

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

PRINTED: 10/20/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185440	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/07/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER VILLAGE CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2980 RIGGS AVENUE ERLANGER, KY 41018
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
--------------------	--	---------------	---	----------------------

<p>F 000</p> <p>F 272 SS=E</p>	<p>INITIAL COMMENTS</p> <p>A Recertification Survey was conducted 10/05-07/10, and a Life Safety Code Survey was conducted 10/07/10. Deficiencies were cited, with the highest Scope and Severity of an "E".</p> <p>483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS</p> <p>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment.</p>	<p>F 000</p> <p>F 272</p>	<p>Preparation or execution of this plan of correction does not constitute admission or agreement to any alleged deficiencies cited in this documented. This plan of correction is prepared and executed, as required by the provider for federal and state law.</p> <p>RECEIVED NOV 15 2010</p> <p>F 272 SS = E BY: _____</p> <p>483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS</p> <p>This facility has a policy of conducting initial and periodic comprehensive, accurate, standardized reproducible assessments of each resident's functional capacity.</p> <p>The resident assessment protocols and care plans of resident #2 have been reviewed to assure all triggered items: delirium, cognition, visual function, communication, ADL function, urinary incontinence, mood state, behaviors, falls dental and nutritional status pressure ulcers and psychotropic drug use, have been addressed in the care plan and include the problem, risk factors, and the need for referrals or further evaluation as indicated.</p>	
------------------------------------	--	---------------------------	---	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Tommy Z...</i>	TITLE <i>Administrator</i>	DATE <i>10/14/10</i>
--	-----------------------------------	-----------------------------

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.

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

PRINTED: 10/20/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185440	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/07/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER VILLAGE CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2990 RIGGS AVENUE ERLANGER, KY 41018
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
F 272	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to assure that comprehensive assessments were completed in accordance with Utilization Guidelines specified as part of the Resident Assessment Instrument (RAI) for seven (7) of twenty one (21) sampled residents (Residents #2, #5, #9, #10, #11, #13 and #16). Areas that triggered for further assessment of problems to develop individualized care plans were not thoroughly reviewed so that an individualized care plan could be developed.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Review of the Resident Assessment Protocol Summaries (RAPS) signed 04/16/10, for Resident #2 revealed the resident triggered for additional review of Delirium, Cognition, Visual Function, Communication, ADL (Activities of Daily Living) Function, Urinary Incontinence, Mood State, Behaviors, Falls, Dental, Nutrition, Pressure Ulcers, and Psychotropic drug use. Review of the RAP keys for these triggered areas revealed the facility failed to address the need for referrals/further evaluation by appropriated health professionals. In addition these RAP keys did not address the complications and risk factors that affected the facility's decision to proceed to plan of care (POC). 2. Review of the RAPS, signed 09/25/10, for Resident #9 revealed the resident triggered for additional review of Cognition, Communication, ADL Function, Urinary Incontinence, Psychosocial Well-Being, Falls, and Pressure Ulcers. 	F 272	<p>Resident #2 has been comprehensively assessed for a significant change in status, completed on 10-22-2010. Each triggered area has individualized documentation present to address the problem, risk factors, any need for referral or further evaluation and decision to proceed or not to proceed to the care plan.</p> <p>The resident assessment protocols and care plans of resident # 5 have been reviewed to assure all triggered items: ADL function, psychosocial well-being, falls, nutrition, dehydration, and psychotropic drug use, has been addressed in the care plan and include the problem, risk factors and the need for referrals or further evaluation as indicated.</p> <p>Resident #5 has several cardiac diagnoses and the care plan has been reviewed to assure it reflects risk factors, possible complications, and need for referrals or further evaluation as indicated. Completed 10-11-2010.</p> <p>The resident assessment protocols and care plans of resident #9 have been reviewed to assure all triggered items: cognition, communication, ADL function, urinary incontinence, psychosocial well-being, falls, and</p>	

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

PRINTED: 10/20/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185440	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/07/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER VILLAGE CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2990 FIGGS AVENUE ERLANGER, KY 41018
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	<p>Continued From page 2</p> <p>Review of the RAP Summary for these triggered areas revealed the facility failed to address the complications and risk factors that affected the facility's decision to proceed to care planning. These trigger areas were reviewed and addressed in a summary not individually, therefore the need for referrals or to proceed to POC was not addressed for all areas.</p> <p>3. Review of the RAPS, signed 07/16/10, for Resident #10 revealed the resident triggered for additional review of Delirium, Cognition, Communication, ADL Function, Urinary Incontinence, Mood, Behavior, Falls, Nutrition, Pressure Ulcers and Psychotropic drug use.</p> <p>Review of the RAP keys for these triggered areas revealed the facility failed to address the need for referrals/further evaluation by appropriated health professionals. In addition, these RAP keys did not address the complications and risk factors that affected the facility's decision to proceed to plan of care (POC).</p> <p>4. Review of the RAPS, signed 08/12/10, for Resident #16 revealed the resident triggered for additional review of Delirium, Cognition, Visual, Communication, ADL Function, Urinary Incontinence, Mood, Behavior, Falls, Dehydration/Fluid Maintenance, Pressure Ulcers and Psychotropic drug use.</p> <p>Review of the RAP keys for these trigger areas revealed the facility failed to address the need for referrals/further evaluation by appropriated health professionals. In addition, these RAP keys did not address the complications and risk factors that affected the facility's decision to proceed to plan of care (POC).</p>	F 272	<p>pressure ulcers, have been addressed in the care plan and include the problem, risk factors, and the need for referrals or further evaluation as indicated. Completed 10-11-2010.</p> <p>The resident assessment protocols and care plans of resident #10 have been reviewed to assure all triggered items: delirium, cognition, communication, ADL function, urinary continence, mood state, behaviors, falls, nutrition, pressure ulcers and psychotropic drug use, have been addressed in the care plan and include the problem, risk factors, and the need for referrals or further evaluation as indicated. Completed 10-11-2010.</p> <p>The resident assessment protocols and care plans of resident #11 have been reviewed to assure all triggered items: cognition, communication, ADL function, urinary incontinence, mood state, behaviors, falls, activities, nutrition, pressure ulcers, psychotropic drug use, and physical restraints, have been addressed in the care plan and include the problem, risk factors, and the need for referrals or further revaluation as indicated.</p> <p>Resident #11's restraint care plan has been reviewed to assure risk factors and possible complications are included. Completed 10-11-2010.</p>	

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

PRINTED: 10/20/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185440	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/07/2010
NAME OF PROVIDER OR SUPPLIER VILLAGE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2990 RIGGS AVENUE ERLANGER, KY 41018		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 272	<p>Continued From page 3</p> <p>5. Review of the RAPS, signed 11/10/09, for Resident #5 revealed the resident triggered for additional review for ADL Function, Psychosocial well-being, Falls, Nutrition, Dehydration, and Psychotropic drug use.</p> <p>Review of the RAP keys for the triggered areas revealed the facility failed to address the need for referrals/further evaluation by appropriated health professionals. The RAP keys discussed the resident's cardiac diagnoses Coronary Artery Disease, Atrial Fibrillation, Congestive Heart Failure, and placement of a Defibrillator. However, the RAPS did not address when or how complications and risk factors related to these diagnoses would be referred for additional evaluation or treatment should complications arise.</p> <p>6. Review of the RAPS, signed 08/02/10, for Resident #11 revealed the resident triggered for additional review of Cognition, Communication, ADL Function, Urinary Incontinence, Mood State, Behaviors, Falls, Activities, Nutrition, Pressure Ulcers, Psychotropic drug use, and Physical Restraints.</p> <p>Review of the RAP keys for these triggered areas revealed the facility failed to address the need for referrals/further evaluation by appropriated health professionals. In addition, the RAP key for restraints did not address the complications and risk factors that affected the facility's decision to proceed to care planning.</p> <p>7. Review of the RAPS, signed 04/13/10, for Resident #13 revealed the resident triggered for additional review of Cognition, Communication, ADL Function, Urinary Incontinence, Mood State,</p>	F 272	<p>The resident assessment protocols and care plans for resident #13 have been reviewed to assure all triggered items: cognition, communication, ADL function, urinary incontinence, mood state, falls, nutrition, pressure ulcers, psychotropic drug use, have been addressed in the care plan and include the problem, risk factors, and the need for referrals or further evaluation as indicated.</p> <p>Resident #13's care plans for cognition and communication have been reviewed to assure they include possible causative factors and risk factors. Completed 10-11-2010.</p> <p>The resident assessment protocols and care plans of resident #16 have been reviewed to assure all triggered items: delirium, cognition, visual function, communication, ADL function, urinary incontinence, mood state behaviors, falls, dehydration / fluid maintenance, pressure ulcers psychotropic drug use, have been addressed in the care plan and include the problem, risk factors, and the need for referrals or further evaluation as indicated. Completed 10-11-2010.</p> <p>The care plans of residents #2, 5, 9, 10, 11, 13 and 16 were reviewed on 10-8-2010 to assure they are appropriate and individualized to address risk factors related to diagnosis and approaches are</p>		

F272

present to address complications should they arise.

For those residents not included in the survey sample their assessment protocols and care plans were reviewed on 10-11-2010 and 10-12-2010 by the three MDS nurses to assure all triggered items have been fully evaluated for identification of the problems, risk factors, and the need for referrals and further evaluation and appropriate, individualized care plans are in place.

All the MDS nurses were immediately in-serviced on 10-8-2010 by the DON, to include the four points, problem, risk factor, referrals and care plan decision to each individual RAP as opposed to summarizing all the RAP's at the close of the RAP summary documentation as had been done prior to 10-1-2010.

Criteria #3

Effective 10-1-2010 as comprehensive assessments are completed per the calendar, every individual RAP summary will include documentation to address the problem, risk factors, need for referrals or further evaluation and decision to proceed or not to proceed to the care plan. This date is correct because this is the date that the MDS 3.0 went into effect, as well as our new software that will integrate these areas into the MDS process.

Criteria #4

As a part of the ongoing quality assurance, monthly chart audits will be completed by the three MDS nurses and/or their designee, utilizing two charts on each unit. One chart will be a PPS required assessment, and one will be OMRA require assessment. The focus will be on the comprehensive assessment, individual RAP summaries,

pg 4a

to include the four points, problem, risk factors, need for referrals and care planning decision.

The results of this review process shall be included in the regular quality assurance process and meetings conducted on a quarterly basis.

Completion Date: Oct. 12, 2010

Persons responsible:

Cindy Dempsey, RNC, DON

Rita Cahill, LPN, ADON

Pat Feldhaus, RN, In-service, Education

Jenny Hodge, LPN, MDS Coordinator

pg
14b

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

PRINTED: 10/20/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185440	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/07/2010
NAME OF PROVIDER OR SUPPLIER VILLAGE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2990 RIGGS AVENUE ERLANGER, KY 41018		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 272	Continued From page 4 Falls, Nutrition, Pressure Ulcers and Psychotropic Drug use. Review of the RAP keys for these triggered areas revealed the facility failed to address the need for referrals/further evaluation by appropriate health professionals. In addition, the RAP key for communication and cognition did not address the causative factors or risk factors that affected the facility's decision to proceed with the plan of care. Interview, on 10/07/10 at 5:05 PM, with Licensed Practical Nurse (LPN)/Minimum Data Set Nurse #4 on 10/07/10 at 5:05 PM, revealed she was still learning the process and didn't realize the need for referrals was to be addressed. She further stated she thought she had addressed the risk factors, but she had not. Interview with the LPN/MDS Nurse #5 on 10/07/10 at 5:05 PM, revealed she writes one summary for all triggered areas. She further stated she did not know she had to address each area for referrals and risk factors.	F 272	F 272 Continue on Attached Pages.		
F 371 SS=E	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	F 371		Preparation or execution of This plan of correction does not constitute admission or agreement to any alleged deficiencies cited in this document. This plan of correction is prepared and executed, as required by the provision of federal and state law.	

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

PRINTED: 10/20/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185440	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/07/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER VILLAGE CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2990 RIGGS AVENUE ERLANGER, KY 41018
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 371	<p>Continued From page 5</p> <p>by: Based on observation, interview, and record review it was determined the facility failed to store, prepare and distribute food in a sanitary manner.</p> <p>The findings include:</p> <p>1. Observation of the lunch meal on 10/05/10 revealed the dietary aide began serving the meal at 12:10 PM and completed the meal service at 12:25 PM. During the course of the meal service, the dietary aide touched the microwave oven, cupboards, and toaster. The dietary aide handled all bread served for the meal with his gloved hand. Further observation revealed the dietary aide did not change his gloves or wash his hand at anytime during the meal service.</p> <p>Interview, on 10/07/10 at 12:35 PM, with Dietary Aide #2 revealed he should have changed his gloves after having contact with anything other than the serving utensils.</p> <p>2. Observation of the lunch meal, on 10/06/10, revealed Dietary Aide #3 opened the cupboard, retrieved bowls and resumed serving residents without changing her gloves or washing her hands. Additional observations revealed the dietary aide served the sliced tomatoes and onions using her gloved hand.</p> <p>Interview, on 10/06/10 at 12:42 PM, with Dietary Aide #3 revealed she was to use tongs to serve the tomatoes and onions. In addition, the Dietary Aide stated she should have washed her hands and changed her gloves after touching the cupboards.</p>	F 371	<p>F 371 483.35(i) Food Procure, Store/Prepare/Serve-Sanitary SS=E</p> <p>The facility must- Procure food from sources approved or considered satisfactory by Federal, state or local authorities; and store, prepare, distribute and serve food under sanitary conditions.</p> <p>1. All dietary staff have been re-educated related to hand washing and glove use and the need to remove gloves and wash hands between serving food and handling other items while serving meals. This includes touching the microwave, toaster, or opening cabinet to retrieve necessary plates Tongs and other serving utensils may also be used to serve the food This inservice was completed on 10/25/2010 by Pat Feldhaus inservice education coordinator. This process will be monitored by Food Service Director with the assistance of the QA coordinator at least weekly on Quality improvement-Kitchen & Dining room checklist. See Exhibit # 1 attached. This includes monitoring food handling during tray pass to assure sanitary conditions are followed so that no resident is affected by lack of this process.</p>	
-------	---	-------	--	--

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

PRINTED: 10/20/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185440	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/07/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER VILLAGE CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2990 RIGGS AVENUE ERLANGER, KY 41018
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
F 371	<p>Continued From page 6</p> <p>3. Observation of the lunch meal, on 10/07/10, revealed State Registered Nurse Aide (SRNA) #1 pulled bread from the cabinet and placed two (2) pieces of bread into the toaster with his ungloved hand. Additional observation revealed SRNA #1 dropped the bag of bread onto the floor and asked Dietary Aide #2 to pick up the bag of bread. After clearing the steam table Dietary Aide #2 picked up the bag of bread from the floor and returned it to the cabinet, where there were two (2) other bags of bread.</p> <p>Interview, on 10/07/10 at 12:40 AM, with SRNA #1 revealed he had not put on gloves prior to putting the bread into the toaster. The SRNA stated he should have washed his hands and put on gloves prior to putting the bread into the toaster. In additional interview, SRNA #1 stated he should not have touched the bread with his hands. In further interview the SRNA stated he left the bread on the floor because it was contaminated. SRNA #1 was unaware the dietary aide had put the contaminated bread back into the cabinet.</p> <p>In interview, on 10/07/10 at 10:00 AM, the Dietary Manager stated staff were not to touch food with their hands. He stated they should use tongs. In additional interview, the Dietary Manager stated staff were to wash their hands and change their gloves anytime they touch anything other the utensils on the serving line.</p> <p>Review of the facility's policy related to food handling revealed staff were to use tongs when serving roles, pickles, etc. In addition the policy stated staff may be allowed to serve food with gloved hands only if the gloved hand has not come into contact with any other object before</p>	F 371	<p>This Monitoring will be reported Quarterly and as needed as part of the QA process.</p> <p>2 & 3. Nursing & Dietary staff have also been re-educated on using tongs or utensils to handle food and to not handle food with hands as well as not returning wrapped food items to the cabinet after dropping it on the floor. This inservice was completed 10/26/2010 by Matt Knollman Food Service Director. This process will be monitored by Food Service Director with the assistance of the QA coordinator using QA checklist (exhibit #1) at least weekly & reported as part of the Quarterly QA process.</p>	

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

PRINTED: 10/20/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185440	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/07/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER VILLAGE CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2990 RIGGS AVENUE ERLANGER, KY 41018
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	<p>Continued From page 7</p> <p>handling the food item. If the glove touched any object staff were to wash their hands and change gloves.</p> <p>4. Observation of the cabinets in the food service areas on three (3) of three (3) floors revealed the veneer was missing, with the pressed wood underneath exposed. On the first floor, the pressed wood had expanded and separated into several layers. The cabinets were used to store resident eating utensils.</p> <p>Interview, on 10/07/10 at 10:00 AM, with the Dietary Manager revealed the cabinets had been damaged due to the steam created by the dishwashers. He stated the exposed and separated layers created areas for bacteria to grow.</p> <p>Interview, on 10/07/10 at 12:15 PM, with the Maintenance Director revealed he was aware the cabinets were damaged. He explained he had discussed the issue with his supervisor but did not know of any plans to replace the cabinets. The Maintenance Director stated, "I won't know that they are being replaced until the cabinets arrive for me to install."</p> <p>5. Observation during the initial kitchen tour on 10/05/10 at 10:02 AM revealed eight (8) quarter size deep hotel pans stored wet.</p> <p>Interview on 10/05/10 at 10:05 AM, with dietary staff, revealed the pans should not be stored wet secondary to bacteria growth. He/she stated normally the pans were turned upside down to air dry before being stored.</p>	F 371	<p>4. Resident eating utensils have been removed from the drawers & rewashed due to veneer missing and pressed wood exposed. This was done 10/26/2010 by Food Service Director to assure no harm of bacteria to eating utensils. Maintenance is in the process of having these cabinets replaced.</p> <p>5. Dietary staff rewashed the pans And allowed them to air dry properly. All dietary staff were re-educated on the proper air drying process for pans. They are not to be stored wet as this allows bacteria to harbor and grow. No residents were affected due to pans not drying properly. This inservice was completed by Matt Knollman Food Service Director on 10/26/2010. This process will be monitored by the Food Service Director with the assistance of the QA coordinator at least weekly & reported as part of the Quarterly QA process.</p>	

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

PRINTED: 10/20/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185440	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/07/2010
NAME OF PROVIDER OR SUPPLIER VILLAGE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2990 RIGGS AVENUE ERLANGER, KY 41018	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
F 371	<p>Continued From page 8</p> <p>6. Observation during the initial kitchen tour on 10/05/10 at 10:10 AM revealed metal cups stored in the flour and sugar bins.</p> <p>Interview with the Dietary Manager on 10/05/10 at 10:16 AM revealed he had been told by the Health Department he could leave the cups in the flour and sugar bins as long as the handles were not touching the food.</p> <p>7. Observation during the initial kitchen tour on 10/05/10 at 10:12 AM revealed a meat slicer with meat particles on the slice catching surface and around the inside the blade area. The slicer had been stored this way underneath a plastic cover.</p> <p>Interview with the Dietary Manager on 10/05/10 at 10:16 AM revealed the particles appeared to be turkey and the slicer should be cleaned after each use, before being stored under the plastic covering.</p> <p>8. Observation during the initial kitchen tour on 10/05/10 at 10:14 AM revealed white cake mix in dry storage labeled opened 09/30/10. The container was wrapped with a plastic wrap that did not cover the opened portion of the original bag to prevent pests.</p> <p>Interview with the Dietary Manager on 10/05/10 at 10:16 AM revealed the cake mix should be wrapped better and it would not prevent pest as it was wrapped.</p> <p>9. Observation during the initial kitchen tour on 10/05/10 at 10:14 AM revealed two (2) bags of potato chips in dry storage, with approximately one quarter of the chips remaining in the bag. The chips were wrapped in plastic wrap and were</p>	F 371	<p>6. A storage container has been placed near the flour and sugar bins in which to store the metal cups used for measuring. Dietary staff were inserviced on 10/26/10 by Matt Knollman Food Service Director on placing cups in these container when not in use. This process will be monitored by the Food Service Director with the assistance of the QA coordinator at least weekly & reported as part of the Quarterly QA process.</p> <p>7. The meat slicer was cleaned immediately to eliminate any chance of bacteria and the Dietary staff were re-educated 10/26/10 by Matt Knollman on the proper cleaning procedures for the meat slicer after each use. This cleaning is to be completed before covering the slicer. This process will be monitored by the Food Service Director with the assistance of the QA coordinator at least weekly & reported as part of the Quarterly QA process.</p> <p>8, 9 & 10 All items not dated or wrapped properly were discarded. Dietary staff were re-educted on 10/26/2010 by Matt Knollman food service director on wrapping</p>	

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

PRINTED: 10/20/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185440	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/07/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER VILLAGE CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2990 RIGGS AVENUE ERLANGER, KY 41018
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
F 371	<p>Continued From page 9 not dated.</p> <p>Interview with the Dietary Manager on 10/05/10 at 10:16 AM revealed the potato chips should have been dated when they were opened.</p> <p>10. Observation on 10/05/10 at 10:20 AM revealed four (4) bags of gelatin mix in dry storage which had been opened and wrapped in plastic wrap, with no date labeled on them.</p> <p>Interview with the Dietary Manager on 10/05/10 at 10:20 AM revealed the gelatin should have been dated once it had been wrapped for storage.</p> <p>11. Observation on 10/05/10 at 10:22 AM revealed chocolate icing in the dry storage area dated 08/09/10 with approximately one quarter of the icing remaining in the container. Per manufacturer's guidelines, the icing could be kept open for one week at room temperature, after one week the icing should be stored in the refrigerator.</p> <p>Interview with Dietary Manager on 10/05/10 at 10:30 AM revealed he was unaware of the manufacturer's guidelines for use. He further indicates the date labeled on the icing was the date it was delivered, not the date it was opened. He stated it should have been dated with the opened date.</p> <p>12. Observation on 10/05/10 at 10:25 AM revealed one (1) quarter of a bag of elbow macaroni in dry storage wrapped in plastic wrap which had not been dated.</p> <p>Interview with Dietary Aide #6 on 10/05/10 at 10:25 AM revealed the macaroni should have</p>	F 371	<p>unused items such as cake mix, potato chips, macaroni and gelatin mix tightly in plastic wrap after use and dated this items with date opened before placing them back on the shelf in the stock room as to not allow pest & assure safety for residents. This process will be monitored by the Food Service Director with the assistance of the QA coordinator at least weekly & reported as part of the Quarterly QA process.</p> <p>11. Chocolate icing was discarded and Dietary staff re-educated on 10/26/10 by Matt Knollman Food Service Director on reading labels on container after opening to assure their method of storage. Any food product that is labeled by the manufacturer to be refrigerated after opening will be dated when opened and placed in the refrigerator after use. This process will be monitored by the Food Service Director with the assistance of the QA coordinator at least weekly & reported as part of the Quarterly QA process.</p> <p>12. Macaroni was discarded & Dietary staff were re-educated on 10/26/2010 by Matt Knollman on</p>	

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

PRINTED: 10/20/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185440	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/07/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER VILLAGE CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2990 RIGGS AVENUE ERLANGER, KY 41018
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
F 371	<p>Continued From page 10 been dated.</p> <p>13. Observation on 10/05/10 at 10:30 AM revealed two (2) pieces of ham approximately one (1) quarter pound each stored in the walk-in refrigerator wrapped in plastic wrap which had not been labeled or dated. Further observation revealed two (2) bags of parmesan cheese wrapped in plastic wrap approximately one (1) quarter pound each stored in the walk-in refrigerator. The cheese was not dated. A plastic food storage container in which melted butter had been stored in the walk-in refrigerator was also noted to be lacking a label and date.</p> <p>Interview with Cook #7 revealed the ham, parmesan cheese and butter should have been labeled and dated before being stored in the refrigerator.</p> <p>14. Observation of the trayline on the third floor during the lunch time meal service on 10/05/10 at 12:35 PM revealed nine (9) trays stored wet which were being passed out to residents.</p> <p>Interview with the Register Dietitian on 10/06/10 at 12:35 PM revealed the trays should not be stored wet secondary to the possible transmittal of bacteria.</p>	F 371	<p>wrapping unused macaroni tightly in plastic wrap after use and dated this items with date opened before placing them back on the shelf in the stock room. This process will be monitored by the Food Service Director with the assistance of the QA coordinator at least weekly & reported as part of the Quarterly QA process.</p> <p>13. The ham, parmesan cheese & melted butter were discarded. Dietary staff were re-educated on 10/26/10 by Matt Knollman on labeling and dating items before placing them in the walk in. This process will be monitored by the Food Service Director with the assistance of the QA coordinator at least weekly & reported as part of the Quarterly QA process.</p> <p>14. Trays were rewashed and allowed to air dry properly as to not harbor bacteria. No residents were effected by lack of this process. Dietary staff were re-educated on 10/26/10 on the proper air drying process for trays on the serving line. They are not to be stored wet as this allows bacteria to harbor and grow. This process will be monitored by the Food Service Director with the assistance of the QA coordinator at least weekly & reported as part of the Quarterly QA process.</p>	
F 441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>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.</p> <p>(a) Infection Control Program</p>	F 441	<p>All of the above items are included on Quality Improvement form Exhibit #1 See attached.</p> <p>Date of Completion: Oct. 29, 2010 Persons responsible: Matt Knollman Food Service Director, Rita Cahill LPN Director of Quality and Reporting & Tony Zubrowski, Administrator</p>	

Exhibit # 1

Quality Improvement
Review Form

Content Area: F 371 Sanitary Conditions Date: _____

Area of Review: Kitchen & Dining Room Evaluator: _____

Standard: The facility must Procure food from sources approved or considered satisfactory by Federal, State or local authorities and store, prepare and serve food under sanitary conditions.

Data Source: Direct observation

INDICATORS	1	2	3	4	5	6	7	8	9	10	Yes	No	% COMP
1. Hands washed prior to food prep													
2. Gloves worn if appropriate													
3. Gloves changed during process if needed													
4. Tongs used to handle food if appropriate													
5. Food items dropped on floor are not used													
6. Utensils are removed from cabinets in dining room until cabinet replaced													
7. pans are stored dry													
8. Meat slicer is clean before storing													
9. All open food items in dry storage area are wrapped appropriately													
10. All open food items are dated													
11. All open food items are stored in refrigerator if indicated.													
12. All open food items in refrigerator are dated													
13. Trays on serving line are stored dry													
14. Metal scoops stored in storage container													

Remarks : _____

**VILLAGE CARE CENTER
STAFF DEVELOPMENT REPORT**

F371
+ N 283

DATE 10/26/10 TIME STARTED 1:00pm

TIME ENDED 1:15pm

SUBJECT Sanitary Conditions INSTRUCTOR Matt Knollman

Brief outline of Subject Matter: Staff must wash hands prior to apply gloves and when removing them. Gloves must be changed after touching any other surface besides serving utensils. Serving Spoon or Tongs are to be used when handling any food items on the serving line. Do not return food items dropped on floor to storage for further use. Air dry pans - don't store wet. -

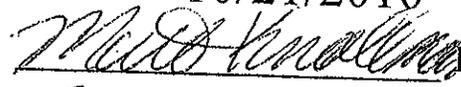
SIGNATURE	DEPT.	ON DUTY?	SIGNATURE	DEPT.	ON DUTY?
<i>Mphala M Baldick</i>	Dietary	yes			
<i>Cyrene Enoch</i>	Dietary	yes			
<i>Mike Postle</i>	Diet	yes			
<i>Julie Washburn</i>	Dietary	yes			
<i>Phil Wal-</i>	"	"			
<i>Jean Stevens</i>	Dietary	yes			
<i>J. W. W.</i>	Dietary	yes			
<i>C. Spurr</i>	Dietary	yes			
<i>Carolyn Henderson</i>	Dietary	yes			
<i>Amita McRay</i>	Dietary	yes			
<i>Bronckley New</i>	Dietary	yes			
<i>Debbie Wells</i>	Dietary	yes			
<i>Matt Knollman</i>	Dietary	yes			

- Storage of cups in flour + sugar bins.
- all equipment must be cleaned before storing.
- store all dry cooking supplies completely covered.
- all open food items must be dated + wrapped
- assure directions are followed for food storage once open (refrigerate if needed)

Dietary
Policy & Procedure Manual

Updated and Revised

10/21/2010


_____ Food Service Director


_____ Administrator

Dietary Glove Use #17
Tongs #8

Policy:

Food items shall be prepared to conserve maximum nutritive value, develop and enhance flavor and be free of injurious organisms and substances.

Procedure:

1. The kitchen shall be maintained in a neat and orderly condition.
2. The kitchen and equipment shall be clean.
3. Food items are received, checked and stored properly as soon as they are delivered.
4. The food is kept refrigerated except when being handled.
 - Food is covered for storage
 - Food is cooked as soon as possible after defrosting.
5. Raw, unprocessed fruits and vegetables are to be thoroughly washed under running water before use.
6. Food coming from broken packages or swollen cans, or food with abnormal appearance or odor will not be served.
7. Food will be prepared and served with clean tongs, scoops, forks, spoons, spatulas or other suitable implements so as to avoid manual contact with prepared foods.
8. Utensils, cups, glasses, and dishes will be handled in such a way as to avoid touching surfaces with which food or drink will come in contact. Use tongs when serving rolls, pickles, etc.; plate cakes and pie with a spatula.
9. Individual portions of food, once served, will not be served again.
10. Prepared food will be transported to other areas in covered containers
11. Single-service articles will be discarded after one use.
12. Silverware is stored in such a manner as to encourage contact with handles only.
13. All meats and stuffings are to be heated thoroughly to a minimum temperature of 165 degrees F, poultry 185 degrees F. (Use meat thermometer.) Dressing should be baked in separate pans.
14. All meat salads, poultry salads, potato salads, egg salads, cream filled pastries and other potentially hazardous foods shall be prepared from chilled products and refrigerated below 40 degrees F IMMEDIATELY after preparation.

15. No raw eggs are to be served. Eggs must be cooked before serving.
16. Leftovers must be dated, labeled, covered, cooled and stored (within ½ hour of preparation) in a refrigerator, not at room temperature. All drinks, packaged or pitched that have been opened for usage (or uncovered in the case of pitchers) (or poured into secondary containers if the package is from the supplier) the container shall be named and dated to show what the contents are and when the product was opened.
17. Fingers are to be kept out of food. Tasting must be done with a tasting spoon. Follow proper tasting procedures. Remove food with serving spoon and transfer to tasting spoon. Always use clean spoons for each test.
18. Any item or food that is dropped on the floor must be discarded if it cannot be properly sanitized.
19. A gloved hand may be allowable for serving only if the gloved hand has not come into contact with any other object before handling the food item. If gloved hand touches any object, change gloves. Remember to wash hands before applying new gloves.
20. Wash all tops of canned foods before opening. Wash and sanitize can opener daily. (See "Cleaning Instructions.")
21. Foods that have stood for several hours at room temperature cannot be considered safe and free from contamination and cannot be made so by refrigeration, especially during the summer seasons. They must be discarded.
22. Separate cutting boards for raw and uncooked food and for raw fruits and vegetables are necessary.
 - Prepared foods should not be cut on the same boards as raw foods.
 - Cutting boards should be of hard rubber construction rather than wood and must be dishwasher safe.
23. Plasticware or china that has lost its glaze or is chipped or cracked must be disposed of. Breaking it will prevent further accidental use.
24. Disposable containers and utensils should be discarded after one use. Only dishwasher safe containers may be reused. Plastic buckets/tubs may not be used for storage or leftovers. (ex. Cottage cheese, margarine, salad dressing containers.)
25. All food grinders, choppers, mixers, etc., should be cleaned, sanitized, dried and reassembled after each use.

26. All meats are defrosted in the refrigerator to a temperature no higher than 45 degrees F.

SUBJECT: Nursing Services

page 1 of 2

TOPIC: Hand washing

Hand washing is the single most important procedure for preventing nosocomial infections.

Hand washing with antimicrobial containing products kills or inhibits the growth of microorganisms.

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

HAND WASHING INDICATIONS:

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

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

HAND WASHING INDICATIONS (Cont.):

page 2, of 2

10. After using bathroom.
11. Before and after lunch.
12. Prior to feeding.
13. Prior to passing ice.
14. When in doubt, wash your hands.

SUBJECT: Dietary

TOPIC: General Handwashing Procedure

Key Procedural Points:

1. Handwashing is the single most important means of preventing the spread of infections.
2. If your hands accidentally touch the inside of the sink, or any other article, during the handwashing procedure, you must start over. Complete the entire procedure again.
3. Use liquid soap from a dispenser, also be sure that paper towels are available at the sink before starting to wash hands.
4. Hand lotion will aid in keeping your skin soft.
5. Moisture barrier is available if needed.
6. Antiseptic solutions are more irritating to the skin than soap and water.
7. Rings harbor bacteria and are difficult to clean. It is recommended that all jewelry be removed before handwashing procedures are implemented.
8. Use an adequate amount of soap to produce lots of lather.
9. Rinse your hands from the clean to the dirty parts. Rinse with running water from two to three inches above the wrists. Hold your hands down so that the water will run downward to the fingertips and prevent backflow over unwashed skin.

KEY PROCEDURAL POINTS (Cont.):

10. Regulate the temperature of the water so that it is comfortable to you.
(Note: Cool or lukewarm water has a less drying effect on the skin).
11. Keep water on your hands so that the soap will not become too dry.
12. Thoroughly rinse the soap from your hands and wrists. Soap left on your skin will cause it to dry and become irritated.

STEPS IN THE PROCEDURE:

1. Stand away from the sink to prevent cross-contamination of your clothing.
2. Regulate the flow of water. Avoid splashing water.
3. Put your hands and wrists under the running water. Allow water to flow gently. Keep your fingertips pointed downward.
4. Once your hands and wrists are completely wet, apply soap or antiseptic solution.
5. Bring hands together and create a heavy lather. Wash at least two to three inches above the wrists. Get soap under your finger nails and between your fingers.
6. Rinse hands well under running water. Hold hands down so that the direction of the water flow is from the wrist to your fingertips.
7. Pat hands dry with a clean paper towel.
8. Turn off water with the paper towel. Discard the paper towel into the wastepaper receptacle.
9. Apply hand lotion as necessary or as needed.

PURCHASING RECEIVING AND STORAGE

Procedures:

1. The food service director will purchase food and supplies:
 - a. from vendors approved by administration.
 - b. from vendors approved by local health agencies, Only government inspected.
 - c. based on current census.
 - d. inventory will be maintained at appropriate levels required by the state requirement and based on the current approved menus.

2. The food service director/cook/cooks helpers may sign for food and supplies received.
 - a. All items indicated on the invoice will be verified as delivered before invoices are signed.
 - b. All invoices will be kept in a designated area of the department.
 - c. Invoices will be turned in to the business office daily/weekly.

3. Food will be stored promptly after receipt by the employee(s) designated by the food service director.
 - a. All perishable foods will be stored at proper temperatures refrigerated, 45 degrees or below; frozen, 0 degrees or below; properly functioning thermometers will be visible in each separate cold storage unit. No food is to be stored on the floor of the walk-in refrigerator or freezer.
 - b. Staple and frozen foods will be stored with new product to the back so that the older product will be used first (FIFO first in/first out).
 - c. Dry food supplies will be stored at least six inches above the floor in a clean, dry, and ventilated room that is not subject to waste-water backflow. Temperature is to be maintained at 50 to 70 degrees.
 - d. Lighting, ventilation, and humidity will be controlled to prevent condensation of moisture and growth of molds.
 - e. All non-food supplies will be stored in separate areas from food; all supplies will be clearly labeled.
 - f. All food will be stored in areas protected from contamination by condensation, leakage, drainage, rodents, or vermin. Pest control Procedures will be followed.

3.
 - g. After opening dry food items the remaining product will be wrapped securely with plastic wrap or placed in an airtight container and labeled and dated with the date opened.
 - h. Any food product that is labeled by the manufacturer to be refrigerated After opening will be dated when opened and placed in refrigerator after use.

Policy revised 10/14/2010

Approved by:  Food Service Director

 Administrator

Sanitization can occur by means of application of heat or concentration of chemicals for enough time to reduce the bacterial count on surfaces of equipment and utensils. Common methods of sanitizing are:

1. mechanical dish machine at 180° F (66° C) at 15-25 psi pressure.
2. immersion for at least one-half (1/2) minute in clean hot water of at least 170° F (77° C).
3. immersion for at least one (1) minute in a clean solution containing at least 50 ppm of available chlorine at a temperature of at least 75° F (24° C).
4. immersion in any other chemical sanitizer approved by the State Board of Health at a strength and for a period as stated on the product's officially approved label.
5. mechanical dishwasher using a chemical sanitizer which is automatically dispensed into the final rinse according to the manufacturer's specification at a temperature specified by the manufacturer.

Once utensils and equipment have been cleaned and sanitized, they should be allowed to air dry; the use of towels may re-contaminate sanitized surfaces.

Once equipment and utensils have been sanitized, they should be handled and stored to protect the equipment and utensils from re-contamination.

When chlorine bleach is to be used as a chemical sanitizer, one (1) tablespoon of a product which contains 5 1/4% of available chlorine added to one (1) gallon of water at least 70° F (24° C) will provide a solution of 100 ppm of available chlorine.

Cleaning Meat Slicers

Policy:

Meat slicer will be maintained in clean, sanitized condition.

Procedure:

1. Clean after each use.
2. Unplug from electrical outlet before beginning to clean.
3. Remove blade guard, blades, and other removable pieces. Wash in warm detergent water. Rinse in clean hot water to which a sanitizer has been added and air dry. Replace immediately.
4. Wipe the slicer blade and base with a sudsy cloth, wipe with clean cloth, then with sanitizer, and wipe dry with a dry cloth.
5. Replace all parts including blade guard.

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

PRINTED: 10/20/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185440	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/07/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER VILLAGE CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2990 RIGGS AVENUE ERLANGER, KY 41018
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
F 441	<p>Continued From page 11</p> <p>The facility must establish an Infection Control Program under which it -</p> <p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(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 and interview it was determined the facility failed to maintain an infection control program to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection, as evidenced by: 1) During the medication pass staff did not wash her hands</p>	F 441		

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

PRINTED: 10/20/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185440	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/07/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER VILLAGE CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2990 RIGGS AVENUE ERLANGER, KY 41018
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 441	<p>Continued From page 12</p> <p>between placing hearing aids into a resident's ears and administering eye drops. 2) Observation during the meal service revealed staff did not sanitize their hands after touching her hair and face and before assisting residents with eating. 3) Observations revealed Resident #8's catheter tubing was dragging on the floor.</p> <p>The findings include:</p> <p>1. Observation of the medication pass on 10/06/10 at 8:30 AM, revealed Licensed Practical Nurse (LPN) #6 to enter a resident's room, wash her hands and apply gloves. She then put the resident's hearing aids in both ears, then she removed her gloves, but did not wash her hands before applying a new pair of gloves and administering eye drops to each eye. After administering the eye drops, she did remove her gloves and washed her hands before leaving the room.</p> <p>During interview with LPN #6 on 10/06/10 at 9:30 AM, she stated she thought she had washed her hands, "but I was so nervous I guess I forgot". She continued with you should always wash your hands when you remove gloves before you apply new gloves, for infection control.</p> <p>2. Observation during meal service on 10/05/10 at 12:40 PM revealed Certified Nursing Assistant (CNA) #2 touched her hair and forehead and proceeded to cut a resident's meat with the resident's knife and fork without sanitizing her hands. Further observation revealed the CNA also loaded a resident's fork with mashed potatoes and gave the fork to the resident and still had not sanitized her hands.</p>	F 441	<p>Preparation or execution of This plan of correction does not constitute admission or agreement to any alleged deficiencies cited in this document. This plan of correction is prepared and executed, as required by the provision of federal and state law.</p> <p>F 441 483.65 Infection Control Prevent spread, linens SS=D The facility must establish and maintain an Infection Control Program designed to provide safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>1. All residents could be affected by the cited deficiency. All staff involved in medication pass were re-educated on 10/25/10 by Pat Feldhaus Inservice Education Coordinator on glove use and hand washing procedures after applying hearing aids and before instilling eye drops. This process will be monitored by the Inservice Education Coordinator and Pharmacist with each med pass and any problems noted will be addressed at the time</p>	
-------	--	-------	---	--

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

PRINTED: 10/20/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185440	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/07/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER VILLAGE CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2990 RIGGS AVENUE ERLANGER, KY 41018
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 441	<p>Continued From page 13</p> <p>Interview on 10/05/10 at 1:10 PM with CNA #2 revealed she was unaware that she touched her hair and forehead. She stated she should have used hand sanitizer after she touched herself and before she touched the residents' utensils.</p> <p>Interview on 10/07/10 at 9:30 AM with LPN #8, Second Floor Unit Manager, revealed the CNA should have sanitized her hands after she touched her hair and face.</p> <p>Interview on 10/07/10 at 3:50 PM with the Director of Nursing revealed the CNA should have washed her hands or used hand sanitizer before she touched the residents' utensils.</p> <p>3. Review of Resident #8's medical record revealed diagnoses which included Diabetes Mellitus, Alzheimer's Disease, Atherosclerotic cerebrovascular disease and urinary retention.</p> <p>Review of the October Treatment Administration Record (TAR) revealed Resident #8 received "Foley" (indwelling) catheter care each shift.</p> <p>Observation on 10/07/10 at 9:22 AM revealed Resident #8's catheter tubing was in contact with the floor in the main hallway as the resident was sitting in his/her wheelchair preparing for an activity which was to take place in the hallway in front of the nurse's station. The resident's catheter tubing was noted to lay on the floor during the activity for a total of thirty (30) minutes.</p> <p>Observation on 10/07/10 at 9:50 AM revealed Resident #8 using his/her wheel chair for transport down the hallway after the activity had ended with the catheter tubing noted to still be in contact with the floor.</p>	F 441	<p>they are found. This information will be logged on the med pass review sheet and reported as part of the Quarterly QA process.</p> <p>2. Staff were re-educated on 10/25/2010 by Pat Feldhaus Inservice Education Coordinator on hand washing prior to feeding resident and of the need to stop and wash their hands any time during feeding in which they touch their hair, face, chairs, residents, etc. Any problems noted during the feeding process will be addressed as found.</p> <p>3. Resident # 8 F/C bag was replaced and the tubing was placed in a catheter bag cover under W/C by unit manager when noted. Staff were re-educated on all catheter tubing being properly positioned so as not to touch, or drag on the floor on 10/25/10 by Pat Feldhaus Inservice Education coordinator. This education included keeping the F/C bag below the level of the bladder, but not touching the floor to help prevent urine backflow/UTI's. No resident has been affected by this lack in process as evidenced by review of all residents with F/C, previous or current UTI's, & further review of the tracking & trending that occur monthly.</p>	<p><i>Exhibit #2</i></p>
-------	--	-------	---	--------------------------

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

PRINTED: 10/20/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185440	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/07/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER VILLAGE CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2090 RIGGS AVENUE ERLANGER, KY 41018
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 441	Continued From page 14 Interview with Unit Manager #7 on 10/07/10 at 9:55 AM revealed Resident #8's catheter tubing should not be in contact with the floor secondary to bacteria and germs.	F 441	<p>The Unit Managers are a part of the QA committee and make rounds on the Units frequently throughout each day. They are observing handwashing, F/C bag positioning and meal observation as do other staff members on the unit. Any problems in these areas are addressed As identified and staff re-educated at the Time noted. Unit managers will monitor F/C tubing positioning & report on this at Stand-up morning meeting as well as bring reports for any patterns found on their units from the above findings to the weekly risk meeting and will also report on these as part of the Quarterly QA meetings.</p> <p>Date of Completion: Oct 26, 2010 Persons responsible: Rita Cahill LPN Director of Quality and Reporting, Pat Feldhaus RN Inservice Education, Consulting Pharmacist, Unit Managers, & Tony Zubrowski, Administrator</p>	<p><i>exhibit 3</i> <i>+ exhibit #4</i></p>
-------	---	-------	---	---

Stand up Report

Exhibit 3

Unit: _____

Date: _____

New Admits/Readmits

Room	Name	Room	Name

Discharge

Room	Name	D/C to	Reason

Incidents

Room	Name	Fall	Other

Behavior Issues

Room	Name	Brief Description

Sick

Room	Name	Brief Description

Nutrition	
Hydration	
BM	

F/C	Bag/Tubing off Floor	F/C	Bag/Tubing off Floor
103-2	Yes or No		Yes or No
102-1	Yes or No		Yes or No
103-5	Yes or No		Yes or No

Exhibit #4

Staff Education for Peri Care

Employee: _____

Time: _____

Observation of Technique:

- | | | | | |
|----|---|-----|----|-----|
| 1. | Appropriate Hand washing | Yes | No | |
| 2. | Gloves Used | Yes | No | |
| 3. | Proper Technique observed for Peri care | Yes | No | |
| 4. | Briefs if used disposed of properly | Yes | No | N/A |
| 5. | Soiled Linen handled properly | Yes | No | |

Signature of observer: _____

Date: _____

Form initiated June 2010

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

PRINTED: 10/19/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185440	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/07/2010
--	--	---	--

NAME OF PROVIDER OR SUPPLIER VILLAGE CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2990 RIGGS AVENUE ERLANGER, KY 41018
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

<p>K 000</p> <p>K 050 SS=E</p>	<p>INITIAL COMMENTS</p> <p>A Life Safety Code survey was initiated and concluded on 10/07/2010. The facility was found to not meet the minimal requirements with 42 Code of the Federal Regulations, Part 483.70. The highest scope and severity deficiency identified was an "F".</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a code announcement may be used instead of audible alarms. 19.7.1.2</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review it was determined the facility failed to ensure fire drills were held under various conditions. The deficiency affects all residents and staff.</p> <p>The findings include:</p> <p>Record review on 10/07/2010 at 1:53 PM, revealed fire drills conducted on 11/30/2009, 05/27/2010, and 08/23/2010 for 2nd shift were all conducted at 2:30 PM. Fire drills must be conducted to address various conditions at the facility. The observation was confirmed with the Maintenance Director.</p> <p>Interview on 10/07/2010 at 1:53 PM, with the</p>	<p>K 000</p> <p>K 050</p>	<p>Preparation or execution of This plan of correction does not constitute admission or agreement to any alleged deficiencies cited in this document. This plan of correction is prepared and executed, as required by the provision of federal and state law.</p> <p>K 050 NFPA 101 Life Safety Code Standard SS=F</p> <p>This facility has a policy in place for conducting quarterly fire drills on each shift. Although the drills were conducted at the same time on 11/30/2009, 5/27/2010 and 8/23/2010, they were on different units of the nursing home. We have re-educated staff on this policy and will be conducting fire drills at various times on the shifts quarterly. The safety committee will monitor the times of these fire drills.</p> <p>Date of Completion: Oct. 26, 2010 Persons responsible: Rodney Kannady, Executive Director of Maintenance, Brian Blair, Safety Committee Chairperson, Tony Zubrowski, Administrator</p>	
------------------------------------	---	---------------------------	--	--

RECEIVED
NOV - 1 2010

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE ADMINISTRATOR	(X6) DATE 10/28/10
---	----------------------------	---------------------------

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.

Preparation or execution of
This plan of correction does not
constitute admission or
agreement to any alleged
deficiencies cited in this
document. This plan of
correction is prepared and
executed, as required by the
provision of federal and state
law.

K 050 NFPA 101 Life Safety
Code Standard
SS=F

This facility has a policy in
place for conducting quarterly
fire drills on each shift on
different units of the nursing
home. We have re-educated
staff on this policy and will
be conducting fire drills
at various times on the shifts
quarterly. The safety committee
will monitor the times of these
fire drills.

Date of Completion: Oct. 27, 2010
Persons responsible: Rodney
Kannady, Executive Director of
Maintenance, Brian Blair, Safety
Committee Chairperson, Tony
Zubrowski, Administrator

Village Care Center
Fire Drills

Regulation:

K 050

NFPA 101 Life Safety Code Standard

Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9PM and 6AM a coded announcement may be used instead of audible alarms.

Policy:

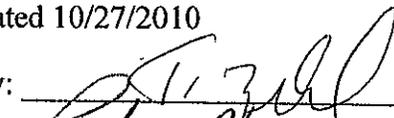
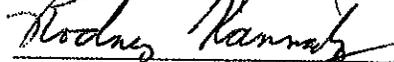
It is the policy of this facility that there will be a fire drill on each shift every quarter and at various times through out the shift. Results of fire drill are documented on fire drill log and forwarded to Maintenance.

Procedure:

1. When the fire alarm sounds, an overhead page (pressing 01 & overhead page button on phone) is made for "Code Red" and the location, from a staff member on the 1st floor. The location is found on the fire panel box in the hall between the nurse's station and the nourishment/med room.
2. Residents are to be removed from the hall and placed in secure rooms with doors closed.
3. One staff member from each unit is to procedure to fire location with a fire extinguisher.
4. Remaining staff on unit are to monitor the residents to assure they are in a safe location and to also monitor the exit doors as the security on the doors releases any time the fire alarm is activated. Staff should actually press on door to assure it does open at this time.
5. Someone on each unit should call the 1st floor to let staff know that their unit is secure once everyone is in a safe place. Confirm the resident count against the Daily Census Report to insure that all residents are accounted for.
6. Once the fire drill is complete. An announcement of "Code Red All Clear", will be made and staff may then help residents back to the areas they prefer to be in.
7. Staff member in charge of fire drill will log on Fire Drill log sheet the time of the drill, date and staff members who monitored and checked the exit doors and then forward this sheet to maintenance.
8. Staff member in charge will debrief staff after the drill explaining which aspects of the drill were handled correctly & which areas need improvement educate on areas needing improvement.

Policy updated 10/27/2010

Approved by: _____

Administrator

Maintenance Director

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

PRINTED: 10/19/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185440	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 10/07/2010
NAME OF PROVIDER OR SUPPLIER VILLAGE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2990 RIGGS AVENUE ERLANGER, KY 41018		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE	
K 050	Continued From page 1 Maintenance Director, revealed the fire drills were conducted at 2:30 PM so maintenance staff could get them completed, before they left for the night. Reference: NFPA 101 (2000 edition) 19.7.1.2* Fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. Exception: Infirm or bedridden patients shall not be required to be moved during drills to safe areas or to the exterior of the building	K 050			
K 061 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1 This STANDARD is not met as evidenced by:	K 061	Preparation or execution of This plan of correction does not constitute admission or agreement to any alleged deficiencies cited in this document. This plan of correction is prepared and executed, as required by the provision of federal and state law.		

Preparation or execution of
This plan of correction does not
constitute admission or
agreement to any alleged
deficiencies cited in this
document. This plan of
correction is prepared and
executed, as required by the
provision of federal and state
law.

K 061 NFPA 101 Life Safety
Code Standard
SS=F

Required automatic sprinkler
systems have valves supervised so
that at least a local alarm will
sound when the valves are
closed. Post indicator valve
had a tamper switch installed by
Alpha Fire Protection on Oct. 27,
2010 and this valve was wired to the
fire alarm system by Rescomm
Security on 10/29/2010.

This system will be monitored
through our Fire alarm system
and testing will be completed by
Alpha Fire Protection during the
Sprinkler inspections.

Date of Completion: Oct. 29, 2010
Persons responsible: Rodney
Kannady, Executive Director of
Maintenance, Tony
Zubrowski, Administrator

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

PRINTED: 10/19/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185440	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 10/07/2010
NAME OF PROVIDER OR SUPPLIER VILLAGE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2990 RIGGS AVENUE ERLANGER, KY 41018		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE	
K 061	<p>Continued From page 2</p> <p>Based on observation and interview, it was determined the facility failed to maintain the sprinkler system, according to NFPA standards. This deficiency affects all residents and staff.</p> <p>The findings include:</p> <p>Observation on 10/07/2010 at 2:31 PM, revealed that the post indicator valve was not electronically supervised. The post indicator valve supplies outside water to the sprinkler system. The post indicator valve must be electronically supervised to prevent the post indicator valve from being mistakenly turned off and shutting off the outside supply of water to the Sprinkler System. The observation was confirmed with the Maintenance Director.</p> <p>Interview on 10/07/2010 at 2:31 PM, with the maintenance Director revealed that he was unaware of the post indicator valve not meeting code until the Life Safety Code survey.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>9.7.2.1* Supervisory Signals. Where supervised automatic sprinkler systems are required by another section of this Code, supervisory attachments shall be installed and monitored for integrity in accordance with NFPA 72, National Fire Alarm Code, and a distinctive supervisory signal shall be provided to indicate a condition that would impair the satisfactory operation of the sprinkler system. Monitoring shall include, but shall not be limited to, monitoring of control valves, fire pump power supplies and running conditions, water tank levels and temperatures, tank pressure, and air pressure on</p>	K 061	<p>K 061 NFPA 101 Life Safety Code Standard SS=F</p> <p>Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. Post indicator valve had a tamper switch installed by Alpha Fire Protection on Oct. 27, 2010 and this valve was wired to the fire alarm system by Rescomm Security on 10/29/2010.</p> <p>This system will be monitored through our Fire alarm system and testing will be completed by Alpha Fire Protection during the Sprinkler inspections.</p> <p>Date of Completion: Oct. 29, 2010 Persons responsible: Rodney Kannady, Executive Director of Maintenance, Tony Zubrowski, Administrator</p>		

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

PRINTED: 10/19/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185440	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 10/07/2010
NAME OF PROVIDER OR SUPPLIER VILLAGE CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2990 RIGGS AVENUE ERLANGER, KY 41018		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 061 K 070 SS=D	<p>Continued From page 3 dry-pipe valves. Supervisory signals shall sound and shall be displayed either at a location within the protected building that is constantly attended by qualified personnel or at an approved, remotely located receiving facility.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure, portable space heaters used in the facility were according to NFPA standards. This deficiency affects all staff in the basement area offices.</p> <p>The findings include: Observation on 10/07/2010 at 12:03 PM, revealed that an unapproved space heater was being used in the Social Services Office. Unapproved heaters cannot be used in health care facilities due to increased risk of fire. The observation was confirmed with the Maintenance Director.</p> <p>Interview on 10/07/2010 at 12:03 PM, with the Maintenance Director, revealed the facility could not produce any documentation that the heater was approved for use in health care facilities.</p> <p>Reference: NFPA 101 (2000 edition) 19.7.8 Portable Space-Heating Devices. Portable space-heating</p>	K 061 K 070	<p>Preparation or execution of This plan of correction does not constitute admission or agreement to any alleged deficiencies cited in this document. This plan of correction is prepared and executed, as required by the provision of federal and state law.</p> <p>K 070 NFPA 101 Life Safety Code Standard SS=D Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee area where the heating elements of such device do not exceed 212 degrees F. After investigation by Executive Director of Maintenance, of portable heating units on the market, it was determined than the heating elements were higher than the 212 degree F permitted, so no portable heating units will be permitted in this facility at this time.</p> <p>Date of Completion: Oct. 26, 2010 Persons responsible: Rodney Kannady, Executive Director of Maintenance, Tony Zubrowski, Administrator</p>	

Village Care Center
Policy for Portable Heating Units

Policy:

In accordance with K070 & NFPA 101 Life Safety Code Standards, Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping employee areas where the heating elements of such devices do not exceed 212 degrees F. After investigation by Executive Director of Maintenance, of portable heating units on the market, it was determined that the heating elements were higher than the 212 degree F permitted, so no portable heating units will be permitted in this facility at this time.

Policy initiated 10/26/2010

Approved by: Tony Zule 10/26/10
Administrator Date
Rodney Hannaf 10/26/10
Executive Director of Maintenance Date

Attention Staff

In accordance with K070 & NFPA 101 Life Safety Code Standards, Portable space heating devices are prohibited in all health care occupancies.

Please do not bring them in and if you have one here, it must be removed from the facility Immediately.

Thanks
Maintenance Department

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

PRINTED: 10/19/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185440	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/07/2010
NAME OF PROVIDER OR SUPPLIER VILLAGE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2990 RIGGS AVENUE ERLANGER, KY 41018	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 070	Continued From page 4 devices shall be prohibited in all health care occupancies. Exception: Portable space-heating devices shall be permitted to be used in nonsleeping staff and employee areas where the heating elements of such devices do not exceed 212°F (100°C). NFPA 101 LIFE SAFETY CODE STANDARD	K 070	Preparation or execution of This plan of correction does not constitute admission or agreement to any alleged deficiencies cited in this document. This plan of correction is prepared and executed, as required by the provision of federal and state law.	
K 073 SS=F	No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure decorations used inside the facility were nonflammable. This deficiency affects approximately (28) residents. The findings include: Observation on 10/07/2010 between 10:31 AM and 11:20 AM, revealed resident room doors (320, 305, 307, 308, 205, 207, 209, 210, 101, 102, 103, and 105) had wreath decorations on the doors. The observation was confirmed with the Maintenance Director. Decorations in health care facilities must be flame retardant to limit the spread of fire. Interview on 10/07/2010 at 10:31 AM, with the Maintenance Director, revealed the decorations were not treated with spray to make the decorations flame retardant. Reference: NFPA 101 (2000 edition) 19.7.5.4 Combustible decorations shall be	K 073	K 073 NFPA 101 Life Safety Code Standard SS=F Based on the survey findings of wreaths on doors in rooms 320, 305, 307, 308, 205, 207, 209, 210, 101, 102, 103 and 105 not being flame retardant, the Executive Director of Maintenance has purchased flame retardant spray. This spray will arrive by 11/4/2010 and all wreaths will be sprayed at that time. Activity Department will monitor the resident doors on a monthly basis for wreaths and document this on a QA monitoring log. This monitoring will become part of the quarterly QA process. Resident newsletter that goes out to residents and families monthly will contain an entry about	

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

PRINTED: 10/19/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185440	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/07/2010
NAME OF PROVIDER OR SUPPLIER VILLAGE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2990 RIGGS AVENUE ERLANGER, KY 41018	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
K 073	Continued From page 5 prohibited in any health care occupancy unless they are flame-retardant. Exception: Combustible decorations, such as photographs and paintings, in such limited quantities that a hazard of fire development or spread is not present.	K 073	wreaths being brought in for the residents to enjoy, must be flame retardant. Maintenance & Activity staff have been educated related to this issue. Date of Completion: Nov 4, 2010 Persons responsible: Rodney Kannady, Executive Director of Maintenance, Sue McVey Activity Director, Tony Zubrowski, Administrator	
K 144 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on interview and record review it was determined the facility failed to ensure the emergency generator was maintained according to NFPA standards. This deficiency affects all staff and residents. The findings include: Record review on 10/07/2010 at 2:09 PM, revealed the facility had not exercised the emergency generator underload for the months of January, May, and September 2010. The emergency generator must be exercised underload every month to ensure its reliability during a power outage. The observation was confirmed with the Maintenance Director.	K 144	Preparation or execution of This plan of correction does not constitute admission or agreement to any alleged deficiencies cited in this document. This plan of correction is prepared and executed, as required by the provision of federal and state law.	

Quality Improvement
Review Form

Content Area: K 073 & NFPA 101 Life Safety Code Date: _____

Area of Review: Wreaths on resident doors Evaluator: _____

Standard: No furnishings or decorations of highly flammable character are used.

Data Source: Direct observation of resident doors

Room # >																			
INDICATORS																			
1. Is wreath present on door																			
2. Was wreath there last month																			
3. If No was Maint/Act Dir notified?																			

Y=Yes N=No

Note: The following rooms have flame retardant treated wreaths:

101, 103, 105, 201, 205, 207, 209, 210, 305, 307, 308, 320

Remarks : _____

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

PRINTED: 10/19/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185440	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/07/2010
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VILLAGE CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2990 RIGGS AVENUE ERLANGER, KY 41018
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

K 144	<p>Continued From page 6 .</p> <p>Interview on 10/07/2010 at 2:09 PM, with the Maintenance Director, revealed that the emergency generator was exercised underload each month by his assistance.</p> <p>Interview on 10/07/2010 at 2: 15 PM, with the Assistant Maintenance Director, revealed that he was unsure how to document that the emergency generator had been exercised. He further stated he was not sure if the emergency generator had been exercised underload for the Months of January, May, or September.</p> <p>Reference: NFPA 110 (1999 edition) 6-4.1* Level 1 and Level 2 EPSSs, including all appurtenant components, shall be inspected weekly and shall be exercised under load at least monthly. Exception: If the generator set is used for standby power or for peak load shaving, such use shall be recorded and shall be permitted to be substituted for scheduled operations and testing of the generator set, provided the appropriate data are recorded.</p>	K 144	<p>K 144 NFPA 101 Life Safety Code Standard SS=E Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. The Executive Director of Maintenance will review all log books on a monthly basis to assure all policies are being followed related to checking generator weekly and exercising under load for 30 minutes per month. All maintenance department staff have been re-educated on logging of their monitoring of the generator load testing as the policy was in place, but not followed. This monitoring will be reported on Quarterly at the QA meeting by Maintenance designee.</p> <p>Date of Completion: Oct 26, 2010 Persons responsible: Rodney Kannady, Executive Director of Maintenance, Tony Zubrowski, Administrator</p>	
-------	---	-------	---	--

