

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

PRINTED: 02/24/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185447	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/10/2012
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NAME OF PROVIDER OR SUPPLIER VILLASPRING OF ERLANGER	STREET ADDRESS, CITY, STATE, ZIP CODE 630 VIOX DRIVE ERLANGER, KY 41018
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F 000	INITIAL COMMENTS	F 000	Without admitting or denying the validity or existence of the alleged deficiencies, Villaspring Health Care and Rehabilitation ("Villaspring") provides the following plan of correction. However, the law requires us to prepare a plan of correction for the citation regardless of whether we agree with it.	
F 282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to ensure the comprehensive plan of care was followed for one (1) of twenty-four (24) sampled residents (Resident #10). Resident #10 had a plan of care to have the resident wear long sleeves or geri sleeves due to the resident being prone to skin tears and having fragile skin. Observations on 02/07/12, 02/08/12 and 02/09/12 revealed the plan of care was not followed.</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Care Plans", dated 02/09/12, revealed care plans are to be unique and patient specific. A care plan is developed to identify strengths or possible barriers to guide the resident in reaching their maximum functional level. Additionally, each discipline is responsible for implementing any interventions to assist the patient in achieving their goals and desired outcomes.</p>	F 282	<p>This plan of correction is not meant to establish any standard of care, contract, obligation or position and Villaspring reserves all rights to raise all possible contentions and defenses in any civil or criminal claim action or proceeding.</p> <p>THIS PLAN OF CORRECTION SERVES AS VILLASPRING'S CREDIBLE ALLEGATION OF SUBSTANTIAL COMPLIANCE AS OF MARCH 21, 2012.</p>	
		F 282 S/S = E	<p>Villaspring provides services by qualified staff persons in accordance with the individualized comprehensive written care plan.</p> <p>Long sleeves and long pants have been consistently worn by Resident #10 for skin tear prevention. Family was notified of the need to remove all short sleeve garments from the Resident's room and they have done so. The use of geri-sleeves were discontinued for Resident #10 and her Resident Information Sheet (RIS) and care plans have been updated accordingly.</p> <p>The care plans and RIS for each Resident identified at risk for skin tears have been reviewed and revised as needed to accurately reflect appropriate interventions related to skin tear prevention by March 9th, 2012 by the RN Unit Managers.</p>	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE Administrator	(X6) DATE 3-5-2012
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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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F 282	Continued From page 1 Review of Resident #10's medical record revealed the facility admitted Resident #10 on 11/20/07, with diagnoses which included Diabetes Mellitus, Dementia, and Cerebral Vascular Accident. Review of the most recent Quarterly Minimum Data Set (MDS) Assessment, dated 12/12/11, revealed the facility assessed the resident to be severely impaired with cognition skills for daily decision making, required extensive assist with bed mobility and transfers, and being at risk for skin breakdown. Review of Resident #10's Comprehensive Care Plan, with a review date of 12/12/11, revealed problems of potential for skin breakdown related to fragile skin and prone to skin tears with nursing interventions which included the resident was to wear long sleeve tops or geri sleeves. Interview, on 2/10/12 at 12:00 PM, with the LPN #6 MDS Coordinator revealed she developed the care plan for Resident #10. Further interview revealed the purpose for the invention for Resident #10 to wear long sleeves or geri sleeves was related to the resident's history of skin tears and fragile skin. Observation during lunch meal service, on 02/07/12 at 12:40 PM, revealed Resident #10 was sitting up in a wheelchair, wearing a short sleeved shirt. Observation, on 02/08/12 at 9:00 AM, revealed Resident #10 was wearing a short sleeve top while sitting up in wheelchair in the dining room. Observation, on 02/08/12 at 2:40 PM, revealed Resident #10 was sitting up in wheelchair after	F 282	Additionally, Residents are having their individual care plans consistently implemented to meet their care needs including but not limited to interventions related to skin tear prevention including long sleeves. An in-service will be provided to licensed nurses and the STNA's by the DON and Nursing Management Team on March 7 th , 8 th & 13 th , 2012. The education will reinforce the expectations of consistent implementation of Resident interventions as directed by the care plan and RIS. The DON/ADON and/or RN Unit Managers, as part of their daily duties, perform routine informal nursing rounds to observe the care that is being delivered to the Residents, including observations of interventions related to skin tear prevention included in the Residents plan of care and RIS. If issues are noted interventions will be taken at that time that will include 1) correcting any concerns and 2) additional one on one education with Team members. The DON or designee shall complete a PI audit (Exhibit A) related to care plan revisions and/or implementation as well as observations of direct care for several residents. These audits are being performed once weekly for 4 weeks then monthly. The results of the PI audit will be reported to the QA Committee for a determination of the need for further ongoing formal auditing. DON will monitor.	3/21/12	

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F 282	<p>Continued From page 2 having a skin assessment wearing a short sleeve top.</p> <p>Observation, on 02/09/12 at 7:20 AM, revealed Resident #10 was sitting up in her wheelchair in the dining room with the torn arm rest wearing a three fourths (3/4) sleeve shirt.</p> <p>Interview, on 02/09/12 at 9:35 AM, with SRNA #1 who provided direct care to Resident #10 revealed the SRNAs on the night shift dressed Resident #10 for the day. Additionally, SRNA #1 stated the resident wore long sleeves due to families request and if the resident was not dressed in long sleeves she would ensure the resident was wearing long sleeves. Further interview revealed the SRNA was unaware Resident #10 was wearing three fourths (3/4) length sleeves on 02/09/12 or had on a short sleeved shirt on 02/08/12.</p> <p>Interview, on 02/09/12 at 8:18 PM, with SRNA #9 who cared for Resident #10 and worked the 11 PM to 7 AM shift revealed she unaware if the resident was always dressed in long sleeves.</p> <p>Interview, on 02/08/12 at 2:40 PM, with Licensed Practical Nurse (LPN) #1 who cared for Resident #10 revealed the resident usually had long sleeves on and it was on his/her care plan "because he/she is a picker".</p> <p>Interview, on 02/09/12 at 9:45 AM, with SRNA #6 revealed the SRNA did not know Resident #10 was supposed to have long sleeves and had not ever noticed any issues with the resident's skin.</p> <p>Interview, on 02/09/12 at 10:50 AM, with LPN #2</p>	F 282		

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F 282	Continued From page 3 who provided care to Resident #10 revealed she monitored that the SRNAs followed the care plans by observation and would follow up in making sure that the resident had on long sleeves because the resident was non compliant with geri sleeves. Interview with Unit Manager RN #1, on 02/09/12 at 10:50 AM, revealed the floor nurses monitored the SRNAs for compliance with following the care plans. Further interview revealed she monitored to ensure the floor nurses and SRNAs are following care plans by making rounds every two (2) weeks and then update the care plans as needed.	F 282		
F 323 SS=D	483.26(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of facility policy, it was determined the facility failed to ensure supervision to prevent accidents for three (3) of twenty-four (24) residents (Resident's #10, #1, and #18). Resident #10, who was assessed by the facility to have fragile skin and who had a history of skin	F 323	F323 S/S = E Villaspring ensures that the residents' environment remains as free of accidents and hazards as is possible; and each resident receives adequate supervision and assistive devices to prevent accidents including but not limited to, skin tears. Long sleeves and long pants have been consistently worn by Resident #10 for skin tear prevention. Family was notified of the need to remove all short sleeve garments from the Resident's room and they have done so. The uses of geri-sleeves were discontinued for Resident #10 and her Resident Information Sheet (RIS) and care plans have been updated accordingly. Additionally, the arm rests on Resident #1 and 10's wheelchair were replaced by the Maintenance Director on February 8 th , 2012 and the wheelchairs were inspected. The Maintenance Director replaced the footboard of Resident #18's bed on February 9 th , 2012.	

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F 323	<p>Continued From page 4</p> <p>tears, had damaged plastic type fabric with rough and sharp areas on the wheelchair arm-rest. In addition, Resident #10 had a plan of care to wear long sleeves or geri-sleeves due to fragile skin and the resident being prone to skin tears. Observations, on 02/07/12, 02/08/12 and 02/09/12 revealed the plan of care was not followed.</p> <p>Resident #1 was assessed by the facility to have impaired skin integrity and had a history of skin tears. Observations on 02/07/12 and 02/08/12 revealed Resident #1 was in a wheelchair that had arm rests with torn and jagged plastic type fabric.</p> <p>Resident #18 had an area of wood like material missing from the foot board of the bed that had rough, sharp, jagged edges.</p> <p>The findings include:</p> <p>Review of the Facility's policy titled 'Wheelchair and Geri Chair Usage, dated 10/04, revealed the maintenance department will perform at least yearly a safety check on all wheelchairs and Geri chairs, as well as any necessary adjustments and repairs are completed. Inspection and repairs would be noted on the preventative maintenance log. Further record review revealed all wheelchairs and Geri chairs are cleaned weekly and as needed by the 11 PM to 7 AM shift. Additionally, facility's policy titled 'Maintenance Department Policies', dated 03/10/03, revealed a requisition form is completed by any employee for repair or maintenance service which is sent to maintenance department or the maintenance department may be called, conformed by a</p>	F 323	<p>The care plans and the RIS for Residents #1, 10 and 18 have been reviewed and revised as needed to reflect the current interventions to prevent skin tears. The care plans and RIS for each Resident identified at risk for skin tears are being reviewed and revised as needed to accurately reflect appropriate interventions related to skin tear prevention by March 9th, 2012 by the RN Unit Managers. Additionally, Residents are having their individual care plans consistently implemented to meet their care needs including but not limited to interventions related to skin tear prevention including the use of long sleeves.</p> <p>The Maintenance Director and Housekeeping/Central Supply Director completed an entire facility audit, with direct caregivers input, of wheelchairs and bedroom furniture by February 13th, 2012. The Maintenance Director replaced wheelchair arm rests, identified as in need of repair, throughout the facility by February 13th, 2012. Additionally, the Maintenance Director repaired any bed head or footboard identified on the audit as in need of repairs by February 13th, 2012.</p> <p>An additional in-service will be provided to licensed nurses and the STNA's and separately to the Housekeeping and Maintenance staff by the DON and Nursing Management Team along with the Maintenance Director and Housekeeping/Central Supply Director on March 7th, 8th & 13th, 2012. The education will reinforce the 1) the importance of identification of potential safety risks involved in the equipment utilized by Residents, 2) the process for reporting to maintenance any need for equipment repair, and 3)</p>	

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F 323	<p>Continued From page 5 written request.</p> <p>Interview with the Maintenance Director, on 02/10/12 at 10:10 AM, revealed the maintenance department made rounds through the facility every day and the maintenance department depended on the staff to notify them of any damages or repairs needed to equipment either by requisition or verbal. Further interview revealed the requisitions are destroyed once the repair was completed.</p> <p>1. Review of Resident #10's medical record revealed the facility admitted Resident #10 on 11/20/07, with diagnoses which included Diabetes Mellitus, Dementia, and Cerebral Vascular Accident. Review of the most recent Quarterly Minimum Data Set (MDS) Assessment, dated 12/12/11, revealed the facility assessed the resident to be severely impaired with cognition skills for daily decision making, required extensive assist with bed mobility and transfers, and being at risk for skin breakdown. Review of Resident #10's care plan with a review date of 12/12/11, revealed problems of potential for skin breakdown related to fragile skin and prone to skin tears with nursing interventions which included the resident was to wear long sleeve tops or geri sleeves.</p> <p>Interview, on 2/10/12 at 12:00 PM, with the LPN #6 MDS Coordinator revealed she developed the care plan for Resident #10. Further interview revealed the purpose for the invention for Resident #10 to wear long sleeves or geri sleeves was related to the resident's history of skin tears and fragile skin.</p>	F 323	<p>to look beyond the obvious and employ, as much as possible, critical thinking skills related to optimizing Resident safety and supervision.</p> <p>The Maintenance Director and Housekeeping/Central Supply Director, as part of their daily duties, perform routine informal rounds to observe the state of equipment being used by and for the Residents, including observations of potential concerns related to skin tear prevention. If issues are noted interventions will be taken at that time that will include 1) correcting any concerns and 2) additional one on one education with Team members on how to report potential concerns so they are addressed/fixd. The Maintenance Director and/or Housekeeping/Central Supply Director shall complete a PI audit (Exhibit B) related to the state of repair of wheelchairs and bedroom furniture. The DON, ADON and/or RN Unit Managers, as part of their daily duties, perform routine informal nursing rounds to observe the care that is being delivered to the Residents, including observations of interventions related to skin tear prevention included in the Residents plan of care and RIS. The Nursing management team will complete a PI audit (Exhibit A) related to observation of delivery of care as care planned and included on the RIS and include the long sleeves, and other skin tear prevention interventions. These audits are being performed once weekly for 4 weeks then monthly. The results of the PI auditing will be reported to the QA Committee for a determination of the need for further ongoing formal auditing.</p> <p>DON will monitor.</p>	3/21/12

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F 323	<p>Continued From page 6</p> <p>Review of Nurses Notes (NN), dated 10/06/11, revealed Resident #10 sustained a bleeding skin tear to the right wrist. Further review of NN revealed the facility determined the skin tear was due to the resident scratching herself/himself. The skin tear was treated with Polypro Ointment (PSO) and dressing per Physician Orders.</p> <p>Review of NN, dated 10/08/11, revealed Resident #10 sustained a bleeding skin tear to the left upper extremity. Further review of NN revealed the skin tear occurred during care delivery. The skin tear was treated with PSO and steri-strips per physician's order. Additional review of NN revealed the resident resident was non-compliant with wearing geri-sleeves and the SRNA was instructed to dress the resident in long sleeves only.</p> <p>Review of NN, dated 01/08/12, revealed Resident #10 sustained a skin tear to the left forearm after sustaining a fall from the wheelchair. The skin tear was treated with PSO and a dressing per physician's order.</p> <p>Observation during lunch meal service, on 02/07/12 at 12:40 PM, revealed Resident #10 was sitting up in a wheelchair, wearing a short sleeved shirt. Further observation revealed both of the resident's arms were moving intermittently back and forth across the arm rests of the wheel chair which had torn plastic type fabric with jagged and sharp edges. Additional observation revealed there were tears measuring three (3) inches long and one half (1/2) inch wide on the right arm rest and one (1) inch long and one half (1/2) inch wide on the seam of the left arm rest of the wheelchair.</p>	F 323		

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F 323	Continued From page 7 Observation of a skin assessed conducted by Licensed Practical Nurse (LPN) #1, on 02/08/12 at 2:40 PM, revealed Resident #10 had healed skin tears on both arms and current abrasions on the residents left upper arm and lower arm just above the residents wrist. Further observation revealed after the skin assessment, State Registered Nursing Assistant (SRNA) # 1 assisted Resident #10 to the resident's wheelchair with the torn arm rest. Resident #10 was wearing a short sleeved blue shirt at that time. Observation, on 02/09/12 at 7:20 AM, revealed Resident #10 was sitting up in her wheelchair in the dining room with the torn arm rest wearing a three fourths (3/4) sleeve shirt. Further observation revealed the resident's arms were intermittently moving back and forth across the torn arm rest. Interview, on 02/09/12 at 9:35 AM, with SRNA #1 who provided direct care to Resident #10 revealed the SRNAs on the night shift dressed Resident #10 for the day. Additionally, SRNA#1 stated the resident wore long sleeves due to families request and if the resident was not dressed in long sleeves she would ensure the resident was wearing long sleeves. Further interview revealed the SRNA was unaware Resident #10 was wearing three fourths (3/4) length sleeves on 02/09/12 or had on a short sleeved shirt on 02/08/12. SRNA #1 stated she had not noticed any problems with Resident #10's wheelchair or that the wheelchair needed any repairs.	F 323			

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F 323	<p>Continued From page 8</p> <p>Interview, on 02/09/12 at 8:18 PM, with SRNA #9 who cared for Resident #10 and worked the 11 PM to 7 AM shift revealed she cleans the wheelchairs she had never noticed any torn or worn areas on any wheelchairs for the past year. SRNA #9 stated "I guess I never paid attention to the fabric on the wheelchairs". Additional interview revealed she was unaware if Resident #10 was always dressed in long sleeves.</p> <p>2. Review of the medical record revealed Resident #1 was admitted to the facility, on 03/06/07, with diagnoses which included Dementia and Diabetes Mellitus. Review of the most recent Quarterly MDS, dated 12/15/11, revealed the facility assessed Resident #1 to be severely impaired with cognition skills for daily decision making, required extensive assistance with transfer and bed mobility and was at risk for skin breakdown. Review of the resident's plan of care, reviewed 12/15/11, revealed Resident #1 had impaired skin integrity.</p> <p>Review of NN, dated 01/27/12, revealed Resident #1 sustained a bleeding skin tear to the resident's right lower leg. Further review of NN revealed the area was treated with PSO and steri-strips per physician's order.</p> <p>Observation, on 02/07/12 at 4:20 PM and 02/08/12 at 9:00 AM, revealed Resident #1 was in her/his wheelchair with short sleeves on and the resident's arms were resting on the arm rest. Further observation of Resident #1's wheelchair revealed the left arm rest had torn, damaged plastic type fabric measuring eight (8) inches along the seam of the arm rest as well as a three (3) inches long and one half (1/2) inch wide tear</p>	F 323		

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F 323	<p>Continued From page 9</p> <p>on top of the arm rest. The right arm rest had a five (5) inch long area of cracked fabric that had rough edges,</p> <p>Interview, on 02/08/12 at 2:40 PM, with LPN #1 who cared for Resident #10 and Resident #1 revealed the damaged fabric on the residents wheelchair arm rest could cause skin tears due to the resident having fragile skin and a history of skin tears. Additionally, LPN #1 stated that in order to have equipment repaired such as wheelchairs, the staff could fix it themselves, go get another wheelchair or complete a maintenance requisition for maintenance to repair the damaged area. LPN #1 stated "you would think me being here fourteen (14) hours a day I would have noticed the torn fabric on the wheel chair arm rest, I am embarrassed". Further interview with LPN #1 revealed the State Registered Nurse Aides (SRNAs) cleaned the wheelchair's once a week on 11 PM-7 AM shift and they could report damages to equipment, including wheelchairs to maintenance with a Maintenance Requisition ticket</p> <p>3. Review of the medical record revealed Resident #18 was admitted to the facility on 10/22/11 with diagnoses which included Subadural Hematoma, and Diabetes Mellitus. Further record review revealed the facility assessed the resident to be independent with cognition skills for daily decision making and to be alert and oriented.</p> <p>During an interview with Resident #1, on 02/10/12 at 9:50 AM, the resident pointed to her/his footboard of the bed and stated she had told the nurse about her/his foot board. The resident did</p>	F 323		

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F 323	Continued From page 10 not state who she told or when she told the nurse. Observation, at that time, revealed the footboard of the resident's bed had an area of wood like material missing measuring ten (10) inches long and two(2) inches wide with jagged, sharp edges. After rubbing her hand over the footboard, on 02/10/12 at 9:55 AM, LPN #1 stated she felt like the rough edges could cause a skin tear or some other injury if the resident was to bump into or rub their body over the area with missing wood like material. Interview, on 2/10/12 at 10:00 AM, with Maintenance Employee #8, revealed he was in Resident #18's room last week to fix the drawers in the dresser and did not notice or even look for the damage on the foot board, "I certainly can see someone getting hurt on those sharp edges".	F 323			
F 371 SS=F	483.35(l) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility's policy it was determined the facility failed to prepare, store and distribute food under	F 371	F371 S/S=F This facility ensures food is stored, prepared, served and distributed under sanitary conditions. The facility only stores intact, not dented, cans in the dunnage racks of the dry storage room. The facility has purchased and is utilizing a new label that includes the item name, employee's initials who prepared, the date prepared with time, the 'use by' date with time, and circling the day of the week the food is prepared. The food stored in the refrigerator is labeled with this more specific label to eliminate any confusion as to correct storage time frames.		

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F 371	<p>Continued From page 11</p> <p>sanitary conditions as evidenced by dented cans stored in the dunnage racks of the dry storage room; food stored in the refrigerator that was not labeled or dated correctly; plastic containers of dried cereal with cracked lids and not consistently labeled or dated; spatulas that were cracked and stained stored in the utensil drawer; dried grease and food build-up on the back splashes of counters and handles of drawers; and employees not fully covering their hair with a head covering while in food preparation areas.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, 'Food Storage', dated 05/08, revealed all leftovers would be labeled, dated, covered and discarded within seventy-two (72) hours. Additional review of the policy revealed all 'opened potentially hazardous food items' would be labeled, dated, covered and discarded within seven (7) days.</p> <p>Interview with the Executive Chef (EC), on 02/08/12 at 2:20 PM, revealed he did not know why the facility's food storage policy stated to discard leftovers within seventy-two (72) hours because he had always gone by discarding food within seven (7) days. After reviewing the storage policy, the EC verified that food prepared at the facility should be discarded within seventy-two (72) hours and already prepared food should be discarded within seven (7) days after opening. He stated potentially hazardous foods should be labeled as to what the food item was, the date the food was opened or made, and the date the food was to be discarded.</p> <p>Observation during initial tour of the kitchen, on</p>	F 371	<p>The plastic containers of cereal were immediately replaced by the Executive Chef (EC) on February 8th, 2012. In response to the concerns over food storage time frames the facility has purchased and is utilizing a new label that includes the item name, employee's initials who prepared, the date prepared with time, the 'use by' date with time, and circling the day of the week the food is prepared. The spatulas were discarded immediately and the facility uses intact utensils for preparation of food. The kitchen backsplashes and draw handles were immediately cleaned and remain so. The employees do cover their hair correctly, within the FDA Food Code guidelines, in hair restraints or hats while in the food preparation areas.</p> <p>The Executive Chef was provided an additional inservice regarding the policy of storage of food cans with the Administrator on February 13th, 2012. The EC will review the storage of food cans with his entire Dietary staff on March 7th, 8th, & 9th, 2012 in the event they were the staff that stocked cans on the dunnage racks as to the importance and procedure of accepting and storing only intact, not dented, cans.</p> <p>The Executive Chef reviewed the Food Storage policy with the Administrator to clarify the definition of 'leftovers' and 'food prepared in-house to be served at a later date' on February 13th, 2012. The new labeling procedure has been incorporated into the policy to remove any doubt as to the storage requirements of the food item. The Facility continues to utilize the 2005 FDA Food Code as the source document for guidance on food storage compliance. The Executive Chef will review the food labeling and discarding procedure with his entire Dietary Staff on March 7th, 8th, & 9th 2012.</p>	

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F 371	<p>Continued From page 12</p> <p>02/ 07/ 12 at 10:30 AM, revealed there was a dented can of vanilla pudding and a dented can of crushed pineapples stored in the dunnage racks of the dry good store room.</p> <p>Interview with the EC, on 02/08/12 at 2:20 PM, revealed he usually put the cans in the dunnage racks after they were delivered and should have put the dented cans in his office to be returned to the vendor.</p> <p>Observation, on 02/07/12 at 10:35 AM, revealed a large oblong clear plastic container which contained ingredients to include a beige colored meat, cooked whites of eggs, chopped celery and white colored liquid substance was on the shelf in the walk-in refrigerator. Additional observation revealed a label was on the lid of the plastic container with a date of 02/13/12, six (6) days from the observation date. There was no other information on the label.</p> <p>Continued observation during initial tour of the kitchen, on 02/07/12 at 10:45 AM, revealed a large round clear plastic container which contained ingredients such as a beige colored meat, noodles, sliced carrots, celery was stored in the stand up two-door refrigerator. Further observation revealed a label was on top of the lid with a date of 02/13/12, six (6) days from the date of the observation. There was no other information on the label.</p> <p>Interview with Dietary Staff #3 on 02/08/12 at 02:20 PM, revealed the plastic container in the walk-in refrigerator was a facility made chicken salad and the plastic container in the stand up refrigerator was a facility made chicken noodle</p>	F 371	<p>The Executive Chef immediately removed the cereal containers and lids and replaced them with new, functional containers on February 8th, 2012. The new containers were labeled utilizing the previously described labeling system, which identifies the item, who and when it was put it in service, and when it expires. The Executive Chef will review the cereal containers and all storage vessels and their need to be in good working order and repair with the entire Dietary Staff on March 7th, 8th, & 9th 2012.</p> <p>The Executive Chef and the Dietary Staff have thoroughly and completely cleaned the metal back splash boards and the metal handles of the utensil boards as well as the entire kitchen.</p> <p>The Executive Chef and the Administrator developed a revised the systematic, routine, clearly defined cleaning schedule for the Dietary Department to utilize in an ongoing manner on February 28th, 2012. The Executive Chef will review this cleaning schedule with the entire Dietary Staff on March 7th, 8th, & 9th 2012.</p> <p>The citation indicates that Dietary Staff were observed with hair nets but the survey team observed some hair not totally covered by the nets. The 2005 FDA Food Code provides no qualitative guidance on the amount of hair that is required to be covered while in a food preparation area. However, the facility has purchased and is utilizing a new, larger, style of hairnet that easily covers more volume of hair and is white in color versus the previous hairnet that was the color of dark hair and could be difficult to discern even when worn properly. The Executive Chef and Administrator reviewed the policy on dress code in the Dietary Department. The Executive Chef will specifically</p>

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F 371	<p>Continued From page 13</p> <p>soup. Further interview revealed leftover food was discarded within seven (7) days, unless the food contains raw eggs or raw food such as celery and then it was discarded within three (3) days. The cook stated the label should contain what the food item was and the date the food was to be discarded.</p> <p>Observation of the preparation table, on 02/07/12 at 10:40 AM, revealed there were two (2) tall clear oval plastic containers labeled 'Raisin Bran' and 'Rice Krispies' with plastic lids that were cracked and chipped and the cereal was not fully covered. Additional observation revealed there was another container that contained light brown dried flakes that was not labeled and had a cracked lid.</p> <p>Interview with the EC, on 02/08/12 at 2:20 PM, revealed he was responsible for ensuring the lids on the cereal containers were replaced when cracked and he would replace the lids right away.</p> <p>Observations, on 02/07/12 between 10:30 AM and 11:30 AM and 02/08/12 between 2:00 PM and 2:20 PM, revealed there were three (3) white plastic spatulas stored in a utensil drawer that were cracked and stained. Further observation revealed all the metal back splash boards of the metal preparation counters had grease build-up. Additional observation revealed the metal handles of the utensil drawers had grease build-up.</p> <p>Interview with Dietary Staff #3 and #4, on 02/08/12 at 9:20 AM, revealed counters and equipment were cleaned daily after use. Further interview revealed thorough/deep cleaning of the kitchen was conducted every weekend by whoever was working that weekend. Dietary Staff</p>	F 371	<p>educate the dress code to all members of the Dietary Department on March 7th, 8th, & 9th 2012 and the Administrator publicized to the staff, via posting in the break room, letter with paychecks at Villaspring that a hat and/or hairnet must be worn in food preparation areas that "are designed and worn to effectively keep their hair from contacting the exposed food;" (FDA Food Code, 2005).</p> <p>The dietary staff will receive additional in-service education to reinforce their knowledge of the proper storage, preparation, distribution and serving of food under sanitary conditions by the Dietary Manager and Registered Dietician on March 7th, 8th, & 9th 2012. The education included the proper storage of food cans, the new labeling system and to eliminate any confusion regarding when to discard food items, the cereal and all storage containers being in good working order, clean, and labeled, that all utensils used in food preparation are clean and in good repair, the kitchen maintain its cleanliness and to utilize the written cleaning schedule to do so, and that hairnets or hats should be worn in the food preparation areas and that the hairnets substantially restrain the staff members hair.</p> <p>Observation audits (Exhibit C) of the dietary staff during the preparation, distribution and serving of food including the stored cans being free of dents, the prepared food items being labeled and stored correctly, the cereal and all storage containers being intact and functional, the spatulas and all utensils being in serviceable order, the absence of grease build up and overall cleanliness of the kitchen, including cleaning schedule, and the wearing of new, more readily identifiable hairnets shall be conducted by the Dietary Manager and/or</p>		

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F 371	<p>Continued From page 14</p> <p>stated there was not a written cleaning schedule or directions as to what and how to clean. Additional interview revealed they tried to clean all areas but may have missed something, like the back splash counters or drawer handles.</p> <p>Interview with the EC, on 02/10/12 at 11:15 AM, revealed staff knew they were supposed to do thorough cleaning on weekends. Additional interview revealed he did not have a written cleaning schedule or procedures for cleaning. He further stated he probably should have a written cleaning schedule to ensure all areas of the kitchen were thoroughly cleaned.</p> <p>Observations of the kitchen during meal preparation and service, on 02/07/12 from 10:30 AM through 12:45 PM and 02/08/12 from 2:00 PM through 2:30 PM, revealed three (3) dietary staff did not fully cover their hair with a head covering while preparing or serving food.</p> <p>Interviews with Dietary Staff #3 and #4, on 02/08/12 at 09:20 AM, revealed employees hair was supposed to be fully covered, but sometimes the hairnets the facility purchased would not reach all the way down to cover the bangs or back of the head at the same time.</p> <p>Interview with the EC, on 02/10/12 at 11:15 AM, revealed staff should wear hairnets and fully cover their hair when serving or preparing food. Further interview revealed he conducted monthly sanitation observations of the kitchen and had not noticed hair not being fully covered because the observation sheet he utilized did not identify checking to see if staff had hairnets on that were fully covering the head.</p>	F 371	<p>the Registered Dietician weekly until 100% compliance with sanitary conditions is maintained for 4 weeks. The findings of the audits shall be reported to the Quality Assurance Committee as part of the facility's Quality Assurance Program for review, additional recommendations and the need for ongoing formal monitoring.</p> <p>Executive Chef will monitor.</p>	3/21/12
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F 514 SS=D	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to maintain clinical records on each resident in accordance with accepted professional standards and practices that were complete, accurately documented, readily accessible, and systematically organized for three (3) of twenty-four (24) sampled residents (Resident #3, #7, and #16).</p> <p>Resident #3 and Resident #7 had orders on the Physician's Order Form, dated 02/12, for Full Code; however, review of the Emergency Medical Service (EMS) Form and the Do Not Resuscitate (DNR) Policy Kentucky (KY) Form revealed the residents' code status was DNR. In addition, although Resident #16 had a Physician's Order for code status, the code status was not on the monthly printed Physician's Order Sheet for</p>	F 514	<p>F514 S/S = D</p> <p>Villaspring maintains clinical records for each resident within the accepted professional standards and the records are complete, accurately documented, readily accessible and systematically organized.</p> <p>The medical records of Resident #3, 7, and 17 were reviewed and corrected to accurately reflect the Resident's ordered Code Status. The documentation reflects that the physician orders, Emergency Medical Services (EMS) Form, and the Do Not Resuscitate (DNR) Policy Kentucky Form all indicate the same code status information. Additionally, the March 2012 physician order form for Resident #7 has been corrected and accurately reflects the resident's current status related to no Foley Catheter.</p> <p>Each resident's current Physician Order Form has been reviewed by the RN Unit Managers and Nursing Management Team for accuracy by March 7th, 2012. March 2012 Physician Order Forms are correct and accurately reflect the current physician orders of each resident. Corrections/revisions were made immediately when/if inaccuracies/errors were noted.</p> <p>An additional in-service will be provided to licensed Nurses by the DON and Nursing Management Team on March 7th, 8th, & 13th, 2012</p>	
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F 514	<p>Continued From page 16 January and February of 2012.</p> <p>Also, Resident #7 had orders on the Physician's Order Form, dated 02/12 related to a Foley Catheter, however, observation of a skin assessment on 02/08/12 revealed the resident no longer had a Foley Catheter.</p> <p>The findings include:</p> <p>Review of the facility "Do Not Resuscitate Policy-Kentucky Specific" Policy, dated 07/05, revealed once the completed DNR Policy Form KY and the EMS DNR Form was signed, the charge nurse was to notify the attending Physician, and the forms were to be placed in the Advanced Directives tab in the medical record.</p> <p>1. Review of Resident #7's clinical record revealed the Physician's Order Form dated 02/12 that stated the resident's code status was "Full Code".</p> <p>Review of the Kentucky Emergency Medical Services (EMS) Do Not Resuscitate (DNR) Order Form, revealed "I hereby state that this Do Not Resuscitate (DNR) Order is my authentic wish not be resuscitated", dated 11/05/11 and signed by the resident's Power of Attorney (POA).</p> <p>Review of the "DNR KY Policy Form", dated 11/15/11, revealed the Form was marked as DNR, and signed by the resident's POA.</p> <p>Interview, on 02/10/12 at 12:10 PM, with the Unit Manager/Registered Nurse (RN) #1 revealed, she trained the nurses on her unit to check the Advanced Directive section of the chart to look for</p>	F 514	<p>to reinforce the process for accurate transcription of physician orders and the process for accurate monthly changeover of physician orders including, but not limited to, code status orders.</p> <p>The DON or Nursing Management team shall complete a PI audit (Exhibit D) related to the accuracy of Physician Orders including, but not limited to, code status orders. These audits are being conducted weekly for 4 weeks then monthly and the results will be reported to the QA Committee for a determination of the need for further ongoing formal auditing.</p> <p>The DON will monitor.</p>	3/21/12
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F 514	<p>Continued From page 17</p> <p>the KY EMS Form, and the DNR KY Policy Form in order to verify a resident's code status. She further stated the Physician's Order Form, dated 02/12 related to code status, was incorrect and there should have been an original Physician's Order in the chart when the resident's code status was changed from Full Code to DNR. However, she was unable to find the order in the current record and stated she would attempt to find the order in medical records.</p> <p>Further interview, on 02/10/12 at 1:40 PM, with RN #1 revealed medical records was unable to find an original Physician's Order for a code status of DNR for this resident. She stated, after reviewing the medical record, she noted that during a family care conference with social services, the resident's POA signed the Forms for DNR status and this was notarized and placed in the chart. She stated nursing was "bypassed" in this situation and that was why a Physician's Order was not received for the DNR. Continued interview, revealed if a family wanted a code status changed, the nurse was to contact the Physician, and receive a Physician's Order for the code status change which was to be faxed to pharmacy in order for pharmacy to change the code status on the Physician's Order Form.</p> <p>2. Review of the Physician's Orders for Resident #7, dated 01/10/12, revealed orders to start bladder training, clamp Foley for four (4) hours, release every fifteen (15) minutes for forty-eight (48) hours, then remove Foley and monitor for 48 hours.</p> <p>Further review of Resident #7's clinical record revealed the Physician's Order Form, dated</p>	F 514		
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F 514	<p>Continued From page 18</p> <p>02/12, revealed orders for Foley Catheter care every shift, change 18 French Catheter as needed, and 18 French Cathter.</p> <p>Observation of a skin assessment, on 02/08/12 at 3:10 PM, revealed the resident no longer had an indwelling Foley Catheter.</p> <p>Interview, on 02/10/12 at 12:00 PM, with Unit Manager/RN #1, revealed the Physician's Order Form (POF), dated 02/12 was incorrect related to the Foley Catheter, and the Physician's Order to discontinue the Foley Cathter should have been faxed to Pharmacy in order for Pharmacy to update the POF. She stated she was unsure if it was faxed because the fax verifications were not kept. Continued interview, revealed the night shift nurses were responsible for the "monthly change over", and this should have been caught at that time when the nurses compared the previous Physician's Order to the new POF. She stated there was no audits completed to ensure the monthly change overs were completed correctly.</p> <p>3. Review of Resident #3's medical record, revealed a Do Not Resuscitate (DNR) Form for Kentucky Emergency Medical Services, a DNR Kentucky Policy Form and a Living Will Directive, which stated, Resident #3 wishes to not be resuscitated, all signed by Resident #3 and a Notary Public. Further review of the February 2012 Physician's Orders, revealed the resident was a Full Code.</p> <p>Interview, on 02/08/12 at 10:00 AM, with Registered Nurse/Unit Coordinator (RN) #2, revealed during order change over at the end of January 2012 the order for DNR was not transcribed over to the February 2012 Physician's</p>	F 514		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/24/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185447	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/10/2012
NAME OF PROVIDER OR SUPPLIER VILLASPRING OF ERLANGER			STREET ADDRESS, CITY, STATE, ZIP CODE 630 VIOX DRIVE ERLANGER, KY 41018	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F.514	<p>Continued From page 19</p> <p>Orders. She stated, she was not sure why it was missed. Further interview revealed all orders should be checked and transcribed over each month.</p> <p>Interview, on 2/09/12 at 10:25 AM with Licensed Practical Nurse (LPN) #5, revealed the process of monthly change over of orders was to compare the Medication Administration Record (MARS), Treatment Administration Records (TARS) and Physician's Orders with the new Physician's Order Form printed by pharmacy to ensure accuracy.</p> <p>Interview, on 2/10/12 at 12:20 PM, with the Assistant Director of Nursing (ADON), revealed orders were to be transcribed monthly with comparing the past month's Physician's Orders. She stated, if any problems were found, the orders should be clarified with the the Physician. She further stated when looking for code status, staff should first look at the forms signed by the resident or responsible party including the DNR Kentucky Policy Form.</p> <p>4. Review of Resident #16's medical record, revealed a Do Not Resuscitate (DNR) Form for Kentucky Emergency Medical Services, a DNR Kentucky Policy Form and a Living Will Directive, which stated, Resident #16 wished to not be resuscitated, all signed by Resident #16 and a Notary Public. Review of Resident #16's printed Physician's Order Forms for January 2012 and February 2012 revealed Resident #16's code status was not identified on the Physician's Order Forms.</p> <p>Interview, on 02/08/12 at 10:00 AM, with RN #2,</p>	F 514		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185447	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/10/2012
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NAME OF PROVIDER OR SUPPLIER VILLASPRING OF ERLANGER	STREET ADDRESS, CITY, STATE, ZIP CODE 630 VIOX DRIVE 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
F 514	Continued From page 20 revealed she was not sure why it was missed. Further interview revealed all orders should be checked and transcribed over each month according to the Physician's Orders and the DNR status should have been included on the Physician's Orders for Resident #16.	F 514		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185447	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 02/08/2012
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NAME OF PROVIDER OR SUPPLIER VILLASPRING OF ERLANGER	STREET ADDRESS, CITY, STATE, ZIP CODE 630 VIOX DRIVE 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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K 000	<p>INITIAL COMMENTS</p> <p>Building: 01</p> <p>Plan Approval: 1999</p> <p>Survey under: NFPA 101 (2000 Edition)</p> <p>Facility type: SNF/NF</p> <p>Type of structure: Two (2) Story with partial basement Type II (111) Protected</p> <p>Smoke Compartment: Seven (7)</p> <p>Fire Alarm: Complete Fire alarm System (Installed 1999)</p> <p>Sprinkler System: Complete Sprinkler System (Wet) Installed in 1999</p> <p>Generator: Type II Diesel Installed in 1999</p> <p>A standard Life Safety Code survey was conducted on 02/08/12. Villaspring of Erlanger was found to be in compliance with the requirements for participation in Medicare and Medicaid.</p>	K 000	<p style="text-align: center;">RECEIVED</p> <p style="text-align: center;">MAR - 5 2012</p> <p>BY: _____</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE <i>Administrator</i>	(X6) DATE <i>3-5-2012</i>
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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.