

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

PRINTED: 05/16/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185447	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 05/16/2014
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NAME OF PROVIDER OR SUPPLIER VILLASPRING OF ERLANGER	STREET ADDRESS, CITY, STATE, ZIP CODE 630 VIOX DRIVE ERLANGER, KY 41018
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{F 000}	<p>INITIAL COMMENTS</p> <p>An offsite revisit survey was conducted 05/16/14. Based on the acceptable POC the facility was deemed to be in compliance on 05/07/14 as alleged.</p>	{F 000}		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	INITIAL COMMENTS	F 000	Without admitting or denying the validity or existence of the alleged deficiencies, Villaspring provides the following plan of correction:	
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's "Nursing Home Residents' Bill of Rights and Responsibilities", it was determined the facility failed to promote care for residents in a manner and environment that maintained or enhanced each resident's dignity and respect for three (3) of twenty-four (24) sampled residents (Residents #2, #4, #15) and two (2) unsampled residents (Unsampled Residents A & B). Observation during meal service revealed facility staff failed to serve all residents at a table, before serving another table leaving Resident #4, Resident #15, Unsampled Resident A and Unsampled Resident B sitting and watching their tablemates eat. Additionally, observation revealed Resident #2 received his/her tray at 1:05 PM, while his/her head was down and eyes were closed; and the tray sat in front of him/her untouched until 1:25 PM, twenty (20) minutes after the tray was served. The findings include:	F 241	THIS PLAN OF CORRECTION SERVES AS VILLASPRING OF ERLANGER'S CREDIBLE ALLEGATION OF SUBSTANTIAL COMPLIANCE AS OF <u>May 7, 2014</u> . F241: Villaspring provides and promotes care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. To ensure dignity and an enjoyable meal service, residents are seated according to a seating chart. These charts help guide meal service delivery and assure that each resident at any given table is served all together before moving on to the next table. Those that enter the DR first receive their meal first. Resident #4 and resident B receive their meals in a timely fashion in the dining room and eat at the same time with their tablemates. Resident A is no longer in the facility. Resident #15 is no longer in the facility. Resident #2 receives cueing to encourage self-feeding and/or assistance by a staff member to ensure intake.	

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MAY - 5 2014

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

[Signature]

TITLE

Administrator

(X6) DATE

6/5/14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 241	Continued From page 1 Review of the facility's, "Nursing Home Residents' Bill of Rights and Responsibilities", revised 12/09/13, revealed each resident should be treated with consideration, respect and in full recognition of his/her dignity and individuality. Further review of the resident rights revealed residents had a right to a dignified existence. 1. Observation of the first floor "rehab" dining room on 04/02/14 at 12:45 PM, revealed Resident #4 and Unsampld Resident A, to be sitting at a table with two (2) other residents who were eating their lunch. Resident #4 and Unsampld Resident A were observed without their trays. Continued observations revealed Resident #4 and Unsampld Resident A did not receive their trays until 1:00 PM. Additionally, observation revealed Unsampld Resident B was also sitting at another table with a resident and two (2) of that resident's family members. Observation revealed the other resident and his/her family members were eating their lunch while Unsampld Resident B sat looking around the dining room without his/her meal tray. Observation revealed Unsampld Resident B's tray was served at 12:57 PM, which the resident immediately began to consume the food on the tray. Further observation revealed the other resident and his/her family members finished their meal and left the table before Unsampld Resident B had eaten half of his/her lunch. Interview with SRNA #6 on 04/02/14 at 1:40 PM, revealed she just tried to get the trays served. She stated she should have requested the resident's tray before she served another table. SRNA #6 stated when residents were watching tablemates eat their meal it was a dignity issue.	F 241	Each facility resident was observed by Management staff, the Administrator, Nursing leadership and the Facility Department Head team, to assure dignity and respect was maintained and/or enhanced in their environment including but not limited to dining room service by 5/7/14. Dietitian, DON, ADON and Nursing Supervisors perform rounds, as a component of their daily duties, observing the direct care staff in rendering care for the residents including monitoring of nurse assistants in the dining room. This monitoring, at a minimum, ensures staff serve all residents seated at a dining room table before serving the next table, as well as the other components of the regulation. Additionally, Charge Nurses each shift monitor care provided 24 hours a day/ 7 days/week. If concerns are noted, appropriate interventions are implemented at that time, including additional one-on-one reeducation of the employee and/or notification of the Administrator or DON will occur. Each facility staff member will receive an in-service by Administrator and/or Director of Nursing before May 7, 2014 regarding Dignity and Respect of the residents, with special emphasis on the promotion of care for residents in a manner and environment that maintains or enhances each resident's dignity and respect in all aspects of care. This in-service will include, but not be limited to, Meal Service maintaining resident dignity, serving all residents at table, and assisting residents eating as well as other components of the regulation.	

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F 241	Continued From page 2 2. Review of Resident #15's records revealed a diagnoses of Diabetes, the resident was cognitively intact and had a risk for potential for alteration in blood sugars. Observation of Resident #15 on 04/01/14 at 6:30 PM, revealed the resident was sitting at a dining table with two (2) other residents who were eating their dinner. Further observation revealed Resident #15 did not have his/her meal tray. Interview with Resident #15 on 04/01/14 at 6:35 PM, revealed he/she had been waiting for over one (1) hour to receive a tray. Resident #15 stated he/she was "very hungry" and needed to eat because he/she had "low blood sugar". Interview with LPN #3 on 04/02/14 at 1:25 PM, revealed all residents at a table should be served before the next table is served. LPN #3 stated if the trays were out of order the SRNAs should request resident trays before serving the next table. LPN #3 indicated it was a dignity issue when residents had to sit and watch their tablemates eat and they had no food. Interview with the Director of Nursing (DON) on 04/02/14 at 3:55 PM, revealed the dining process was for all residents at a table to be served before staff served the next table. The DON stated nursing staff had received training on the dining process; and it was a dignity issue when residents were not served timely and were left sitting to watch their tablemates eat. Additionally, the DON stated it was very important residents receive their trays timely because if they were diabetic their blood sugar might go too low. The DON stated if a resident had to wait one (1) hour	F 241	A PI worksheet focused on Dignity and Respect is being completed by the Director of Nursing or designee weekly for eight weeks and then monthly for two months. The audit is completed on various days of the week/weekend and on various shifts. The findings of the audit shall be reported to the QA committee by the DON for further review and recommendations. If issues are noted the DON or designee takes appropriate action at the time the concern is noted. A copy of the PI worksheet is attached as EXHIBIT A. The Director of Nursing will monitor. Compliance Date: May 7, 2014	5/7/14

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F 241	<p>Continued From page 3 for a lunch tray it was much too long.</p> <p>3. Observation of Resident #2 on 04/02/14 at 1:05 PM, revealed the resident was sitting at the dining table with two (2) other residents. Observation revealed Resident #2 had his/her head down with his/her eyes closed. Continued observation revealed Resident #2 received his/her tray, which sat in front of the resident untouched until the Surveyor interviewed staff about it at 1:25 PM. Further observation revealed after the staff interview, Resident #2 received a new meal tray at approximately 1:35 PM, which he/she was observed to independently consume the food located on.</p> <p>Interview with State Registered Nursing Assistant (SRNA) #4 on 04/02/14 at 1:25 PM, revealed staff was to 'cue' Resident #2 with all meals. She reported there was normally two (2) people assigned to assist residents who needed assistance with meals. SRNA #4 stated Resident #2 required cueing, but could feed himself/herself. She reported staff would remind Resident #2 to eat his/her food, but indicated there was no one assigned to assist with cueing the resident.</p> <p>Interview with SRNA #5 on 04/02/14 at 1:27 PM, revealed she was passing out trays to residents in the dining room and to residents on the unit. She stated anyone who grabbed Resident #2's tray was responsible for assisting the resident with his/her meal. SRNA #5 stated if she had picked up the resident's tray, she would have fed him/her.</p> <p>Interview with Licensed Practical Nurse (LPN) #1 on 04/02/14 at 6:15 PM, revealed no one was</p>	F 241			

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F 241	Continued From page 4 assigned to assist resident's with cueing for their meals. She reported residents who needed assistance with cueing were the responsibility of everyone in the dining area. LPN #1 stated staff's neglect in cueing Resident #2 to eat would be considered a dignity concern. Interview with Registered Nurse (RN) #3/Minimum Data Set (MDS) Coordinator on 04/02/14 at 10:36 AM, revealed the coding on the MDS indicated Resident #2 was able to eat independently, but required cueing from staff. She stated staff should have cued the resident to start eating when his/her tray arrived. Additional interview with the DON on 04/03/14 at 4:12 PM, revealed she would have expected staff to cue Resident #2 to eat when the food was placed in front of him/her. She indicated this was a dignity issue.	F 241			
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's policy, it was determined the facility	F 371	F371 Villaspring stores, prepares, distributes and serves food under sanitary conditions. Each dietary staff member prepares sanitizing solution to the manufactures recommendations. The can opener was cleaned on 4/1/14 at the time it was discovered and is cleaned per policy. Food thermometers are cleaned with a new sanitizing pad after each temperature is taken. The Executive Chef audited the kitchen on 4/3/14 and the Corporate Chef provided an additional kitchen audit on 4/18/14 with no issues noted. The Administrator, Executive Chef and Corporate Chef completed an additional audit by 5/2/14 with no issues noted.		

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F 371 Continued From page 5
failed to store, prepare, distribute and serve food in a sanitary manner.

Observation during the initial kitchen tour revealed the day shift Assistant Preparation (Prep) Cook to prepare a fresh sanitizer solution for a sanitation bucket. Observation revealed when the freshly prepared sanitizing solution was checked the solution did not meet the manufacturer's recommended two hundred (200) parts per million (ppm). Continued observation during initial tour revealed the can opener to have a dark, gummy substance built up on the piercing line and base of the can opener.

In addition, observation of Cook #1 taking the food temperatures for the second floor tray line revealed Cook #1 used one (1) sanitizing pad per every four (4) food temperatures she checked.

The findings include:

1. Review of the facility's policy titled, "Quat Sanitizer", dated December 2009, revealed the sanitizing solution was to be prepared according to manufacturer's guidelines of two hundred (200) ppm. Further review revealed if the solution was not two hundred (200) ppm the solution should be discarded and fresh solution prepared.

Observation on 04/01/14 at 1:05 PM, revealed the Assistant Prep Cook to prepare a fresh bucket of sanitizing solution. Observation of the checking of the fresh bucket of sanitizing solution revealed it was too dilute and did not meet the manufacturer's guidelines of two hundred (200) ppm.

Interview with the Assistant Prep Cook on

F 371 Each facility resident was assessed by RN staff by May 7, 2014 to assure there was no food borne illnesses related to the concerns noted.

The Administrator and Corporate Chef inserviced the Executive Chef on proper cleaning and sanitizing of equipment, use and documentation of cleaning schedules and correct methods of using thermometers when temping food as well as other components of the regulation by 4/3/14. Each dietary staff member will be observed by the Executive Chef properly preparing sanitizing solution and properly cleaning food thermometers and equipment. Dietary staff received an in-service by the Executive Chef on 4/1/14 and another in-service by the Vending Supplier of the sanitation product on 4/3/14 which included the review of the policy and demonstration of proper use of test strips and correct sanitizing solution. Additionally, the Executive Chef and Corporate Chef will have inserviced and observed a return demonstration by each dietary staff member by 5/7/14 regarding proper cleaning and sanitizing of equipment, use and documentation of cleaning schedules, and correct methods of using thermometers when temping food as well as other components of the regulation.

A PI worksheet with a focus on Dietary sanitation is being completed by the Chef or designee and will be completed weekly for eight weeks, then monthly for two months. The audit is completed on various days of the week/weekend and on various shifts. The findings of the audit shall be reported to the QA committee by the Chef for further review and recommendations. If issues are identified, the Chef or designee will take appropriate action at that time, to assure Food is stored, prepared, distributed and served in a sanitary manner. A copy of the PI worksheet is attached as EXHIBIT B.

The Executive Chef will monitor.

Compliance date: May 7, 2014

5/7/14

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F 371	<p>Continued From page 6</p> <p>04/01/14 at 1:10 PM, revealed she was unaware of the needed amount of sanitizing product to dilute in the gallon bucket of water to achieve the manufacturer's recommended two hundred (200) ppm. Continued interview revealed she was unaware of how to correctly use the test strip to check for ppm of sanitizing solution to ensure it was the recommended two hundred (200) ppm.</p> <p>Interview with the Dietary Manager (DM) on 04/02/14 at 10:00 AM, revealed the facility did not have a process for educating staff on dilution ratio of the sanitizing solution to attain the recommended two hundred (200) ppm or for how to use the test strips. The DM stated he was unaware of the required amount of sanitizing product to dilute in the gallon sanitation bucket of water to achieve the manufacturer's recommended two hundred (200) ppm.</p> <p>2. Review of the facility's, "Quality/Continuity of Care" worksheet, dated 03/01/12, revealed one (1) of the areas to observe for was the kitchen was clean and the cleaning schedule was being "followed/completed". However, review of the facility's Dietary Department's daily/weekly cleaning schedules revealed the cleaning of the can opener was not addressed.</p> <p>Interview with the DM on 04/02/14 at 5:35 PM, revealed his expectation was the can opener be cleaned on a daily basis. The DM indicated, however he was not sure of the last time the can opener was cleaned.</p> <p>3. Observation of the second floor tray line on 04/02/14 at 12:12 PM, revealed Cook #1 taking the food temperatures and only using a new sanitizing pad for the thermometer after checking</p>	F 371		

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F 371	Continued From page 7 four (4) different foods. Interview with Cook #1 on 04/02/14 at 12:16 PM, revealed she used one (1) surface area of the sanitizing pad for each food temperature, therefore, she was able to use (1) pad per every four (4) foods. Interview with the DM on 04/02/14 at 12:20 PM, revealed he did not have a policy detailing how to sanitize the thermometer when taking food temperatures. The DM indicated his expectation was for staff to use one (1) sanitizing pad per food temperature taken.	F 371			
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of Infection, the facility must isolate the resident.	F 441	F441 Villaspring has and maintains an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the transmission of disease and infection. Resident # 6, #20 and C oxygen tubing's were discarded on 4/2/14 and have nasal cannula's dated and stored in plastic when not in use. Residents #9, #10, #13, #16, D, E, K, and L toothbrushes were discarded on 4/2/14 and have received new toothbrushes which are labeled, stored in holders (also labeled) separately from their roommate. Resident K, L, J, N, #5, and F bedpans/urinals were discarded on 4/2/14 and replaced with label and storage container.		

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F 441	<p>Continued From page 8</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 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 observations, interviews, record reviews and review of the facility's policy, it was determined the facility failed to maintain an infection control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of disease and infection.</p> <p>Observations revealed resident toothbrushes, bed pans, and urinals unlabeled and not stored in a manner to maintain infection control. Additionally, observation revealed oxygen tubing not dated and observed to be lying on the floor.</p> <p>The findings include:</p> <p>1. Review of the facility's, "Oxygen Monitoring System" policy, revised June 2013, revealed if nursing staff found a nasal cannula (oxygen delivery instrument) the cannula was to be changed and dated. Review of the policy</p>	F 441	<p>Each resident room was observed by Nursing Management, (DON, ADON and Nursing Supervisors) and Environmental Supervisor between 4/8/14 – 4/17/14 for potential infection control issues including but not limited to each Oxygen tubing, toothbrush, bedpan and/or urinal not properly labeled or stored was discarded and replaced with label and storage bag/container.</p> <p>The DON, ADON, and Nursing supervisors perform rounds, as a component of their duties, observing the direct care staff in rendering care for the residents including monitoring of potential infection control issues. Additionally, Charge Nurses each shift monitor care provided 24 hours a day/ 7 days/week including but not limited to infection control issues. If concerns are noted, the nursing supervisor or manager takes appropriate interventions at that time, including additional one-on-one reeducation of the employee and/or reported to the Administrator and/or DON.</p> <p>Facility staff will be in-serviced by May 7, 2014 by the DON, ADON and/or Environmental Supervisor regarding infection control policies including but not limited to labeling and storage of personal items and oxygen tubing storage.</p> <p>A performance improvement worksheet on Infection Control is being utilized by the DON or designee weekly for eight weeks, then monthly for two months. The audit is completed on various days of the week/weekend and on various shifts. The findings of the audit shall be reported to the QA committee by the DON for further review and recommendations. If issues are noted the DON or designee takes appropriate action at the time the concern is noted. A copy of the PI worksheet is attached as EXHIBIT C.</p> <p>The Director of Nursing will monitor.</p> <p>Compliance Date: May 7, 2014</p>	5/7/14	

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185447	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/03/2014
NAME OF PROVIDER OR SUPPLIER VILLASPRING OF ERLANGER		STREET ADDRESS, CITY, STATE, ZIP CODE 630 VIOX DRIVE ERLANGER, KY 41018		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	<p>Continued From page 9</p> <p>revealed plastic bags for the cannulas should be placed on the oxygen concentrator and on wheelchairs for use with portable oxygen tanks. Policy review revealed the oxygen cannulas should be placed in plastic bags when not in use and the bags changed weekly when the cannula was changed.</p> <p>Observation on 04/01/14 at 11:00 AM, during the initial tour of the facility revealed in Unsampld Resident C's and Resident #6's room undated oxygen tubing lying on the floor.</p> <p>Observation on 04/03/14 at 9:40 AM, of Resident #20's room revealed an oxygen concentrator in the room at Resident #20's bedside with nasal cannula oxygen tubing dated 04/02/14 lying uncovered coiled on top of the concentrator. Continued observation revealed a portable oxygen tank hanging on the back of Resident #20's wheelchair with nasal cannula tubing dated 04/02/14, uncovered, coiled and hanging on top of the portable oxygen tank.</p> <p>2. Observation on 04/01/14 at 11:00 AM, during the initial tour of the facility revealed in Resident #13's and Resident #16's two (2) toothbrushes were observed to be in the bathroom which were not labeled. Continued observation during the initial tour revealed in Unsampld Resident D's and Resident #10's room there were two (2) unlabeled toothbrushes observed in a basket in the bathroom with the bristles of the toothbrushes touching. Further observation revealed in Resident #9's and Unsampld Resident E's room there were four (4) unlabeled toothbrushes observed in the bathroom, with two (2) of the toothbrushes bristles touching. Additionally, observation on the initial tour of the facility at</p>	F 441		

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NAME OF PROVIDER OR SUPPLIER VILLASPRING OF ERLANGER			STREET ADDRESS, CITY, STATE, ZIP CODE 630 VIOX DRIVE ERLANGER, KY 41018		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	<p>Continued From page 10</p> <p>12:58 PM, revealed in Unsampled Resident K's and Unsampled Resident L's bathroom there were two (2) uncovered and unlabeled toothbrushes in a cup.</p> <p>3. Observation on the initial tour of the facility at 12:58 PM, revealed in Unsampled Resident K's and Unsampled Resident L's bathroom a bed pan on the floor of the bathroom, uncovered and unlabeled. Continued observation during the initial tour revealed in Unsampled Resident J's and Unsampled Resident N's bathroom a bedpan covered with a towel on the floor near the sink. Observation revealed the bed pan was not labeled or stored in a plastic bag. Further observation during the initial tour revealed in Resident #5's and Unsampled Resident F's bathroom a bed pan near the sink which was uncovered and unlabeled.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 04/03/14 at 10:20 AM, revealed that the nasal cannula oxygen tubings should have been stored in bags when not in use to ensure infection control. Additional interview with LPN #1 on 04/03/14 at 3:15 PM, revealed if she saw a resident's oxygen tubing on the floor, she would throw it away and get the resident a new one and date it. LPN #1 stated if she saw a toothbrush which was not labeled she would get a new one and label it with the resident's name. She stated she would speak with the nursing assistants and nurses regarding the proper storage of oxygen tubing and resident toothbrushes.</p> <p>Interview with the Director of Nursing (DON) on 04/03/14 at 3:50 PM, revealed it was her expectation oxygen tubing be dated and if oxygen tubing was observed on the floor she would</p>	F 441			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185447	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/03/2014
NAME OF PROVIDER OR SUPPLIER VILLASPRING OF ERLANGER			STREET ADDRESS, CITY, STATE, ZIP CODE 630 VIOX DRIVE ERLANGER, KY 41018		
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F 441	Continued From page 11 expect the oxygen tubing to be discarded and replaced with new tubing which was to be dated. Continued interview revealed she expected nasal cannula oxygen tubing to be stored in a bag when not in use. She stated it was her expectation all resident toothbrushes be labeled and stored properly in the residents' rooms and the toothbrush bristles should not be touching the bristles of another toothbrush. Additionally, she stated bedpans should be labeled and stored in plastic bags. The DON indicated these were all potential infection control issues.	F 441			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185447	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 04/02/2014
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NAME OF PROVIDER OR SUPPLIER VILLASPRING OF ERLANGER	STREET ADDRESS, CITY, STATE, ZIP CODE 630 VIOX DRIVE ERLANGER, KY 41018
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K 000	INITIAL COMMENTS Building: 01 Plan Approval: 1999 Survey under: NFPA 101 (2000 Edition) Facility type: SNF/NF Type of structure: Two (2) Story with partial basement Type II (111) Protected Smoke Compartment: Seven (7) Fire Alarm: Complete Fire alarm System (Installed 1999) Sprinkler System: Complete Sprinkler System (Wet) Installed in 1999 Generator: Type II Diesel Installed in 1999 A Life Safety Code Survey was conducted on 04/02/14. The findings revealed the facility met requirements for compliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The census on the day of the survey was one hundred and thirty-four (134) residents. The facility is licensed for one hundred and forty (140) beds. No deficiencies cited.	K 000		
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RECEIVED
MAY - 5 2014
BY: _____

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE Administrator	(X6) DATE 5/5/14
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.