STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185440	A. Building B. Wing	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Village Care Center	2990 Riggs Avenue Erlanger, KY 41018

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, record review, and facility policy review, the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life, recognizing each resident's individuality for 4 of 32 sampled residents (Resident (R) 2, R3, R41, and R84.Observation on 09/23/2025 during dinner service in the second-floor dining room revealed R3 did not receive his food at the same time as those that sat at his table did. Additionally, State Registered Nurse Aide (SRNA)7 was observed standing beside R2 feeding and coaxing her to eat, and SRNA5 was observed sitting between two residents, R41 and R84, feeding both simultaneously. The findings include:Review of the facility's policy, Resident Rights, reviewed 2022, revealed the facility would inform the resident both orally and in writing, in a language that the resident understands, of his or her rights and all rules and regulations governing resident conduct and responsibilities during their stay in the facility. Further review revealed the resident had a right to be treated with respect and dignity.1. Review of R3's Face Sheet revealed the facility admitted the resident on 04/12/2021 with diagnoses of type II diabetes mellitus with other circulatory complications, polyneuropathy, hyperglycemia, chronic peripheral insufficiency, heart failure, and hyperlipidemia.Review of R3's quarterly Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 07/07/2025, revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of 15, indicating R3 was cognitively intact.Observation of dinner service in the second-floor dining room on 09/23/2025 at 6:12 PM revealed R3 did not receive his food at the same time those that sat at his table received food. R3 waited from 6:10 PM to 6:28 PM without food because dietary staff forgot to bring buns from the kitchen. When R3 received his burger, he was unhappy with the hamburger because it did not have cheese and vegetables on it. Staff removed the hamburger and R3 waited from 6:28 PM to 6:43 PM to receive a hamburger with cheese, vegetables, and condiments. All other residents seated at his table were finished eating by the time he received his food. In an immediate interview with R3 on 09/23/2025 at 6:28 PM, he stated he was angry, and they always messed up his food.In an interview with SRNA6 on 09/25/2025 at 10:03 AM, she stated dietary staff was notorious for not bringing up buns with the hamburgers and residents had to wait on their food when that happened.2. Review of R2's Face Sheet revealed the facility admitted the resident on 08/21/2025 with diagnoses of cerebral infarction, type II diabetes mellitus with other neurological and specified complications, delusional disorders, and cognitive communication deficit. Review of R2's Nursing Home Comprehensive (NC) Item Set MDS, dated 08/07/2025, revealed the facility assessed the resident to have a BIMS score of 3, indicating R2 was severely cognitively impaired.Review of R41's Face Sheet, revealed the facility admitted the resident on 05/26/2020 with diagnoses of late onset Alzheimer's disease, major depressive disorder, anxiety disorder, and hypertension.Review of R41's quarterly MDS, with an ARD of 09/13/2025, revealed the resident had not been assessed for a BIMS score. However, review of R41's previous quarterly MDS, with an ARD of 06/13/2025, revealed the facility assessed the resident to have a BIMS score of 3, indicating R41 was cognitively impaired.Review of R84's Face Sheet, revealed the facility admitted the resident on 12/08/2022 with diagnoses of epilepsy, repeated falls, (continued on next page)

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.

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	major depressive disorder, and anxiety disorder.Review of R84's quarterly MDS, with an ARD of 09/07/2025, revealed the resident had not been assessed for a BIMS score. However, review of R84's previous quarterly MDS, with an ARD of 06/07/2025, revealed the facility assessed the resident to have a BIMS score of 3, indicating R84 was cognitively impaired.Observation of dinner service in the second-floor dining room on 09/23/2025 at 6:23 PM revealed SRNA7 was standing beside R2 feeding and coaxing her to eat, even though a chair was available to sit in on the other side of R2.In an immediate interview with SRNA7 on 09/23/2025 at 6:23 PM, she stated she should sit to feed residents or help them eat. She further stated standing to feed a resident could be seen as a dignity issue.Observation of dinner service in the second-floor dining room on 09/23/2025 at 6:43 PM revealed SRNA5 was sitting between two residents, R41 and R84, feeding both residents simultaneously. In an immediate interview with SRNA5 on 09/23/2025 at 6:43 PM, she stated it was common practice to feed two residents at once, but she should not be doing so. She further stated it could be seen as a dignity issue and an infection prevention issue. R2, R41, and R84 were not able to be interviewed due to their severe cognitive impairment.In an interview with the Unit Manager (UM) for the second floor on 09/25/2025 at 1:55 PM, she stated usually meals go smoothly and that the dinner observation on 09/23/2025 was a fluke. She stated residents did not have to wait while staff retrieved hamburger buns and condiments normally, and in the case of R3 having to watch all those around him eat their dinner while he waited nearly 30 minutes for staff to get the buns and condiments, it was not a dignity issue. She further stated, however, it was not how she would want residents to be treated.In further interview with the UM for the second floor, she stated standing over a resident while feeding them could be seen as a dignity issue but if there was not a chair available, she would rather that staff feed the resident while the food was hot rather than spend time looking for a chair. She stated staff should only feed one resident at a time due to the potential for cross-contamination and the possibility of accidently feeding a resident from the wrong plate. She further stated feeding two residents at once could be a dignity issue because the staff member was not giving the resident their full attention when feeding them. In an interview with the Director of Dining Services (DDS) on 09/25/2025 at 2:33 PM, she stated she was aware of the incident with R3, who did not get his meal in a timely manner due to kitchen staff forgetting portions of the meal in the kitchen. She stated typically buns were kept on each floor in the dining room stock areas, but they had to stop that practice because many of the buns were not getting used before expiring. She further stated to prevent similar incidents from occurring, dietary staff have been printing production sheets the previous day and going back over the production sheets prior to sending the boxes containing the food to the floor. The DDS stated she felt it was a dignity issue to watch others eat while you were waiting for your food to be served.In an interview with the Assistant Director of Nursing (ADON) on 09/26/2025 at 7:55 AM, she stated she did not feel R3 having to wait 30 minutes for his cheeseburger was a dignity issue. She stated it was a problem, and he should not have had to wait that long, but it was not an everyday occurrence. The ADON stated she did not consider SRNA7 standing to feed R2 as an issue. She further stated there was no chair available and she would rather staff feed a resident standing than to take time to find a chair to sit and feed. She stated feeding two residents at once was not an issue if there was not cross-contamination, and she did not feel it was a dignity issue. In an interview with the Director of Nursing (DON) on 09/26/2025 at 8:15 AM, she stated she was aware of R3 getting upset about having to wait for his cheeseburger due to dietary staff not having the appropriate food items to make his meal. She stated no one likes to wait for their food but R3 often changes his mind on what he wants when it comes time to eat, and she did not feel it was a dignity issue that he had to wait. In further interview with the DON, she stated there had been an influx of residents recently that needed assistance with eating or being fed. She stated they had been looking into a different set up for feeding and helping those residents. She further stated she did not think standing to feed someone was an issue if a chair was not readily available, and even if there was a chair, it was not a dignity issue to stand while feeding residents, and she would rather the resident be (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	fed. The DON stated she expected staff to provide the best care they could for residents and if they could do so while feeding two residents, that was not a dignity issue either. She stated staff should take into consideration infection prevention, temperature, and if the resident felt they were not being treated with dignity. The DON stated ideally, she would like for a resident to have one to one feeding time where they were able to eat at their own pace and not be rushed. In an interview with the Administrator on 09/26/2025 at 8:37 AM, she stated a resident having to watch others eat was not what she would want for anyone. She stated it was not a dignity issue for R3 to have to wait on his food while other residents ate, it was a customer service issue instead. She stated R3 was prone to changing his mind about what he wanted to eat and while residents had the right to change their dinner choices, they might have to wait for those options to be served. She stated standing to feed was better than not feeding a resident while searching for a chair, allowing their food to get cold. The Administrator stated feeding two residents at once was acceptable, but staff needed to pay attention to what they were doing and not change hands. She further stated it would only be a dignity issue depending on the perception and preferences of the resident.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, record review, and review of the facility's policies, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 3 resident refrigerators, the refrigerator located on the second floor.Observation on 09/24/2025 of the resident refrigerator located on the second floor revealed two unlabeled lunch boxes sitting next to resident food.The findings include:Review of the facility's policy titled, Use and Storage of Food Brought in by Family or Visitors, reviewed 11/2024, revealed it was the right of the residents of the facility to have food brought in by family or other visitors; however, the food must be handled in a way to ensure the safety of the resident. Further review revealed all food brought in already prepared by the family or visitor must be labeled with content and dated.Review of the facility's policy titled, Food and Supply Storage, revised 01/2025, revealed all food items and supplies used in food preparation shall be stored in such a manner as to prevent contamination to maintain the safety and wholesomeness of the food for human consumption. Observation on 09/24/2025 at 2:45 PM of the resident refrigerator located on the second floor revealed two lunch boxes, not labeled, sitting on the third shelf of the refrigerator next to resident food.In an interview with State Registered Nurse Aide (SRNA) 3 on 09/25/2025 at 9:25 AM, she stated there was an office area in the basement of the facility that contained a refrigerator to place staff lunches in and that it was against facility rules for staff to place their lunches in the resident food refrigerators, located on the units.In an interview with SRNA5 on 09/25/2025 at 9:49 AM, she stated staff should not place personal lunches in the resident food refrigerators, but she could not give a reason why that was important. In an interview with SRNA6 on 09/25/2025 at 10:03 AM, she stated management gave approval for staff to place their personal lunches in the resident food refrigerators.In a concurrent interview with Licensed Practical Nurse (LPN) 4 and Kentucky Medication Aide (KMA) 2 on 09/25/2025 at 9:23 AM, both stated they did not have a break room to store their lunches in, however, it was not facility practice to store their lunches in the resident food refrigerators located on the units nor in the nourishment refrigerators in the dining rooms.In an interview with the Unit Manager (UM) for the second floor on 09/25/2025 at 1:55 PM, she stated staff should not store personal food in the resident food refrigerators or the nourishment refrigerators. She stated there was a potential for residents and staff of taking incorrect food, or if food was left there, it could become spoiled and outdated and potentially cause illness. She stated she was unaware of a refrigerator in the basement that staff could use to store their lunches. In an interview with the General Manager of Dining Services on 09/25/2025 at 8:35 AM, she stated dietary staff did not maintain the contents of the resident refrigerators on the units, they only maintained the refrigerators in the dining rooms. In an interview with the Assistant Director of Nursing (ADON) on 09/26/2025 at 7:55 AM, she stated the resident food refrigerators located behind the nursing station had a shelf that was for staff lunches only. She did not see any issues with staff storing their lunches in the refrigerator with residents' personal food if staff kept them on a shelf all to themselves. She further stated housekeeping staff were assigned to go through the refrigerators and throw away outdated or spoiled food. In an interview with the Director of Nursing (DON) on 09/26/2025 at 8:15 AM, she stated it was acceptable for staff to store personal lunches in the resident food refrigerator, she did not see any issues with that.In an interview with the Administrator on 09/26/2025 at 8:37 AM, she stated staff could put their personal lunches in the resident food refrigerators if food items were labeled and dated.