acknowledge that all residents are at risk for the possibility of having missing item(s). The facility shall continue to encourage families to label all personal items and to promptly alert staff to any item noted missing.</p> <p>All grievances are reported promptly to the Social Service Department. In the case of a missing item, the staff member receiving the complaint shall promptly report to the unit Charge nurse. Once the Charge nurse has determined the item is not present in</p>		

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F 166	Continued From page 3 members. The SSD stated she would complete a "write-up" and investigate whatever the grievance was in regards to. She stated she would follow-up with family and/or residents of the progress toward a resolution of the complaint or grievance; however, she stated this process was not completed for Resident #6's missing beard trimmer. Interview, on 12/19/13 9:20 AM and on 12/19/13 at approximately 3:55 PM, with the Administrator revealed there had been a break down in communication in regards to Resident #6's missing beard trimmer. He stated he thought that the incident should have been reported to Social Services. He stated the facility process was if a resident had something missing, nursing was to forward the information related to the missing item to Social Services to investigate. The Administrator stated all grievances and complaints were handled through Social Services. He indicated Social Services was to follow-up and notify residents or family members of the progress toward a resolution of the complaint and/or grievance. Interview, on 12/19/13 at approximately 4:00 PM, with the Director of Nursing (DON) revealed staff members were to communicate a grievance reported by a resident to the SSD by writing the information down on paper; through the SSD's voicemail; or, through email. The DON stated residents and/or family members were to be notified of the findings of the investigation.	F 166	the resident belongings or on the unit, the nurse will complete a missing item report,(See Exhibit #1) located in the file cabinet at each nursing station, and forward to Social Service, L. Donegan, LSW. The S.S. department then initiates an investigation in conjunction with the Nursing department to include an in depth search of the unit and facility, interviews with staff, other residents and the families. Outcome of investigation and resolution shall promptly be shared with the resident and /or the responsible party and documented on the Missing Items		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a				

1 of 2
continued
pages
F166 continued
from page 4 of 26

Report Form. SS dept shall QA all
missing items for 90 days and
randomly thereafter.

From 12/19/2013 thru 01/23/2014,
staff were in-serviced related to the
prompt reporting of all missing
items. All staff in-servicing includes
that they are responsible for
reporting any complaints or
concerns voiced related to a missing
item promptly to the charge nurse.

Unit charge nurses are then
responsible for initiating the
Missing Items Report which is

2 of 2
Continued
pages

FILE Continued
from page 4 of 26

available to them at each nursing
station in the file cabinet.

Social Services shall communicate
progress and outcome of
investigative findings with resident
and/or their responsible party and
document the findings on the
Missing Items Report Form.

Completed By: Jan. 24, 2014

Persons Responsible:

Cindy Dempsey, RNC, DON

Kristi Hilbert, RN, ADON, Staff

Development Coordinator

Rita Cahill, LPN, Director of

Quality and Reporting

Lori Donegan, LSW

Unit Managers and House

Supervisors

REPORT OF MISSING PERSONAL ITEM

Date: _____

Name of individual who lost the item(s): _____

Floor the individual lives on: _____

If not a VCC resident, specify residence and connection to VCC: _____

Name of individual who reported item(s) was/were lost: _____

Relationship to individual who lost item(s) or position at BCC: _____

Description of Lost Item(s):

Individual completing this form: _____

Signature Date

Form received by unit social worker: _____

Signature Date

WHEN ITEM IS FOUND, BE SURE TO COMPLETE BELOW AND RETURN FORM TO SOCIAL SERVICE!

DATE ITEM FOUND: _____

PLACE ITEM FOUND: _____

DISPOSITION OF ITEM: _____

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F 322 Continued From page 4
resident, the facility must ensure that --

(1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident's clinical condition demonstrates that use of a naso gastric tube was unavoidable; and

(2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.

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 treatment and services were provided to prevent complications related to Gastrostomy tubes (G-tubes) for one (1) of twenty (20) sampled residents (Resident #6). Observation revealed nursing staff failed to check the placement of the G-tube prior to administering medications.

The findings include:
Review of the facility "Enteral Tube" policy/procedure, undated, revealed prior to medication administration nursing staff were to verify placement of the tube per air bolus

F 322 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.

483.25(g)(2)
F322, SS = D
NG Treatment/Services,
Restorative Eating Skills
It is the policy of this facility that all residents receiving nutrition and/or medications will receive the appropriate treatment and services

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F 322	Continued From page 5 (injection of air). Record review revealed the facility admitted Resident #6 on 01/17/13, and readmitted the resident on 07/05/13, with diagnoses which included Cerebrovascular Accident, Right Hemiparesis, Dysphasia and G-Tube Placement. Review of the Quarterly Minimum Data Set (MDS) dated 10/04/13 revealed the facility assessed Resident #6 to be severely cognitively impaired. Observation during medication administration on 12/18/13 at 11:05 AM, revealed Licensed Practical Nurse (LPN) #4 failed to check for placement of Resident #6's G-tube by air bolus as per facility policy. Continued observation revealed LPN #4 administered medication via Resident #6's G-tube. Interview with LPN #4 on 12/18/13 at 11:15 AM, revealed she should have checked placement prior to giving medication. She indicated she usually checked placement every day, and, she had checked Resident #6's G-tube placement that morning. LPN #4 stated she was aware of the facility policy to check G-tube placement prior to administering medication via G-tubes. Interview with Licensed Practical Nurse (LPN) #3, who was the Unit Manager of Resident #6's unit, on 12/18/13 at 11:35 AM, revealed staff were to check for placement every time prior to medication administration via G-tub. Further interview revealed LPN #4 should have checked for placement prior to administering Resident #6's medication as per facility policy. Interview with LPN #5 on 12/19/13 at 10:22 AM,	F 322	to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. Resident #6 and the other three residents were assessed for possible complications related to G/T medication administration by J. Hodge, 3 rd floor charge nurse on 12/18/13. At no time did these Residents show any signs of adverse effects. From 12/19/13 to 1/23/14, all facility nurses were re-educated by R. Cahill, LPN, Director of Quality		

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F 322	Continued From page 6 revealed prior to administering G-tube medications, nurses were to check for placement. LPN #5 stated it would be inappropriate to administer medications without checking for G-tube placement first. Interview with the Director of Nurses (DON) on 12/19/13 at 2:30 PM, revealed proper administration for medication via G-tube included checking placement with air bolus prior to medication administration as indicated in the facility policy. The DON stated LPN #4 should have checked the G-tube placement before administering Resident #8's medications as per facility policy.			
F 323 SS=E	483.25(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 and review of the facility's policy, it was determined the facility failed to ensure the resident environment remained as free of accident hazards as was possible as evidenced by failure to ensure cabinets that contained chemicals were locked in two (2) of the three (3) satellite kitchen areas. The findings include:		F 322 & Reporting or B. Wilhoit, LPN, 2 nd Shift House Supervisor, related to proper technique administering feedings or medication to residents who have a GTube. On 12-18-2013, LPN #4 was immediately re-educated to proper G/T medication administration technique by Jan Turner, LPN, Unit Manager. On 1-18-2014, B. Wilhoit LPN, the 2 nd shift supervisor re-educated LPN #4 related to medication administration via G/T, and verified approved facility procedures to assure proper technique. (See	

*Pg 1062
continued*

*F322 continued
from page 7 of 26*

exhibit #2) Thereafter the Unit
Managers will monitor all nurses
responsible for G/T feeding and /or
medication administration at least
quarterly. All newly hired nurses
will be educated by the Staff
Development coordinator or her
licensed designee. The Unit
Manager will then include these
nurses in the quarterly monitoring as
part of our ongoing Quality
Assurance Program.

Completion Date: Jan. 24, 2014

*Pg 2 of 2
Continued*

*F322 Continued
from page 7 of 26*

Persons Responsible:

Cindy Dempsey, RNC, DON

Kristi Hilbert, RN, ADON,

Staff Education Coordinator

Rita Cahill, LPN, Director of

Quality and Reporting

Unit Managers and House

Supervisors

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F 323 Continued From page 7

Review of the facility's policy, untitled and dated 03/12/13, revealed all hazardous materials, cleaning or chemical agents and any potentially harmful substance was to be under lock at all times when not in use. Further review revealed no cleaning or chemical agent should be stored in any unlocked area or in any resident areas due to potential of harm if ingested or inhaled.

Observation, on 12/17/13 at 11:32 PM, of the Unit One (1) satellite kitchen during initial tour, revealed a cabinet to be unlocked with chemicals stored inside. Continued observation revealed the chemicals to be three (3) quart bottles of Glance Cleaner, two (2) gallon bottles of Super Trump Detergent and one (1) gallon bottle of Bleach.

Observation, on 12/18/13 at 11:10 AM, of the Unit Three (3) satellite kitchen, revealed a cabinet under the sink to be unlocked and to contain chemicals. Further observation revealed the chemicals to be R/O Free Rinse Additive, Super Trump Detergent, Austin A-1 Bleach, Greasecutter Plus, Lime Away and Glance Cleaner.

Review of the facility's Materials Safety Data Sheets (MSDS) revealed Austin A-1 Bleach to be a hazardous corrosive that could cause the following: corrosion of mucous membranes, severe esophageal burns, perforation of the esophagus or stomach, bronchial irritation, difficulty breathing, pulmonary edema, irritation to the eyes and could cause severe and permanent damage.

Review of the Greasecutter Plus MSDS, revealed

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 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. On each unit the satellite kitchen has a cabinet under the sink that should be locked for safe storage of chemicals at all times when not in use. Facility staff re-education began on 12/19/13 and was completed by 1/23/2014 related to hazardous chemicals and proper storage, the cabinet being locked when chemicals are not in use, and location of the key to lock the cabinet. This re-education was completed by Rita Cahill LPN, Director of Quality & Reporting, Linda

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F 323	<p>Continued From page 8</p> <p>It was a corrosive material and could cause digestive tract, eye and skin burns; was corrosive to the eyes and skin and caused burns to mouth, throat and stomach.</p> <p>Review of the MSDS for Lime-A-Way, revealed it to be a corrosive material that caused digestive tract, eye and skin burns; and was corrosive to eyes and skin.</p> <p>Review of the MSDS for Glance Cleaner, revealed it to be a corrosive material and could cause eye and skin burns, and was harmful or fatal if swallowed.</p> <p>Review of the MSDS for Super Trump, revealed it was a corrosive material that caused respiratory tract, digestive tract, eye and skin burns and might be harmful if swallowed.</p> <p>Review of the MSDS for R/O Free Rinse Additive to be an irritating material that could cause eye and skin irritation.</p> <p>Interview with Dietary Aide (DA) #3, on 12/19/13 at 4:15 PM, revealed the chemicals should have been locked in the cabinet. Further interview revealed there was a key located in the satellite kitchen area.</p> <p>Interview with DA #4, on 12/19/13 at 4:20 PM, revealed the keys to the cabinet were kept in the satellite kitchens and the cabinets with the chemicals should have been locked.</p> <p>Interview with the Food Service Manager, on 12/19/13 at 4:25 PM, revealed the cabinet with the chemicals should have been locked as per facility policy.</p>	F 323	<p>Smith Bidwell, Food Service Manager & Bobbi Jo Wilhoit LPN, Evening Shift Supervisor. A QA monitoring sheet was put into place on 1/16/2014 (exhibit # 3) and will be the responsibility of the Dietary aide serving each meal on the unit to assure the cabinet is locked and all chemicals secured before leaving the unit after each meal. In addition, the monitoring sheet will be completed by designated staff on a daily basis. A copy of the QA monitoring sheet will be forwarded weekly to the Director of Quality & Reporting. Any issues found related to the monitoring will be addressed immediately and reported in daily stand up and as part of the regular quality assurance process and reviewed in the quarterly meetings.</p> <p>Completion Date: January 24, 2014 Persons responsible: Linda Smith Bidwell, Food Service Director, All Dietary Aides serving the units, Rita Cahill, LPN, Director of Quality and Reporting Kristi Hilbert, RN, In-service Director, Unit Managers, House Supervisors & Sue McVey, Director of Activities.</p>		

F323

Exhibit # 3

Review Form

Content Area: Hazardous Chemicals Date: _____

Area of Review: Cabinet under the sink in Satellite Kitchens Evaluator: Dietary Server at each meal

Data Source: Direct Observation

INDICATORS	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
1. Cabinet under sink is locked & key put away after breakfast																														
2. Cabinet under sink is locked & key put away after lunch																														
3. Cabinet under sink is locked & key put away after dinner																														
4. Cabinet under sink is locked & key put away random check																														
5. Cabinet under sink is locked & key put away random check																														
6. Cabinet under sink is locked & key put away random check																														

On random checks please write time & initials

initiated 1/16/2014

Remarks: _____

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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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 12/19/2013
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)	IO 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 323	<p>Continued From page 9</p> <p>Interview with the Administrator, on 12/19/13 at 4:47 PM, revealed the chemicals should have been locked as per facility policy. Further interview revealed not locking the chemicals was unacceptable. The Administrator stated the unlocked chemicals "could be dangerous to wandering residents".</p> <p>F 364-SS=E 483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP</p> <p>Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's policy, it was determined the facility failed to ensure foods were palatable and served at proper temperatures. Observation of test trays revealed on two (2) of three (3) units tray line foods were not served at the proper temperatures.</p> <p>The findings include:</p> <p>Review of the facility's policy, untitled, with no effective date revealed all meats and stuffings were to be heated thoroughly to a minimum temperature of one hundred sixty five (165) degrees Fahrenheit; and, poultry heated to one hundred eighty five (185) degrees Fahrenheit.</p> <p>Review of the facility policy titled, "Food</p>	F 364	<p>F 364 483.35(d)(1)-(2) Nutritive Value Appear, Palatable/Prefer Temp Each Resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.</p> <p>1. All dietary staff have been re-educated related to food temps. These inservice were completed between 12/23/2013 and 1/17/2014 by Linda Smith Bidwell, Food Service Director and Rita Cahill LPN Director of Quality & Reporting. The food temperatures will be monitored on a Temperature Log (exhibit # 4) prior to and after each meal by the Dietary Aide assigned to each unit at each meal. The Monitoring sheet has the appropriate Food Temperatures references on the back of the Temperature Log. The night cook will check the monitoring sheets each evening to assure they were completed for the day. Linda Bidwell Food Service Director or Dietary person in charge when she is not here will be checking daily to assure these sheets are being completed. There will be additional random spot checks by Rita Cahill LPN Director of Quality & Reporting & by Colette Truett Registered Dietician. 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>	
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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)	IO 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 364	<p>Continued From page 10</p> <p>Preparation and Service" with no effective date revealed food was to be prepared by methods which ensured retention of flavor, appearance, and nutrients. Continued review of the policy revealed food was to be maintained at proper temperatures during service and transport in a sanitary manner.</p> <p>Review of the facility policy titled, "Food Preparation and Service" with no effective date revealed food was to be placed on the steam table to maintain acceptable temperatures during meal service. Food was to be served at acceptable temperatures; and trays were to be delivered on a timely basis and served to residents at appropriate temperatures.</p> <p>Observation, on 12/18/13 at 12:30 PM, during the lunch meal on Unit One, of the beginning tray line food temperatures and the ending tray line food temperatures revealed a decrease in the holding temperatures to below one hundred and forty (140) degrees Fahrenheit. Observation revealed the food temperatures of three (3) of the nine (9) foods served were below one hundred and forty (140) degrees Fahrenheit.</p> <p>Observation, on 12/18/13 at 12:50 PM, during the lunch meal on Unit Three of the beginning tray line food temperatures and the ending tray line food temperatures revealed a decrease in the holding temperatures to below one hundred and forty (140) degrees Fahrenheit. Observation revealed the food temperatures of six (6) food products of the twelve (12) foods served were below one hundred and forty (140) degrees Fahrenheit.</p> <p>Interview, on 12/19/13 at 5:30 PM, with Dietary</p>	F 364	<p>Date of Completion: 1/24/2014</p> <p>Persons responsible: Linda Bidwell Food Service Director, Rita Cahill LPN, Director of Quality and Reporting, & Colette Truett Registered Dietician.</p>	
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F 364	Continued From page 11 Aide (DA) #3 revealed food temperatures were to be one hundred and sixty (160) to one hundred and sixty-five (165) degrees Fahrenheit. DA #3 indicated the danger zone was less than one hundred and forty (140) degrees Fahrenheit. She further stated if a food was not to the appropriate temperature she would send the food back to dietary to be reheated. Interview, on 12/19/13 at 5:32 PM, with DA #4 revealed food temperatures were to be one hundred and sixty-five (165) to one hundred and eighty (180) degrees Fahrenheit for hot food; and, cold food was to be forty (40) degrees Fahrenheit or below. She stated if temperatures were not one hundred and sixty-five (165) to one hundred and eighty (180) degrees Fahrenheit she would tell the Dietary Manager and would replace the food with fresh hot food. Interview, on 12/19/13 at 5:34 PM, with the Food Service Manager revealed temperatures could be low due to the steam table wells. She stated if food was not to the appropriate temperature it should be sent back to the kitchen to be reheated or thrown out and replaced. The Food Service Manager stated she preferred the food remained at one hundred and sixty-five (165) degrees Fahrenheit and higher for point of service to ensure food was hot for resident consumption. According to the Food Service Manager, if food was one hundred and sixty-five (165) degrees Fahrenheit or colder it was to be returned to the kitchen. Interview, on 12/19/13 at 5:35, with Night Cook #2 revealed if food was not the correct temperature, the food was sent back and reheated. She stated the food temperature was to be one hundred and				

exhibit #4 front

Temperature Log for Serving Line

Week of

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Breakfast	Before/After						
Eggs							
Hot Cereal							
Meat							
Pureed Meat							
Ground Meat							
Other							
Other/Pureed							

Lunch							
Meat							
Alternate							
Ground Meat							
Ground Meat Alt							
Pureed Meat							
Pureed Meat Alt							
Vegtable 1							
Vegtable 1							
Pur Vegtable 1							
Pur Vegtable 2							
Starch 1							
Starch 2							
Pureed Starch 1							
Pureed Starch 2							
Dessert							
Pureed Dessert							

Dinner							
Meat							
Alternate							
Ground Meat							
Ground Meat Alt							
Pureed Meat							
Pureed Meat Alt							
Vegtable 1							
Vegtable 1							
Pur Vegtable 1							
Pur Vegtable 2							
Starch 1							
Starch 2							
Pureed Starch 1							
Pureed Starch 2							
Dessert							
Pureed Dessert							

Exhibit #4
Back

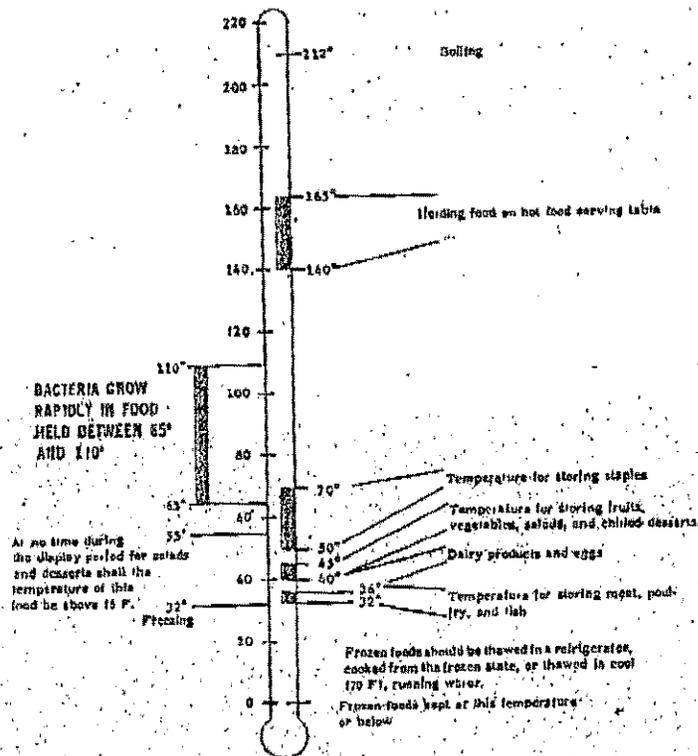
FOOD TEMPERATURES

Proper temperatures will be observed during the preparation, holding, and service of food. The following temperature ranges will be observed:

	Preparation/ Storage	Steam Table	Point of Service
Cold Foods			
Milk, Colcaw, Puddings, etc.	35-40	N/A	40-50
Hot Foods			
Meat	140 or above	140 or above	115-125
Pureed Meat	140 or above	140 or above	115-125
Eggs	140 or above	140 or above	115-125
Vegetables	140 or above	140 or above	115-125
Soup	140 or above	140 or above	115-125
Hot Cereal	140 or above	140 or above	115-125

Reheat leftovers to 165°

TEMPERATURES IMPORTANT FOR CARE OF FOOD



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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 364	<p>Continued From page 12</p> <p>fifty-five (155) to one hundred and sixty (160) degrees Fahrenheit. Night Cook #2 stated food was all to be reheated; and, the only time food would be thrown out was if it smelled bad or did not look "okay" to send out.</p> <p>F 371 483.35(l) FOOD PROCURE, SS=F 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 follow proper sanitation and food handling practices to prevent the outbreak of foodborne illness. As evidenced by failure to ensure food items were properly labeled and dated; failure to ensure dietary staff hair was restrained; failure to ensure resident food was in a sanitary manner; failure to ensure staff washed their hands when gloves were changed between dietary tasks. Additionally, observations during the initial tour of the kitchen revealed a dried substance on the surface of the ceiling vent; a dust-like substance on the scoop holder of the ice machine, and oil in the deep fryer oil was dark brown in color.</p>	F 371	<p>F 371 SS=F</p> <p>483.35(l) 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>1.All dietary staff re-educated between 12/23/13 & 1/20/2014 related to:</p> <ul style="list-style-type: none"> • labeling & dated bread, liquid butter substitute & other food items in the cabinet when opened • labeling cheese, yogurt and any other food items that they may be placing in the refrigerator. • on proper restraining of hair in hair nets or hat. • on handling food in a sanitary manner, washing their hands when gloves were changed between dietary tasks and removing gloves and washing hands on tray line after touching potentially contaminated objects. <p>Additionally the ceiling vents in the kitchen were cleaned by 1/17/2014, the dust like substance was removed from the scoop holder on the ice machine on 12/18/2013 and an oil tester was ordered on 1/15/2014 to check the oil in the deep fryer. A QA</p>	
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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 371 Continued From page 13
The findings include:

Review of the facility's dietary policy titled, "Sanitation and Food Handling", undated, revealed sanitary conditions were to be maintained in the storage, preparation and distribution of food. Continued review revealed the following: staff should observe personal cleanliness and exercise satisfactory food handling techniques; leftover food items were to be covered, labeled, dated, cooled and stored in a refrigerator within a half hour of preparation; and all drinks, packaged or pitched, were to be named and dated at the time the product was opened. Continued review revealed: a gloved hand was allowed for serving only if the gloved hand had not come into contact with any other object before handling the food item; if the gloved hand touched any object, staff were to remove the gloves and wash hands prior to donning clean gloves; all hair was to be contained within a hair net or hat; and a beard cover was to be worn in the food prep area.

1. Observation during the initial kitchen tour, on 12/17/13 at 11:30 AM, revealed the Food Service Manager's hair was not completely restrained under a hair net or hat. Continued observation revealed ceiling vents were soiled with a dried dark substance on the surface. Fryer oil was dark brown to black in color, and dust was observed on the scoop holder for the ice machine.

Interview with the Food Service Manager on 12/17/13 at 11:30 AM, revealed she wanted maintenance to clean the ceiling.

Interview with Cook #2, on 12/18/13 at 3:15 PM,

F 371 monitoring sheet was initiated (exhibit # 5) on 1/17/2014 and all areas cited will be reviewed by Cook each evening before they leave to assure all areas are clean and items are dated and labeled as listed above. The cleaning schedule (exhibit #6) has been revised to include cleaning of the ice machine scoop holder and the deep fryer at least weekly. Cleaning of the vents was on the cleaning schedule twice a month. In meetings held with Dietary staff between 12/23/2013 & 1/20/2014 the cleaning schedule was reviewed. The cook on each shift is responsible for assuring that all cleaning schedules are followed. Linda Smith Bidwell, Food Service Director will monitor these sheets to assure they are completed. Random spot checks will also be completed by Rita Cahill LPN, Director of Quality & Reporting and by Colette Truett, RD. A copy of this monitoring will be turned into QA coordinator weekly and will be reported on as part of the ongoing QA process.

2. Registered Dietician contacted Karen Hatfield, US Foods Representative, on 1/14/2014 and placed an order for beard guards. They are a special delivery item which is scheduled to arrive by 1/24/2014. In the interim, Dietary staff with facial hair will wear Medical Procedure Face Masks to contain facial hair. Dietary staff were educated on 1/15/2014 to use these beard guards when preparing or serving food. Fryer cleaning policy initiated (exhibit #7) and all dietary staff were educated on this policy for changing fryer oil and cleaning

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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)	IO 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 14 revealed the deep fryers were to be changed once a week.</p> <p>An additional interview, on 12/18/13 at 3:20 PM, with the Food Service Manager revealed if the deep fryer was not cleaned this could change the taste of food and the cooking temperature. She stated no current fryer cleaning policy was available. She further revealed the fryer oil should be changed once to twice a week or as necessary, and, the fryer oil should appear clear.</p> <p>Observation, on 12/18/13 at 9:40 AM during food preparation, revealed the Food Service Manager and Dietary Aide (DA) #1 had unrestrained hair, and Cook #1 had no covering over his mustache.</p> <p>Interview with Cook #1, on 12/18/13 at 2:40 PM, revealed he did not know of a policy related to covering mustaches. He stated he had not been trained about hair restraints.</p> <p>Subsequent interview with the Food Service Manager, on 12/18/13 at 9:45 AM, revealed she usually wore a hair net which covered all of her hair, but, was not wearing it at the time of the kitchen tour. She stated all dietary staff were required to have their hair fully contained.</p> <p>Interview with the Food Service Manager, on 12/18/13 at 2:50 PM, revealed she could not locate a policy concerning hair restraints.</p> <p>Observation, on 12/18/13 at 11:10 AM of the third floor serving area, revealed a toaster on the counter which had dried bread crumbs built up around the outside and behind the toaster. In addition, the toaster was greasy in appearance and to the touch. Continued observation revealed the outside of the cabinets were greasy to touch.</p>	F 371	<p>of the deep fryer between 1/15 & 1/20/2014.</p> <p>The existing toaster on the third floor was cleaned and a new toaster was ordered on 1/15/2014 to replace the existing one. A tester for the deeper fryer oil was also ordered on this date. Both of these items are special order from US foods and are scheduled to arrive by 1/24/2014. Cooks responsible for cleaning the deep fryer as well as all other dietary staff will be educated on this tester by the Dietary Manager as soon as it arrives.</p> <p>Housekeeping Staff will assist with the cleaning of all cabinets in the satellite kitchens on 1/17/2014 to remove any built up grease on the out side of the cabinets and to remove any dried substance found on the inside. The dietary staff will be responsible for the continued cleaning after this date.</p> <p>Control panel on the dishwasher was cleaned on 1/15/2014.</p> <p>Cleaning of the toaster and dishwasher to assure there are no dried substances on the control panel, cleaning of the cabinets, cleaning of the refrigerator and cleaning of the utility carts were all also added to the QA monitoring sheet and will be checked by the night cook to assure the cleaning is completed. (exhibit #5) The night shift cook is to assure satellite kitchens are clean. If any problems are found, they are to have dietary aide for that unit clean up</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) 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)
F 371	<p>Continued From page 15</p> <p>and the dishwasher had a build-up of a dried brown substance around the control panel. Observations revealed the following: Inside of the cabinets had a yellow dried substance on the shelves and in the back of the cabinets; a lidded container of a yellow liquid substance was not labeled or dated; and a loaf of bread on the shelf inside the cabinet was not labeled or dated. Further observation revealed a two-shelf utility cart located by the tray line had a dried black substance over the cart and on both shelves.</p> <p>Observation of the second floor, on 12/18/13 at 11:30 AM, revealed the upper cabinet contained three (3) loaves of unlabeled and undated bread, and a container of a liquid yellow substance with no date and no label. Further observations revealed the following: the outside of the cabinets were greasy to touch; the toaster, located on the counter, had dried brown crumbs around the outside and along the base of the wall; and, the utility cart had a dried black substance over the cart and on the two (2) shelves.</p> <p>Observation of the first floor serving area, on 12/18/13 at 11:45 AM, revealed the refrigerator held one package of wrapped cheese slices with no date or label, and a container of yogurt with no date. In addition, observation revealed a dried purple substance was on the inside base of the refrigerator.</p> <p>Interview with Dietary Aide (DA) #2, on 12/18/13 at 12:30 PM, revealed dietary staff were responsible for keeping the serving area clean.</p> <p>Interview with Cook #2, on 12/18/13 at 3:15 PM, revealed Cook #2 checked each unit for cleanliness for cleaning on the units, and tells</p>	F 371	<p>any unacceptable areas prior to leaving for the night. Linda Bidwell Dietary Manager will be monitoring these areas daily or assigning day cook to monitor on days she is not here to assure all areas are checked and cleaning schedules followed. Additional random spot checks will be completed by Dietary Manager, Rita Cahill LPN Director of Quality & Reporting & by Colette Truett Registered Dietician. If problems are noted during weekly checks they will be addressed immediately. All dietary staff were re-educated related to cleaning schedules between 1/15 & 1/20/2014 by Linda Smith Bidwell, Food Service Director and Rita Cahill LPN Director of Quality & Reporting.</p> <p>All dietary Staff were re-educated between 12/23/13 & 1/20/2014 on labeling and dated food in the cabinets and in the refrigerator. Yellow butter substitute will now be labeled and dated and kept in the refrigerator.</p> <p>All Dietary as well as Nursing staff were re-educated between 12/23/13 & 1/20/2014 on sanitary conditions related to food handling. Hands should be washed by all staff prior to serving trays. Gloves or utensils should be used for handling all food. No food should be handled with bare hands. If gloves are used, hands must be washed prior to applying gloves and after removing them. Hands should also be washed any time any staff touches inanimate objects during the serving process. Monitoring of food handling and</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)	IO 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 16</p> <p>staff if they need to complete the cleaning task; and, if staff did not complete the cleaning she would inform the Food Service Manager.</p> <p>Interview with the Food Service Manager, on 12/18/13 at 2:50 PM, revealed the liquid butter, which was the yellow substance observed, should have been stored in the refrigerator instead of in the cabinet, and should have been labeled and dated. She indicated foods should be labeled and dated. She stated the cleaning of the serving areas on each floor was to be checked by the night cook before leaving. If the serving area was not clean, dietary staff were to correct the problem before leaving for the day. An additional interview, on 12/19/13 at 4:25 PM, with the Food Service Manager revealed Night Cook #2 was responsible for checking the serving areas on each unit for sanitation. She stated on 11/25/13 Night Cook #2 received a verbal warning concerning her responsibility in checking all the dining rooms to ensure the areas were cleaned and supplies were stored in the proper locations.</p> <p>Observation of the second floor lunch service line, on 12/18/13 at 12:30 PM, revealed Dietary Aide #2 touched inanimate objects and changed her gloves; however, did not wash her hands between tasks while working the tray line.</p> <p>Interview, 12/19/13 at 1:00 PM, with DA #2 revealed the times gloves were to be changed was when cabinets, the refrigerator or something else was touched. DA #2 stated she "messed up" and should have washed her hands before putting on new gloves.</p> <p>Interview, 12/19/13 at 4:25 PM, with the Food Service Manager revealed hand washing should</p>	F 371	<p>hand washing will be completed by the respective Unit Charge Nurse monitoring the dining room at each meal using the QA exhibit # 8 form.</p> <p>Date of Completion: 1/24/2014 Persons responsible: Linda Bidwell Food Service Director, Rita Cahill LPN, Director of Quality and Reporting, & Colette Truett Registered Dietician.</p>	

Exhibit # 5

Quality Improvement
Review Form

Content Area: F364 Food Temps & F371 Sanitary Conditions

Area of Review: Kitchen

Date: (please include date in space below)

Standard: F364 Food Served at Proper Temp & F371 The facility must store, prepare and serve food under sanitary conditions.

Evaluator: (Please print name below)

Data Source: Direct observation of the kitchen

Indicators	Day of the week>>>>	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
F364 Food Temps Dietary Staff Name>>>								
1. Food Temps are monitored on Temp Log								
2. Water in steam table wells touches bottom of pans to assure food holds proper temperature								
F371 Sanitary Conditions								
3. Food items in the cabinets are labeled								
4. Food items in the cabinet & refrigerator are dated								
5. Dietary staff hair is properly restrained								
6. gloves used when handling food								
7. Hands washed prior to & after removal of gloves								
8. Ceiling vents are clean								
9. scoop holder free of dust								
10. deep fryer oil clean								
11. Cleaning schedules followed								
12. toaster free of bread crumb build up								
13. toaster is not greasy to touch								
14. cabinets clean & are not greasy to touch								
15. Dishwasher is clean including control panel								
16. Utility Cart Clean								
17. Refrigerator is clean on inside								

Initiated 1/15/2014

Cook's Cleaning Schedule

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
	Clean Oven Walk through and make sure everything is labeled and dated	Clean wall behind ovens, fryer and stove. Then sweep and mop behind them	Clean can opener & all ice scoops & holder Clean Stove and Grill	Clean and wipe out the drawers in cooks area	Clean Fryer Clean the vents and hood over stove, ovens and fryer. Run them through the dishwasher	Delime the dishmachine
Clean fans in walk-in freezer Bleach all pitchers, coffee pots and tea machines	Check ice build up in freezer, if present, clean it off Clean Oven	Wash walls behind the dish machine Wash down front and back of all doors in kitchen area.	Clean Stove & Grill Clean can opener & all ice scoops & holder	Clean and wipe out the drawers in cooks area	Clean Fryer Clean up under all cook & prep counters	Clean & Degrease Knife Rack Clean and Delime Steamers
Clean the fans in the walk in and freezer	Clean oven Take Oven Mitts to Laundry to be washed	Clean wall behind ovens, fryer and stove. Then sweep and mop behind them	Clean Stove & Grill Clean can opener & all ice scoops & holder	Clean and wipe out the drawers in cooks area	Clean Fryer Clean the vents and hood over stove, ovens and fryer. Run them through the dishwasher	Delime the Dishmachine
Bleach all pitchers, coffee pots and tea machines Clean fans in walk-in freezer	Clean Oven Check dust on the condait in walkin	Wash down front and back of all doors in kitchen area Wash walls behind the dishmachine	Clean Stove & Grill Clean can opener & all ice scoops & holder	Clean and wipe out the drawers in cooks area	Clean up under all cook & prep counters Clean Fryer	Clean and Delime Steamers
Clean the fans in the walk in and freezer	Clean Oven Check ice condensation in freezer, if present, Clean it off	Clean the walls behind the ovens, fryer & stove and then sweep and mop behind them	Clean Stove & Grill Clean can opener & all ice scoops & holder			

revised January 2014

First Cook-Responsible to assure cleaning is completed daily
Second Cook-Responsible to assure cleaning is completed daily

exhibit # 12

exhibit #7

DEEP FRYER CLEANING

TURN OFF

LET GREASE COOL

DRAIN OLD GREASE OUT OF FRYER

CLEAN WELL WITH (CLEAN FORCE)

RINSE

REFILL FRYER WITH CLEAN OIL

CLEAN OUTSIDE OF FRYER WITH (OASIS 146)

**CLEAN 1 TO 2 TIMES PER WEEK
DEPENDING ON OIL TESTER**

WEAR GLOVES

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

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OMB NO. 0938-0391

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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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(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 371	<p>Continued From page 17 be done between changing gloves and tasks.</p> <p>2. Observation during the lunch meal pass, on 12/17/13 at 12:30 PM, revealed Certified Nursing Assistant (CNA) #1 delivering meal trays to residents. Further observation revealed CNA #1 cut a sandwich in half with his bare hands. Further observation during the lunch meal pass, at 12:35 PM, revealed CNA #2 assisting residents with meal set-up. Further observation revealed CNA #2 applied ketchup to a resident's sandwich, cut the sandwich in half, and picked the sandwich up with her bare hands.</p> <p>Interview with CNA #1, on 12/19/13 at 10:25 AM, revealed he should have used the resident's utensils to cut the sandwich due to the risk of possible contamination.</p> <p>Interview with CNA #2, on 12/19/13 at 1:09 PM, revealed she should have used a fork to assist the resident with his/her sandwich due to the risk of potential contamination.</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 431 SS=D	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the</p>	F 431	<p>F 431 SS=D 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p>	

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F 431	<p>Continued From page 18</p> <p>appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of facility policy, it was determined the facility failed to ensure medications were locked and inaccessible to residents. One (1) of two (2) medication carts on the second floor was observed to be unlocked with the keys located on top of the cart.</p> <p>The findings include: Review of the facility policy titled "Medication Storage", undated, revealed medications were to be stored safely and securely. The medication carts and medication supplies were to be locked by persons with authorized access. Further</p>	F 431	<p>It is the policy of this facility to ensure all medications are locked and inaccessible to residents.</p> <p>While no residents were directly affected by this practice, any resident with cognitive or sensory deficits that are able to mobilize themselves are considered to be at risk to be affected by this practice.</p> <p>LPN # 2 was immediately re-educated on 12-17-2013 by L. McMasters LPN, 2nd floor Unit Manager, related to proper security of the medication cart and the keys.</p> <p>All nurses have also been re-educated related to proper security</p>		

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F 431	<p>Continued From page 19</p> <p>review revealed medication storage conditions were monitored and corrective action taken if problems were identified.</p> <p>Review on 12/18/13 of a list provided by the facility revealed there were sixteen (16) residents on the second floor identified as wanderers. One (1) of the sixteen (16) residents was ambulatory; and, the other fifteen (15) were mobile in wheelchairs.</p> <p>Observation, on 12/18/13 between 4:40 PM and 4:50 PM, revealed the West medication cart on the second floor was unlocked and the keys were lying on top of the cart. Further observation revealed several residents in wheelchairs were in the vicinity of the unlocked cart.</p> <p>Interview with Licensed Practical Nurse (LPN) manager #1, on 12/18/13 at 4:50 PM, revealed the medication cart should have been locked, and the keys should not have been left on top of the cart. Further interview revealed there were wandering residents on the unit and a resident could get into an unsecured medication cart.</p> <p>Interview with LPN # 2, on 12/18/13 at 5:00 PM, revealed the medication cart should have been locked and the keys secured. Further interview revealed residents could get into an unlocked cart.</p> <p>Interview with Pharmacy Consultant #13, on 12/19/13 at 11:50 AM, revealed the medication carts should be locked and the keys should not be unattended. Continued interview revealed an unlocked medication cart was a safety concern for the residents.</p>	F 431	<p>of medication carts and keys by R. Cahill, LPN, Director of Quality and Reporting and B. Wilhoit, LPN, 2nd shift supervisor, from 12-18-2013 thru 1-23-2014.</p> <p>Ongoing monitoring of all medication carts and keys will be included in the adaptive equipment rounds conducted 3 times weekly on each unit. In addition, the house Supervisors and the Management Team were in-serviced by K. Hilbert, RN, ADON on 1-15-2014, to do daily spot checks of the medication carts as part of the ongoing monitoring and include in</p>

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F 431	Continued From page 20 Interview with the Director of Nurses (DON), on 12/19/13 at 2:30 PM, revealed the medication cart policy stated the cart was to be locked at all times. She stated she considered an unsecured medication cart to be a safety issue.	F 431	our Quality Assurance program to ensure continued compliance.	
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS 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. (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. (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.		Completion Date: Jan. 24, 2014 Persons Responsible: Cindy Dempsey, RNC, DON Kristi Hilbert RN, ADON, Staff Development Coordinator Rita Cahill LPN, Director of Quality and Reporting Unit Managers and House Supervisors	

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F 441 Continued From page 21

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and review of the facility's policy, it was determined the facility failed to 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 for one (1) sampled resident (Resident #17) and two (2) unsampled residents (A and B). Observations revealed staff did not perform proper hand hygiene prior to providing hands-on care to the residents. In addition, staff were observed to handle resident food without gloves. Other staff did not change gloves and wash their hands between dietary tasks in the satellite kitchens.

The findings include:
Review of the facility's policy titled "Hand Washing", undated, revealed hand washing was the single most important procedure for preventing nosocomial (facility-acquired) infections. Further review revealed staff should wash their hands before taking care of residents, after taking care of residents, between care of different anatomical sites on the same resident, after touching inanimate sources that are likely to be contaminated, after removing gloves, and when in doubt to wash hands.

F 441

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 441 SS-E
483.65 Infection Control
Prevent spread, linens

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.

(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.

(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.

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F 441	<p>Continued From page 22</p> <p>Observation of Licensed Practical Nurse (LPN) #7, on 12/19/13 at 10:54 AM, revealed she did not wash her hands upon entering the room and prior to providing care for Resident A. Continued observation revealed LPN #7 donned gloves and began to perform a skin assessment. The nurse touched the resident's peri-area and proceeded to re-dress the resident, touching the resident's clean clothing and linen without removing the soiled gloves and washing her hands.</p> <p>Interview with LPN #7, on 12/19/13 at 11:02 AM, revealed she should have washed her hands when she entered the resident's room. She stated she should have washed her hands and changed her gloves when moving from a contaminated area of the body to a clean area. Continued interview revealed proper hand hygiene decreased cross contamination.</p> <p>Interview with the Infection Control Director, on 12/19/13 at 5:16 PM, revealed staff should wash their hands prior to providing care to a resident and after providing care to a resident. Further interview revealed hands should be washed and gloves changed when going from a soiled area to a clean area on the body to prevent the spread of infections.</p> <p>Observation of LPN #8, on 12/19/13 at 2:05 PM, revealed she did not wash her hands upon entering Resident B's room, or prior to initiating a skin assessment.</p> <p>Interview with LPN #8, on 12/19/13 at 2:15 PM, revealed she should have washed her hands prior to the skin assessment. She stated staff should perform proper hand hygiene prior to and after any resident care to keep from spreading</p>	F 441	<p>(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.</p> <p>(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>1. There were no corrective actions required for Residents #17, A and B as a result of this deficient practice. Although all 3 of these resident's identified had the potential to be affected, none of the identified residents resulted with a negative outcome. All Nurses involved in skin assessments including LPN #7 (Resident A) & LPN #8 (Resident B) were re-educated between 12/19/13 & 1/17/2014 by Rita Cahill LPN, Director of Quality & Reporting & Bobbi Jo Wilhoit LPN, Evening Shift Supervisor on glove use and hand washing procedures during skin assessments to include: hand washing 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 who complete skin assessments will be monitored by Fitzgerald Chibamu LPN, Staff Development Nurse or another licensed nurse using exhibit #9 to assure they are washing hands when needed during skin assessments. This monitoring will be completed by 1/23/2014. After the initial monitoring, as part of our ongoing QA process Fitzgerald Chibamu LPN, Staff</p>	

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F 441 Continued From page 23 germs".

Observation of the Infection Control Nurse, on 12/19/13 at 11:15 AM, revealed she entered the room and assisted another staff to reposition Resident #17, without washing her hands prior to providing the hands-on care.

Interview with the Infection Control Nurse, on 12/19/13 at 5:20 PM, revealed she should have washed her hands prior to assisting with repositioning of Resident #17, to prevent the spread of infection. She stated staff were to wash their hands when they entered a resident's room.

2. Review of the facility's dietary policy titled "General Handwashing Procedure", undated, revealed handwashing to be the single most important means of preventing the spread of Infections.

Review of the facility's policy titled "Sanitation and Food Handling", undated, revealed food would be prepared and served with clean tongs, scoops, forks, spoons, spatulas or other suitable implements to avoid manual contact with prepared food. Further review revealed utensils, cups, glasses, and dishes should be handled in such a way to avoid touching surfaces with which food or drink would come into contact. Continued review revealed tongs should be used when serving rolls, and cakes and pies should be served with a spatula. Additional review revealed a gloved hand was allowable for serving food only if the gloved hand had not come into contact with any other object before handling the food item; if the gloved hand touched any object, staff were to change gloves and wash hands before applying

F 441 Development Nurse or another licensed nurse will monitor at least 3 nurses doing skin assessments per quarter and log the information on Exhibit #9 re-educating nurses if needed when problems are noted during the process. Charge Nurses, Unit Managers and House Supervisors have been instructed to spot check staff on an on going basis for hand washing prior to providing and resident care and to immediately addresses any staff member not washing their hands prior to providing care. In addition, to ensure continued compliance with hand washing the Staff Development Nurse will also monitor 3 additional nursing employees per quarter to assure they are washing their hands prior to providing care for the residents. Exhibit # 9 will be used for this as well. This information will be reported as part of the Quarterly QA process.

The Infection Control Nurse was re-educated 12/19/2013 by Kristi Hilbert RN, ADON related to hand washing prior to resident care in reference to Resident #17. All other staff were re-educated by Rita Cahill LPN, Director of Quality & Reporting & Bobbi Jo Wilhoit LPN, Evening Shift Supervisor between 12/19/13 & 1/17/2014 on hand washing prior to providing any hands on care for a resident.

2. All Dietary Staff including Dietary Aide #4 were re-educated by Rita Cahill LPN, Director of Quality & Reporting, Bobbi Jo Wilhoit LPN, Evening Shift Supervisor & Linda Smith Bidwell, Food Service

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F 441	<p>Continued From page 24 clean gloves.</p> <p>Observation of the Unit Two dining room lunch service, on 12/18/13 at 12:30 PM, revealed Dietary Aide (DA) #4, touched potentially contaminated inanimate objects between dietary tasks. DA #4 changed her gloves between tasks; however, did not wash her hands after taking off the soiled gloves and prior to donning the clean gloves, in accordance with facility policy.</p> <p>Interview with DA #4, on 12/19/13 at 1:00 PM, revealed the facility's process was to change gloves when touching cabinets, refrigerator or other items. She stated she "messed up" and should have washed her hands before putting on clean gloves.</p> <p>Continued observation of the meal pass, on 12/17/13 at 12:30 PM, revealed Certified Nursing Assistant (CNA) #1 delivered meal trays to residents. CNA #1 touched a resident's food with his bare hands while cutting a sandwich in half without wearing gloves.</p> <p>Interview with CNA #1, on 12/19/13 at 10:25 AM, revealed he should have used the resident's utensils to cut the sandwich. He stated he should have washed his hands and donned gloves prior to touching the resident's food.</p> <p>Further observation of the meal pass, on 12/17/13 at 12:35 PM, revealed CNA #2 assisted residents with meal set-up. The CNA was observed to apply ketchup to a resident's sandwich, cut the sandwich in half, and pick the sandwich up with her bare hands.</p> <p>Interview with CNA #2, on 12/19/13 at 1:09 PM,</p>	F 441	<p>Director between 12/23/2013 & 1/20/2014 on food handling procedures and that all food should be handled with a gloved hands or utensils and that gloves should be removed and hands washed between dietary tasks if touching potentially contaminated inanimate objects.</p> <p>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 #8) related to Infection Control & 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>Hand washing policy was reviewed by the Infection Control Nurse on 1/16/2014 and date of review added to bottom of the sheet. All new hires are educated on this policy as part of their orientation process.</p> <p>Date of Completion: 1/24/2014 Persons responsible: Rita Cahill LPN Director of Quality and Reporting, Fitzgerald Chibamu LPN, Staff Development, Unit Managers, Charge Nurses</p>

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F 441	<p>Continued From page 25</p> <p>revealed she should have used a fork to assist the resident with his/her sandwich due to the risk of contamination.</p> <p>Interview with the Food Service Manager, on 12/19/13 at 4:25 PM, revealed her expectation was for staff to wash their hands and don clean gloves between dietary tasks. Further interview revealed staff should not touch resident food with their bare hands.</p> <p>Continued interview with the Infection Control Director, on 12/19/13 at 5:16 PM, revealed staff should not be touching a resident's food ungloved. Further interview revealed staff should be washing their hands and changing gloves between dietary tasks to prevent the spread of infection.</p>			
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Exhibit # 1

Quality Improvement
Review Form

Content Area: F441 Infection Control
Area of Review: Skin Assessments

Date: _____
Evaluator: _____

Standard: F441 The facility must establish 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.

Data Source: Direct observation

Employee>>>	Observation of Technique																% COMP	
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	Yes	No
1. Hands washed before procedure																		
2. gloves used & changed as needed during assessment																		
3. Remove gloves & Hands washed after completing assessment																		

Remarks : _____

Implemented: 1/15/2014

SUBJECT: Infection Control

TOPIC: Hand washing

Hand washing is the single most important procedure for preventing nosocomial infections. Hand washing with antimicrobial containing products kills or inhibits the growth of microorganisms.

Hand washing technique: For routine hand washing, a vigorous rubbing together of all surfaces of lathered hands for at least 10 seconds, followed by thorough rinsing under a stream of water is recommended.

Hand Washing Indications:

In the absence of a true emergency, personnel should always wash their hands, paying particular attention to fingernails, and between fingers.

1. Before performing invasive procedures
2. Before taking care of residents
3. Before and after touching wounds
4. After situations during which microbial contamination of hands is likely to occur, especially those involving contact with mucous membranes, blood or body fluids, secretions or excretions
5. After touching inanimate sources that are likely to be contaminated (bed pans, urinals, graduates, emesis basins, soiled linen)
6. After taking care of residents
7. Between residents in the same unit
8. Between care of different anatomical sites on the same resident
9. After removing gloves
10. After using bathroom
11. Before and after lunch
12. Prior to feeding
13. Prior to passing ice
14. When in doubt, wash your hands

Reviewed: 1/16/2014

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

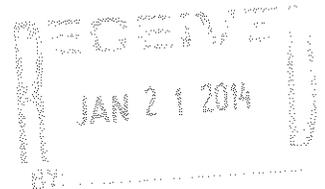
PRINTED: 01/08/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185440	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 12/19/2013
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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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(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
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K 000	INITIAL COMMENTS CFR: 42 CFR §483.70 (a) BUILDING: 01 PLAN APPROVAL: 8/12/99 Construction Date SURVEY UNDER: 2000 Existing FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: Three (3) stories, Type II (222) Protected SMOKE COMPARTMENTS: Eight (8) smoke compartments. COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM FULLY SPRINKLED, SUPERVISED (Dry SYSTEM) EMERGENCY POWER: Type II Diesel Generator. A life safety code survey was initiated and concluded on 12/19/13. 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-five (95) the day of the survey.	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE ADMINISTRATOR	(X6) DATE 1/12/14
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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.