

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

PRINTED: 11/20/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185145	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/06/2012
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NAME OF PROVIDER OR SUPPLIER CEDAR RIDGE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1217 US HIGHWAY 62 E CYNTHIANA, KY 41031
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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)	(X6) COMPLETION DATE
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F 000	INITIAL COMMENTS A Standard Recertification Survey was conducted 11/04/12 through 11/06/12. Deficient practice was identified and deficiencies were cited at a Scope/Severity of an "E".	F 000	This Plan of Correction constitutes our written allegation of compliance for the deficiency cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by State and Federal law.	
F 371 SS=E	483.36(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	It is the policy of this campus to ensure proper sanitation levels. 1. The sanitizer dispenser was replaced on 11-7-12 on the 3 compartment sink. The sanitizer manufacturer guidelines states that acceptable range is 100-400ppm. The new dispenser was operating correctly upon replacement and checked by the technician from GFS. The dispenser was replaced by the GFS trained service technician who provides service on the equipment in dietary department. There were no residents affected by the deficient sanitation level.	

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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 food was stored, prepared, and served under sanitary conditions as evidenced by failure to ensure the sanitizer level was at the appropriate level in the sanitizer buckets at food preparation (prep) areas.

The findings include:
Review of the facility's policy titled, "Dining Services", undated, revealed the first sanitizer bucket was to be prepared at 5:30 AM, then checked at 7:00 AM and 9:00 AM and every two (2) hours thereafter to ensure it met the appropriate disinfectant level of two hundred (200) parts per million.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Chelsea Adams</i>	TITLE ED	(X6) DATE 12-11-12
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PROVIDER OR SUPPLIER CEDAR RIDGE HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 1217 US HIGHWAY 62 E CYNTHIANA, KY 41031	
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F 371	Continued From page 1 Observation during the tour of the kitchen, on 11/06/12 at 4:07 PM, revealed Dietary Aide #1 checked the sanitizer level in the sanitation bucket and the test strip did not change to the appropriate color to indicate the sanitizer was at an appropriate level. Interview with Dietary Aide #1 at the time of the check, revealed the acceptable level was two hundred (200) parts per million (ppm) or greater. Observation of the test strip revealed the sanitizer level was not within two hundred (200) parts per million (ppm) range. Interview, on 11/06/12 at 4:07 PM, with Dietary Aide #2 revealed he had changed the sanitizer bucket when he came in after lunch. Interview, on 11/06/12 at 5:12 PM, with the Dietary Manager revealed the sanitizer level in the sanitizer buckets was checked when filled at approximately 5:30 AM, then at 7:30 AM and 9:00 AM. She stated if the sanitizer level was not at the acceptable level of two hundred (200) parts per million then it was changed and checked again to ensure it was acceptable. Then the sanitizer buckets were checked again at 11:00 AM, 1:00 PM, 3:00 PM, and after dinner. She stated Dietary Aide #1 should have checked the sanitizer level in the sanitizer bucket at 3:00 PM and obviously had not done so as the sanitizer did not register on the test strip. She stated this could harm a resident in that it could cause a food borne illness.	F 371	2. The DHS/ED completed an audit of orders written within 48 hours prior to and 48 hours following the identification of the deficient practice to ensure no residents were diagnosed food borne illness. This audit was completed on 12/7/12. There were no residents identified to have been affected by the deficient practice. The 5:30am and 12:15pm sanitizer level are recorded daily by the designated cook. The levels will be checked every two hours beginning at 5:30am by the ADPS/DFS/Cook. If at any time during those changes the reading levels are not within acceptable range, the range will be recorded by the DFS/ADPS/Cook and a new mix is prepared with a new reading level recorded. The Director of Food Services conducted an in-service with all dietary staff regarding the appropriate levels of PPM. This in-service was completed by 11/30/12 in order to educate all dietary staff. The daily PPM reading will be reported in morning CQI by the DFS/ADPS to ensure standards are being met. 3. The ED will conduct random audits at a minimum of 3 times per week to ensure compliance with levels and documentation. These weekly audits will be done for 1 month, if 100% compliance is achieved, then audits will be conducted 2x monthly. If at anytime, 100% compliance is not achieved, then audits will return to 3 times/week until 100% compliance.	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system	F 431		

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F 431	Continued From page 2 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. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. 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. 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility's policy, it was determined the facility failed to store all drugs and biological in locked compartments and in accordance with current	F 431	Upon 100% compliance then audits will return to monthly as part of the QA program. F431 It is the policy of this facility to properly store all drugs and biologicals correctly. 1. The DHS/ADHS conducted an audit of all medication carts and medication rooms to ensure no further deficient practice. There were no deficient practices identified on 11-7-12. The misplaced container of Sani-cloths was moved at time of deficient practice as to not be next to medications. The staff identified as practicing deficient practice was educated at the time by the DHS. 2. The ED/DHS conducted an in-service with all licensed nurses to ensure knowledge of proper location for storing	12/14/12	

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F 431	Continued From page 3 accepted professional principles. The findings include: Review of facility's policy, "Medication Storage In the Facility", revised 02/01/10, revealed medications and biological should be stored safely, securely, and properly. The procedure for storing potentially harmful substances, such as cleaning supplies, should be to stored in a locked area separately from medication. Observation on Legacy Lane (Memory Care Unit) of the facility, on 11/05/12 at 10:00 AM, revealed a container of Sani-Cloth Plus Germicidal Disposable Cloths sitting on top of the medication cart, next to a container of Sani Hands Gel Hand Wipes and bottle of hand sanitizer. Warning on top of Sani-Cloth Plus Germicidal Disposable Cloths stated not a skin wipe, to be used on hard surfaces. Staff was not present at the medication cart at that time. Interview with Registered Nurse (RN) #1, on 11/05/12 at 10:10 AM, revealed it was not necessary to have a container on top of the medication cart due to residents could come into contact with the germicidal cloths. Interview with Licensed Practical Nurse (LPN) #3, on 11/06/12 at 2:15 PM, on Legacy Lane revealed Sani-Cloth Plus Germicidal Disposable Cloths were used to sanitize the Glucometer to decrease possible spread of infection. When asked where the container of germicidal cloths was stored, LPN #3 unlocked the medication cart and opened the 3rd (thlrd) drawer, revealing a container sitting directly next to liquid	F 431	drugs and biologicals. This in-service was completed on 11/30/12 to ensure that all licensed staff educated properly. The ED/DHS did not identify any resident that was affected by the deficient practice during the review of all QA Infection Control Logs and audits which showed no trending with regards to storage of biologicals and medication. This audit was completed by 12-7-12. 3. The ED/DHS will conduct random audits 3x weekly to ensure 100% compliance with storing of drugs and biologicals. If 100% compliance is achieved within 1 month, then audits will be moved to 2x monthly as long as 100% compliance is maintained. If 100% compliance is not achieved, then audits will return to 3x/week for 1 month or until 100% compliance and will then return to 2x monthly.	12-4-12

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F 431	Continued From page 4 medications. Oral medications were also stored in this drawer. Interview with RN #2, Assistant Director of Nursing (ADON), on 11/06/12 at 2:55 PM, revealed SanI-Cloth Plus Germicidal Disposable Cloths were used to sanitize the Glucometer to decrease the possible spread of infection. When asked where the container of germicidal cloths was stored, the ADON unlocked and opened the drawer of the treatment cart, revealing a container with other medical supplies. The ADON stated the container of germicidal cloths should not be stored with medications. Interview with Director of Nursing (DON), on 11/06/12 at 3:00 PM, revealed SanI-Cloth Plus Germicidal Cloths were not to be stored on top of the medication cart. The DON stated germicidal cloths should be stored in the supply room, behind a locked door, or in the treatment cart with other medical supplies. The DON stated germicidal cloths should be stored away from consumables such as medications. When asked specifically about the Legacy Lane medication cart, the DON stated the container of germicidal cloths should be stored in the bottom drawer of medication cart, away from medications.	F 431		
F 441 SS=D	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	F 441	F441 It is the policy of this facility to maintain a sanitary environment. 1. All facility staff in-serviced on proper handling of and preventing the spread of infection. Training conducted by ED/DHS.	

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F 441	<p>Continued From page 5</p> <p>The facility must establish an Infection Control Program under which it -</p> <ul style="list-style-type: none"> (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. <p>(b) Preventing Spread of Infection</p> <ul style="list-style-type: none"> (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. <p>(c) Linens</p> <p>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, It was determined the facility failed to maintain an infection control program designed to provide a sanitary environment and to help prevent the development and transmission of disease and</p>	F 441	<p>2. ED/DHS will conduct random monthly audits to ensure compliance with prevention of spread of disease during meal service/handwashing/direct patient care/ice pass/linen pass/. If 100% compliance is not achieved at time of audits, then audits will be conducted weekly until 100% compliance is achieved and then audits will return to monthly. These audits will be part of the QA program.</p>	12/14/12
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F 441	<p>Continued From page 6</p> <p>infection. Observation on 11/04/12 around 10:00 AM, revealed the Activity Director (AD) passing ice to the residents and leaving the ice scoop in the ice chest. Observation on 11/05/12, during the lunch meal on hall (200), revealed the domed plate cover lids fell out of the bottom of the tray delivery cart, onto the carpet, and staff pick the lids off the floor and put them back on the bottom of the cart with undelivered resident food trays still in the cart.</p> <p>The findings include:</p> <p>Review of the facility policy entitled "Infection Control- General Policy Statement", no date, revealed all employees were in serviced on the prevention and control of Infections before being assigned to resident care, annually and as deemed necessary by the Infection Control Practitioner (ICP).</p> <p>Observation, on 11/04/12 at 10:00 AM, revealed the AD passing ice on the (200) hall to the residents and leaving the ice scoop in the ice chest. The Director of Nursing Services (DNS) was observing this writer observe the ice pass and stated that she (AD) didn't know to "not leave it in there".</p> <p>Interview with the AD, on 11/05/12 at 9:45 AM, revealed she was aware the ice scoop should not have been left in the ice chest. Further interview revealed she had infection control training but it had been awhile and she "just got distracted sometimes".</p> <p>Interviews with State Registered Nurse Aide (SRNA) #4 and #5, on 11/06/12 at 2:25 PM and</p>	F 441			

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F 441	<p>Continued From page 7</p> <p>2:30 PM, revealed the ice scoop should be stored in the holder because it was an infection control issue to leave it in the ice. Both SRNAs stated they had Infection control training on the computer and in-services yearly and as needed.</p> <p>Observation, on 11/05/12 at 12:20 PM, during the lunch meal on hall (200), revealed the domed plate cover lids fell out of the bottom of the tray delivery cart, onto the carpet, and staff pick the lids off the floor and put back on the bottom of the cart with undelivered resident food trays still in the cart.</p> <p>Interviews with SRNA #6, on 11/04/12 at 12:50 PM, and Licensed Practical Nurse (LPN) #2 at 12:55 PM, revealed the lids should not have been put back in the food cart with undelivered resident trays because it was an infection control issue.</p> <p>Interview with Kentucky Medication Aide (KMA) #5, on 11/04/12 at 1:00 PM, revealed it was an infection control issue for her to have put the contaminated lids back in the food cart with undelivered resident trays on it.</p> <p>Interview with the Staff Educator, on 11/06/12 at 2:35 PM, revealed all staff was given infection control training during orientation, yearly and as needed. The Staff Educator further stated both issues with the ice pass and the tray pass created infection control issues.</p>	F 441		

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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70 (a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 2004 Addition 6/16/2010</p> <p>SURVEY UNDER: 2000 New</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (211) Protected</p> <p>SMOKE COMPARTMENTS: Fourteen (14) smoke compartments.</p> <p>COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM (Original Installation)</p> <p>FULLY SPRINKLED, SUPERVISED (DRY SYSTEM) (Original Installation)</p> <p>EMERGENCY POWER: Type II Diesel Generator. (Original Installation)</p> <p>A life safety code survey was initiated and concluded on 11/05/12. The findings that follow demonstrate compliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility was found to be in substantial compliance with the Requirements for Participation for Medicare and Medicaid Program.</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE ED	(X6) DATE 12-11-12
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