

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

PRINTED: 06/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185242	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 06/03/2015
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NAME OF PROVIDER OR SUPPLIER WINDSOR CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 125 STERLING WAY MOUNT STERLING, KY 40353
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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{F 000} INITIAL COMMENTS

An offsite revisit was conducted and based on the acceptable Plan of Correction (POC) the facility was deemed to be in compliance as alleged on 06/02/15.

{F 000}

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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 371 Continued From page 1
dried black substance/residue on it. Also, the Unit nourishment rooms had food not dated and labeled, and the dry storage temperature, in the Wisteria Unit nourishment room, was above seventy (70) degrees Fahrenheit.

The findings include:

1. Review of the facility's policy titled, "Cleaning Schedule", undated, revealed the facility scheduled thorough cleaning of all food preparation areas to reduce the risk of contamination of food and the spread of food borne illness. The Food Service Supervisor had the responsibility to identify the frequency each task was performed, and to assign dietary staff to each task.

Review of the facility's policy titled, "Equipment Cleaning and Sanitizing", undated, revealed the practice of ensuring bacteria did not enter the food supply through unsanitary equipment surfaces was to use proper methods of cleaning and sanitization of equipment and to protect residents' from food borne illness. Per the Policy, all parts of equipment were to air dry completely and then be re-assembled.

Observation, on 04/28/15 at 10:40 PM, during the initial kitchen tour revealed two (2) clear pitchers, were hanging above the food preparation (prep) table with a approximately an eighth of a clear liquid substance in the pitchers. Continued observation revealed: a clear container with a lid dated 04/20/15, was stored under the food prep table with approximately an eighth of a clear to light brown colored liquid substance in it; plastic pitcher lids stored under the food prep table were chipped and broken; a clear container on the food

F 371 3. Cleaning schedule updated to include cleaning of walls, food can storage rack and dish rack on 4/30/15 by Dietary Manager. New cup racks received on 5/18/15. Dietary staff re-educated on sanitation, food storage and dating of food items on 5/15/15 by Dietary Manager. Nursing staff educated on storage of dry foods in Wisteria nourishment rooms on 4/30/15 by Administrator and ADON. Nursing staff re-education on dating of food and not placing items under sink or in sink began on 5/1/15 and will be completed by 6/1/15 by QA Nurse and ADON.

4. Kitchen and nourishment rooms will be audited weekly x4 for cleanliness and proper storage by Dietary Manager and/or dietary assistant and QA Nurse, then monthly. Results will be reviewed monthly x 3 then quarterly through the QA process.

6-2-15

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F 371 Continued From page 2 F 371

prep counter, which was sticky to the touch, had utensils with handles down and the utensil end turned up; the can opener holder had a black dried substance and the cabinet and floor under the can opener holder had a dried black substance; and the dish drying rack rails had a dried brown sticky substance on them.

Observation, on 04/28/15 at 4:45 PM, revealed the deep fryer contained a black liquid substance and a similar dried black substance around the floor of the fryer. Continued observation revealed thirteen (13) individual plastic cup trays stored in the dish room which were cracked, chipped and broken. Further observation revealed the food can storage rack had a dried black sticky substance on the rails.

Observation, on 04/28/15 at 5:05 PM, revealed in the Wisteria Unit Nourishment room, revealed the cabinet under the sink contained three (3) clear plastic containers, the second of which had a clear liquid with a dried black substance, and a "mold-like" substance between the first and second containers.

Observation, on 04/28/15 at 5:10 PM, in the Lakeview Unit Nourishment room, revealed a soiled plastic beverage glass in the hand sink.

Review of the Dietary Department's, "Sample Daily Cleaning Schedule Form" dated 03/02/15 through 04/26/15, revealed the items listed included: cutting boards, rangetop, microwave, mop room, mixers, "walk-in floors", freezer floors, small carts, coffee machine, toaster, shelving, counters, sweep, mop, tea machine, can openers, food carts, cabinet fronts, store room floor and bathroom. However, further review

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F 371 Continued From page 3
revealed no documented evidence of specific directions given to staff to clean the dish drying rack or rails. F 371

Review of "Sample Weekly Cleaning Schedule Form" dated March 2015 and April 2015, revealed the items listed included: ovens, walls, deck scrub, back dish room, garbage containers, milk cooler and dish machine. However, further review revealed no documented evidence of specific directions given to clean the food can storage rack or rails.

Interview, on 04/29/15 at 11:55 AM, with the Assistant Dietary Manager revealed the deep fryer oil was not used often and was changed about two (2) weeks ago.

Interview, on 04/29/15 at 11:50 AM, with the Dietary Manager (DM)/Registered Dietitian (RD) revealed she kept the thirteen (13) cup racks because she thought the racks were in good shape, but might have enough new cup racks to replace the cracked, chipped and broken cup racks. Per interview, the food can rack and dish drying racks should be cleaned and sanitized weekly, and the deep fryer was not used often, but the oil in it should be changed after every use. According to the DM/RD, the pitchers should not be stored hanging up, but should have been turned over on the shelf to dry. Per the DM/RD, all equipment needed to be cleaned and sanitized to prevent growth of bacteria and cross contamination.

2. Review of the facility's policy titled, "Date Marking Potentially Hazardous Foods", undated, revealed the facility used date marking to identify the date by which a refrigerated food must be

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consumed or discarded. Assigned dietary staff were to inspect all refrigeration units daily and verify all opened or prepared foods had been dated.

Review of the facility's policy titled, "Dry Storage", undated, revealed standards for maintaining safe storage of dry foods, in order to prevent food borne illness included the dry storage food area was to be kept clean and dry with the humidity controlled at a temperature range of fifty (50) to seventy (70) degrees Fahrenheit. Stored foods were to be kept tightly covered and protected from contamination; stored in original packaging and if food was repackaged it was to be clearly labeled.

Continued observation on 04/28/15 at 5:00 PM revealed in the Sterling Unit Nourishment room, a Styrofoam cup stored on top of the nourishment refrigerator with a white powdery substance, written on the side thickener, not dated or covered, an opened sleeve of saline crackers was observed on a shelf not dated or labeled, and in the refrigerator four (4) packages of sliced cheese, wrapped in clear plastic wrap not dated or labeled.

Continued observation on 04/28/15 at 5:05 PM revealed in the Wisteria Unit Nourishment room, the refrigerator had packages of clear plastic wrapped sliced cheese not labeled and not dated. Observation inside of the cabinet storage revealed sleeves of saline crackers, not in the original container, not dated or labeled and a package of hot cocoa mix was left opened on the self. Further observations of the nourishment room revealed temperatures over one hundred (100) degrees Fahrenheit with temperatures

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F 371 Continued From page 5
inside of the food cabinet storage over ninety (90) degrees Fahrenheit.

F 371

Continued observation on 04/28/15 at 5:10 PM revealed in the Lakeview Unit Nourishment room, the refrigerator had three (3) packages of clear plastic wrapped sliced cheese, not dated and not labeled.

Continued interview, on 04/29/15 at 11:50 AM, with the DM/RD revealed dietary employees were assigned to the nourishment rooms daily and should check all foods to ensure they were labeled and dated. Per the DM/RD, the resident units used liquid thickener, and should not have powdered thickener stored in a Styrofoam cup on the unit.

Interview, on 04/30/15 at 3:05 PM, with the Administrator revealed it was the responsibility of staff to perform safe food handling practices to prevent cross contamination from being an issue for residents. Per interview, the Food Service Manager was responsible for keeping the kitchen clean and if the kitchen was not kept clean there could be an issue with bacteria and possible cross contamination for residents.

F 465 483.70(h)
SS=F SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON

The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.

This REQUIREMENT is not met as evidenced by:

F 465 - 483.70(h)

F 465:

1. No residents were harmed by alleged deficient practice.
2. Kitchen was inspected and deep cleaned by Dietary Manager and dietary assistant on 4/30/15. Checked for any other broken or cracked tiles or equipment. No others identified.

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F 465 Continued From page 6

Based on observation, interview and review of the facility's policy, it was determined the facility failed to provide a safe and sanitary kitchen environment as evidenced by broken tiles around the baseboard area, walls and floors with a "soiled" appearance, dried food particles on the wall in the cart cleaning area, and a utility cart which was melted and had a broken top shelf.

The findings include:

Review of the facility's policy titled, "Cleaning Schedule", not dated, revealed the facility scheduled thorough cleaning of all food preparation areas to reduce the risk of contamination of food and the spread of food borne illness. The Policy revealed the Food Service Supervisor was responsible for identifying the frequency each task was to be performed and to assign dietary staff for performance of the tasks.

Review of the facility's policy titled, "Equipment Cleaning and Sanitizing", not dated, revealed to ensure bacteria did not enter the facility's food supply staff should use proper methods of cleaning and sanitization of equipment to protect residents from food borne illness.

Observation on 04/28/15 at 10:40 AM, kitchen initial tour revealed the appearance of the floor and walls with dried dark particles. Continued observation on 04/29/15 at 11:50 AM, revealed in the cart cleaning area, near the dish room, there were dried food particles on the wall.

Review of "Sample Weekly Cleaning Schedule Form" dated March 2015 and April 2015, revealed the items listed to be cleaned weekly included

F 465 3. Broken cart removed from kitchen on 4/30/15 by Dietary Manager. Cleaning Schedule updated on 4/30/15 to include cleaning of walls, food can storage rack and dish drying rack. Dietary staff re-educated on 5/15/15 on sanitation, dating foods and storage and notifying manager of any broken equipment by Dietary Manger.

4. Kitchen will be audited weekly x 4 weeks then monthly for cleanliness, storage, broken equipment or tiles and sanitation by Dietary Manager and/or dietary assistant and/or QA Nurse. Results will be reviewed monthly x 3 then quarterly through the QA process.

5-16-15

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F 465 Continued From page 7
F 465
walls. However, further review revealed no documented evidence of specific directions provided for staff on which "walls" were to be cleaned by the staff assigned on a weekly basis.

Observation, on 04/28/15 at 4:45 PM, revealed a soiled utility cart in the food preparation (prep) area, which had a melted and broken top shelf. Continued observation of the utility cart revealed the broken top was also open below the surface of the shelf, which would allow food debris to accumulate. Further observation of the kitchen area revealed three (3) cracked, missing and/or broken tiles with dried particle-like substance around all the tile base boards. In addition, observation revealed behind the broken tiles, the wall exposed had open holes through which pests could gain entry to the dietary area.

Review of the Dietary Department's, "Sample Daily Cleaning Schedule Form" dated 03/02/15 through 04/26/15, revealed the items listed for daily cleaning included small carts, food carts and staff were to sweep and mop. However, further review revealed no documented evidence of specific directions given to staff to address cleaning the walls in the dish room after the food carts had been cleaned.

Interview, on 04/29/15 at 11:50 AM, with the Dietary Manager (DM)/Registered Dietitian (RD) revealed she was not aware of the broken tiles and the tiles must have been broken by the food carts. Per interview, the walls and tiles should be cleaned, sanitized and the broken or missing tiles replaced so pests could not enter the kitchen through them. Continued interview revealed the utility cart top had melted and broken by staff placing hot pans onto the top of the cart. She

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F 465	Continued From page 8 revealed the utility cart could not be cleaned or sanitized properly and possibly could cause cross contamination of food.	F 465
	Interview, on 04/30/15 at 3:05 PM, with the Administrator revealed the person responsible for keeping the kitchen area clean was the Food Service Manager. Per interview, if the kitchen was not kept clean there could be an issue with bacteria and possible cross contamination which could affect the residents.	

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K 000 INITIAL COMMENTS

K 000

CFR: 42 CFR 483.70(a)

Building: 01

Plan Approval: 1976, 1995, 2002, 2008

Survey under: 2000 Existing

Facility type: SNF/NF

Type of structure: One (1) story Type V000 with partial basement.

Smoke Compartments: five (5)

Fire Alarm: Complete fire alarm system with new panel upgrade in 2008

Sprinkler System: Complete automatic (dry and wet) sprinkler system.

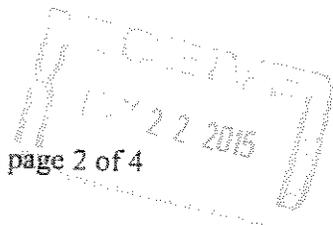
Generator: Type II 60 KW Natural gas generator installed in 1976, Type II 150 KW diesel generator installed in 2002.

A Life Safety Code Survey was conducted using (2786S Short Form) on 04/29/15. The facility was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The census on the day of the survey was one hundred and thirty-four (134). The facility is licensed for one hundred and forty-four (144) residents.

Deficiencies were cited with the highest deficiency identified at "D" level.

The following constitutes the facility's response to the findings of the Department for Health Services and does not constitute an admission of the facts alleged or conclusions set forth on the summary statement of deficiencies.

This plan of correction is prepared as required by the provisions of the Health Safety code, 42 CFR and constitutes the facility's written credible allegation of compliance.



Continued on page 2 of 4

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

TITLE

(X6) DATE

Rebecca Cooley

Administrator

5/22/15

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K 000 Continued From page 1
The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)

K 062 NFPA 101 LIFE SAFETY CODE STANDARD SS=D
Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5

This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure automatic sprinkler heads were free of obstructions, according to National Fire Protection Associations (NFPA) standards. The deficiency had the potential to affect two (2) of five (5) smoke compartments, three (3) residents, staff and visitors.

The findings include:

Observation, on 04/29/15 at 11:37 AM, with the Maintenance Director, revealed a total of eight (8) automatic sprinkler heads were located less than one (1) foot from light fixtures in the kitchen area. The light fixtures also extended below the automatic sprinkler head deflectors obstructing the flow pattern of the automatic sprinkler heads. Interview, with the Maintenance Director at the time of observation, revealed he was not aware the light fixtures were located too close to the automatic sprinkler heads.

K 062 -
K 000 No residents were affected by the alleged deficient practice.

The (8) sprinkler heads located less than one (1) foot from light fixtures in the kitchen were in place and inspected and approved for use during the initial opening of the kitchen when it was constructed in 1999 and opened in 2000, therefore the current environmental services director had no reason to know they did not meet the codes in the NFPA 13 (1999 Edition) as referenced in this citation. However, the maintenance staff began re-locating or removing the light fixtures in the kitchen on 5/11/15 with completion expected on 5/22/15.

The exit sign located near room 120 which was located near a sprinkler head was relocated to meet the regulatory guideline of the NFPA 13 (1999 Edition) on 5/8/15.

On May 19, 2015 a random audit of 11 sprinkler heads throughout the facility has been checked to ensure they are within the specified guidelines and three (3) were found.

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K 062 Continued From page 2

Observation, on 04/29/15 at 11:52 AM, with the Maintenance Director, revealed an exit sign in the corridor near resident room 120 was located too close to the automatic sprinkler head, obstructing the flow pattern for the automatic sprinkler head. Interview, with the Maintenance Director at the time of observation, revealed he had never noticed the exit sign was obstructed the automatic sprinkler head.

The findings were acknowledged by the Administrator during the exit conference.

Reference: NFPA 13 (1999 Edition)

5-5.5.2.1 Continuous or non-continuous obstructions less than or equal to 18 in. (457 mm) below the sprinkler deflector that prevent the pattern from fully developing shall comply with 5-5.5.2.

5-5.5.2.2 Sprinklers shall be positioned in accordance with the minimum distances and special exceptions of Sections 5-6 through 5-11 so that they are located sufficiently away from obstructions such as truss webs and chords, pipes, columns, and fixtures.

Table 5-6.5.1.2 Positioning of Sprinklers to Avoid Obstructions to Discharge (SSU/SSP)

Distance from Sprinklers to side of Obstruction
(A). Maximum Allowable Distance of Deflector above Bottom of Obstruction (in.) (B)
Side of Obstruction (A)
Obstruction (in.) (B)
Less than 1 ft
0
1 ft to less than 1 ft 6 in.

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to be affected and where also repaired or removed by 5/29/15.

To ensure Continued Compliance! Environmental Services Director or other designated Maintenance Staff will audit a minimum of 10 sprinkler heads throughout the facility each month for the next 3 months to ensure there are no other sprinkler heads obstructed. And if any additional found they will also be removed or repaired. This process will be reviewed monthly by QA process until all have been repaired or removed. Once all necessary changes have been made, there will be no reason for continued inspections unless there is a major renovation process to the facility.

5-30-15

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

PRINTED: 05/14/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185242	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 04/29/2015
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NAME OF PROVIDER OR SUPPLIER WINDSOR CARE CENTER	STREET ADDRESS CITY, STATE, ZIP CODE 125 STERLING WAY MOUNT STERLING, KY 40353
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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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21/2
1 ft 6 in. to less than 2 ft
31/2
2 ft to less than 2 ft 6 in.
51/2
2 ft 6 in. to less than 3 ft
71/2
3 ft to less than 3 ft 6 in.
91/2
3 ft 6 in. to less than 4 ft
12
4 ft to less than 4 ft 6 in.
14
4 ft 6 in. to less than 5 ft
161/2
5 ft and greater
18

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For SI units, 1 in. = 25.4 mm; 1 ft = 0.3048 m.
Note: For (A) and (B), refer to Figure 5-6.5.1.2(a).