

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

PRINTED: 04/23/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185226	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/09/2010
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NAME OF PROVIDER OR SUPPLIER CARMEL HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 2501 OLD HARTFORD RD. OWENSBORO, KY 42303
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
F 157 SS=G	<p>An annual survey and an abbreviated survey (KY #14622) was conducted 04/06-09/10 and a Life Safety Code Survey was conducted on 04/06/10 to determine the facility's compliance with Federal Regulatory Requirements. Allegation KY #14622 was substantiated. Deficiencies were identified with the highest S/S being a "G".</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>C A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update</p>	F 157	 <p>Criteria 1: Resident #1 has expired.</p> <p>Criteria 2: Wound status reviews have been conducted with the attending physicians for all residents with current wounds.</p> <p>Criteria 3: Facility RN's and LPN's in-service education was completed on May 10, 2010, on the need to immediately inform the physician of declines in wound status including but not limited to signs/symptoms of infection, and to document this notification in the nurses' notes and 24 hour shift report, as provided by the Nursing Consultant.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Francis Teresa Scully* TITLE: Adm (X6) DATE: 05-11-10

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.

In order to be in compliance with the regulation, we are submitting this plan of correction, without admitting or conceding either the existence or the cope of severity of any of the deficiencies.

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F 157	<p>Continued From page 1</p> <p>the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record review it was determined the facility failed to notify the physician of a significant change in condition and the potential need to alter treatment for one resident (#1), in the selected sample of eight, related to the deterioration of a pressure sore. Resident #1's Stage IV pressure sore continued to show signs of not healing, continued to have exudate (fluid forced out of tissues or capillaries because of inflammation or injury) and began showing signs and symptoms of infection (purulent exudate, swelling, induration or erythema, increasing pain or tenderness around the site or delayed wound healing). The facility transferred Resident #1 to the hospital on 03/21/10 and the resident was admitted with a diagnosis of Sacroiliac Decubitus (pressure sore) and Sepsis (severe infection). Findings include:</p> <p>A review of the facility's Physician/Legal Representative Notification policy and procedure, dated 08/08, revealed the facility would immediately notify the physician when there was a need to alter treatment significantly or to commence a new form of treatment. A review of the facility's Skin Care Management Protocol, dated 02/08, revealed the physician should be contacted if a clean pressure sore is not healing or continues to produce exudate after 2-3 weeks. The physician should be notified if the resident has any symptoms of bacteremia (bacteria in the blood), sepsis (severe infection) and osteomyelitis</p>	F 157	<p>Criteria 4: The CQI indicator for the monitoring of physician notification of changes will be utilized monthly X 2 months and then every six months as per the established CQI calendar under the supervision of the ADON.</p>	<p>May 17 2010</p>	

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F 157	Continued From page 2 (bone infection). A record review revealed Resident #1 was admitted to the facility on 03/17/09 with diagnoses to include Chronic Renal Failure and Congestive Heart Failure. A review of the weekly pressure sore assessment, conducted by the Director of Nursing (DON), dated 01/13/10, revealed a Stage II pressure sore measuring 1.0 centimeter (cm.) x 0.5 cm. x 0.1 was identified on Resident #1's coccyx. On 01/25/10, the pressure sore assessment revealed the wound began having purulent (thick yellow, green or brown) drainage. A review of the wound nurse evaluation, dated 02/01/10, revealed the wound measured 1.30 cm. x 1.20 cm. and she was unable to determine the depth. There was moderate exudate with Serosanguinous (composed of serum and blood) drainage. Review of the February 2010 assessments (02/08/10, 02/15/10, 02/22/10 and 02/28/10) revealed the wound gradually increased in size (2.00 cm. x 1.00 cm). On 02/15/10, the wound assessment documentation revealed the wound had a foul odor and purulent or serosanguineous drainage. The wound was identified as 75 % necrotic (dead) tissue and 25 % beefy red tissue. On 03/01/10, the wound was assessed as 2.0 cm. x 1.00 cm. with no improvement and serosanguinous drainage continued, with a moderate amount of exudate. The DON documented the bone under the wound was palpable (capable of being touched and/or felt). Further reviews of the March 2010 assessments (03/10/10, 03/12/10 and 03/18/10) revealed the wound gradually increased in size (3.0 x 1.5 cm. with a depth of 1.5 cm) and was assessed as having a foul odor with sanguineous (bloody) drainage. The wound bed was described as red, yellow-grey and gradually completely grey.	F 157			

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F 157	<p>Continued From page 3</p> <p>The surrounding skin color ranged from red and irritated to dark and dull with thick edges. The Nursing Progress Notes, revealed the facility notified the wound nurse of the condition of the wound on 03/08/10 and on 03/18/10 and she identified the wound was not improving and had increased to 3.0 cm X 1.5 cm X 1.5cm. Record review revealed while the physician had received requests for changes in treatment, there was no documented evidence that the facility notified the physician of the worsening condition of the wound from 01/28/10 until 03/21/10.</p> <p>A review of the Nurse's Notes, dated 03/18/10, revealed the resident requested to stay in bed. At 8:00 PM, the resident was assessed with an elevated temperature of 100.1 degrees. On 03/19/10 at 6:00 PM, the resident was assessed as lethargic. On 03/20/10 at 1:00 AM, the resident was assessed as lethargic, only responding by opening his/her eyes. On 03/21/10 at 7:30 PM, the resident was assessed as having his/her eyes wide open, unresponsive with a temperature of 99.8 degrees. The physician was notified on 03/21/10 at 8:45 PM, when the resident continued to be non-verbal with staff and the resident's temperature increased to 101.9 degrees. After physician notification, the resident was transferred to the emergency room.</p> <p>An interview with the Director of Nursing (DON), on 04/07/10 at 10:00 AM and 3:15 PM revealed she conducted and documented the weekly skin assessments. When the wound nurse made her monthly visit or the DON updated the wound nurse by phone regarding the condition of the pressure sore, the wound nurse made a recommendation for changes in treatment. She faxed the recommendation to the physician,</p>	F 157			

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F 157	<p>Continued From page 4</p> <p>followed with a call to the office nurse. She informed the office nurse of the recommendation and later the office nurse would call back and inform the DON the physician approved the recommendation. The DON stated she did not notify or consult with the physician regarding the deterioration of the resident's pressure sore. She stated "I must have just missed it when it came to making the physician aware of the continued decline in condition and sign and symptoms of infection of the wound".</p> <p>A review of the Emergency Department Flow Sheet, dated 03/21/10 at 9:58 PM, revealed the emergency room Registered Nurse (RN) described the resident's pressure sore as 4 cm. x 2 cm greenish Stage IV pressure sore on the coccyx with purulent odorous drainage. A review of the consultant physician's hospital discharge summary, dated 03/29/10, revealed he examined the wound and it had a foul odor, had black eschar (a thick covering of dead tissue) with some necrotic tissue with surrounding induration (raised and hardened) and was tender to touch. A wound culture revealed Proteus Mirabilis and E-coli (bacteria). Merrem (antibiotic) was given intravenously to treat the infection. The wound was debrided and a wound vac was put in place. The resident was discharged with a diagnosis of Sacroiliac Decubitus (pressure sore) with Sepsis.</p> <p>An observation of facility's assessment of Resident #1's pressure sore treatment, on 04/07/10 at 9:30 AM, revealed the resident had a Stage IV pressure sore to the coccyx. The wound measured 4.5 cm. x 2.0 cm. with a depth of 2.5 cm. There was tunneling at 6:00 measuring 3 cm. The wound bed was grey and the bone was exposed. There was purulent drainage. There</p>	F 157			

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F 157

Continued From page 5
was no odor. The surrounding skin color was red and irritated. The wound edges were thickened. A wound vac was applied to the wound.

F 157

F 280
SS=D

483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP

F 280

C

The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.

A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

This REQUIREMENT is not met as evidenced by:
Based on observations, interviews and record review it was determined the facility failed to revise the care plan when one resident (#1), in the selected sample of eight developed signs and symptoms of an infected Stage IV pressure sore on the coccyx. The resident was hospitalized on 03/21/10 with diagnoses of a wound infection with Sepsis (severe infection that has spread). Findings include:

Criteria 1: Resident #1 has expired.

Criteria 2: An audit was completed of the care plans of in-house residents with wounds by the ADON on April 10, 11 and 12, 2010, to determine that the comprehensive care plans reflect the monitoring of wounds for signs/symptoms of infection.

Criteria 3: In-service education for the ADON was completed on May 10, 2010, by the Nursing Consultant, on the need to address monitoring wounds for signs/symptoms of infection on the comprehensive care plan.

Criteria 4: The CQI indicator

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F 280	Continued From page 6 A review of the facility's undated Development of a Care Plan policy and procedure, revealed the care plan will be reviewed/revise as per the RAI manual with significant changes and changes in orders as received by the Minimum Data Set (MDS) Coordinator. The updates/changes will be made as soon as possible. The MDS Coordinator will have quickle care plans ready for immediate implementation after making them resident specific (infections, wounds etc.). A record review revealed Resident #1 was admitted to the facility on 03/17/09 with diagnoses to include Chronic Renal Failure and Congestive Heart Failure. A review of the annual MDS assessment and Resident Assessment Protocol (RAP), dated 02/15/10, revealed the resident acquired a Stage II pressure sore. A review of the Comprehensive Care Plan for the Stage II area to coccyx, originally dated 01/13/10 was updated on 03/08/10, only to indicate the Stage II had progressed to a Stage IV pressure sore. The care plan did not include goals or interventions to address the potential for or actual infection to the wound. A review of the wound nurse evaluation, dated 03/01/10, revealed the wound exhibited signs and symptoms of infections as manifested by a serosanguinous (serum and blood) drainage and a foul odor. The treatment was revised by the wound nurse, but no revisions were made to the care plan. A review of the weekly pressure sore records, dated 03/08/10, 03/12/10 and 03/18/10, revealed the wound size gradually increased to 3.0 x 1.5 cm. with a depth of 1.5 cm, continued to	F 280	for the monitoring of wound care plans will be utilized monthly X 2 months and then quarterly as per the established CQI calendar under the supervision of the ADON.	May 17 2010	

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F 280	<p>Continued From page 7</p> <p>have a foul odor and the wound bed was red, yellow-grey and gradually turned completely grey. The surrounding skin color went from red and irritated to dark and dull with thick edges. No revisions were made on the care plan to address signs of infection and lack of healing.</p> <p>A review of the nurse's notes, dated 03/21/10, revealed the resident was sent to the emergency room due to having a temperature of 101.2 degrees (normal 98.6), was lethargic and was not responding to staff. A wound culture was ordered at the hospital and revealed Proteus Mirabillis and E-coli (bacteria). Merrom (antibiotic) was given intravenously to treat the infection. The wound required debridement and application of a wound vac. The resident was discharged with a diagnosis of Sacroiliac Decubitus (pressure sore) with Sepsis. However, a review of the care plan revealed no goals and or interventions had been developed to address the wound infection, the debridement and wound vac.</p> <p>An interview with the MDS Coordinator/Assistant Director of Nursing (ADON), on 04/08/10 at 10:15 AM, revealed the facility addressed the potential for infection of a wound if interventions included nursing assessments on a weekly basis. She stated once an infection has been identified, the care plan is revised. She receives a copy of the physician's order for the antibiotic and it indicates the reason for the antibiotic. Since an antibiotic was never ordered for Resident #1, she was not aware the pressure sore showed signs and symptoms of an infection and the care plan needed to be revised.</p> <p>An observation of Resident #1's pressure sore treatment by facility nursing staff, on 04/07/10 at</p>	F 280			

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F 280	Continued From page 8 9:30 AM, revealed identification of a Stage IV pressure sore to the coccyx. The wound measured 4.5 cm. x 2.0 cm. with a depth of 2.5 cm. There was tunneling at 6:00 measuring 3 cm. The wound bed was grey and the bone was exposed. There was purulent (yellow, green or brown) drainage, but no odor. The surrounding skin color was red and irritated. The wound edges were thickened. A wound vac was applied to the wound.	F 280			
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure care was provided by qualified persons for one resident (#2), in the selected sampled of eight, in accordance with the resident's written plan of care. While providing care for Resident #2 on 09/01/09, a Certified Nurse Aide (CNA) #1 rolled the resident too close to the edge of the bed and the resident slid off the bed onto the floor, hitting his/her head on the floor. According to the care plan, there were supposed to be two staff to provide care for this resident. Findings include: A record review revealed Resident #2 was admitted to the facility on 08/02/07 with diagnoses to include Diabetes Type II, Dementia, Arthritis, Osteoporosis, Hypertension, Dysphagia, History of Heart Disease and Alzheimer's Disease with	F 282	Criteria 1: Resident #2 receives the assistance of 2 staff with transfers and bed mobility in accordance with the care plan. Criteria 2: Resident care plans were reviewed by the ADON and MDS Coordinator to verify that they correctly identified the number of support staff needed for transfers and bed mobility. Criteria 3: Nursing staff in-service education was completed on April 12, 2010, on the provision of transfer and bed mobility assistance for residents in accordance with the		

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F 282	<p>Continued From page 9 Anxiety/Depression.</p> <p>A review of an annual Minimum Data Set (MDS), dated 06/01/09, and a quarterly MDS, dated 02/08/10, revealed the resident required extensive assistance with bed mobility.</p> <p>A review of the CNA care plan record, dated 08/09, revealed the resident required total assistance of two staff for most of his/her activities of daily living (ADLs) to include bed mobility and transfer.</p> <p>Further review of the comprehensive care plan "ADL Function deficits," dated 08/24/09, revealed the staff was to provide assistance and support appropriate to the resident's needs ensuring the highest level of function while maintaining the safety of the resident and the staff.</p> <p>A review of the nurses' notes, dated 09/01/09, revealed the resident rolled out of bed landing on his/her left side. A slight contusion was noted to the back side of the resident's head.</p> <p>An interview with the Assistant Director of Nursing (ADON), on 04/09/10 at 1:00 PM, revealed she investigated this incident and indicated that the care plan was not followed by CNA #1. She revealed CNA #1 performed care for this resident and was aware that the resident required assistance of two staff. CNA #1 pushed the call light for assistance; however, she did not wait for help to arrive to complete the care. As a result, the resident was rolled too close to the edge of the bed and fell to the floor hitting his/her head.</p> <p>Attempts to interview CNA #1 during the survey process were unsuccessful.</p>	F 282	<p>care plan as provided by the ADON/designee.</p> <p>Criteria 4: The CQI indicator for the monitoring of implementation of care plan interventions will be utilized monthly X 2, and then quarterly as per the established CQI calendar, under the supervision of the Director of Nursing.</p>	<p>MAY 17 2010</p>
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F 282	Continued From page 10 A review of the facility's policy/procedure "CNA Care Plan Record," dated 09/02, revealed "it is the purpose of this form to document how each residents' daily care needs are provided by the nursing staff as outlined in the comprehensive care plan in accordance with the guidelines of the RAI process." Information listed on the CNA care plan included "how much assistance the resident required to change positions in bed. By signing in the box for a particular date and shift, the staff member is certifying that the care was provided to the resident as outlined."	F 282			
F 314 SS=G	C 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record review, it was determined the facility failed to ensure one resident (#1) in the selected sample of eight, received the necessary treatment and services to promote healing and prevent infection of a Stage IV pressure sore. Resident #1 acquired a Stage II pressure sore on 01/13/10, which progressed to a Stage IV. The facility failed to notify the physician when the treatment became ineffective in promoting healing, the	F 314	Criteria 1: Resident #1 has expired. Criteria 2: -Wound status reviews have been conducted with the attending physicians for all residents with current wounds -An audit was completed of the care plans of in-house residents with wounds by the		

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F 314	<p>Continued From page 11</p> <p>wound progressively worsened and began exhibiting signs and symptoms of infection. On 03/21/10, the resident became lethargic, unresponsive and had an elevated temperature. The facility transferred the resident to the hospital and the resident was admitted with a diagnosis of a wound infection with Sepsis (severe infection that had spread). Findings include:</p> <p>A review of the facility's Skin Care Management Protocol, dated 02/08, revealed weekly pressure sore assessments shall be done until healed. Progress shall be monitored daily. If no progress is demonstrated in two weeks, reevaluation of the plan of care and adherence to the plan of care will be done. If at anytime, deterioration is noted, reevaluation needs to occur. The physician will be contacted if a clean pressure sore is not healing or continues to produce exudate after 2-3 weeks. A topical or systemic antibiotic may be warranted. The antibiotic should be effective against gram negative, gram-positive and anaerobic organisms. The physician will be notified if the resident has any symptoms of bacteremia (bacteria in the blood), Sepsis (severe infection) and osteomyelitis (bone infection). Appropriate systemic antibiotic therapy will be instituted.</p> <p>A review of the facility's undated Development of a Care Plan policy and procedure, revealed the care plan will be reviewed/revise as per the RAI manual with significant changes and changes in orders as received by the Minimum Data Set (MDS) Coordinator. The updates/changes will be made as soon as possible. The MDS Coordinator will have quickie care plans ready for immediate implementation after making them</p>	F 314	<p>ADON to determine that the comprehensive care plans reflect the monitoring of wounds for signs/symptoms of infection.</p> <p>Criteria 3: Facility RN's and LPN's have received in-service education on May 10, 2010, on the need to immediately inform the physician of declines in wound status including but not limited to signs/symptoms of infection., and to document this notification in the nurses' notes and 24 hour shift report, as provided by the Nursing Consultant.</p> <p>- The ADON has Received in-service education from the Nursing Consultant May 10, 2010 on the need to address monitoring wounds for signs/symptoms of infection on the comprehensive care plan</p> <p>Criteria 4: -The CQI indicator for the monitoring of physician notification of changes will be utilized monthly X 2 months and then every six months as per the established CQI calendar under the supervision of the ADON.</p> <p>-The CQI indicator for</p>		

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F 314	Continued From page 12 resident specific (infections, wounds etc.). A record review revealed Resident #1 was admitted to the facility on 03/17/09 with diagnoses to include Congestive Heart Failure and Chronic Renal Failure. On 01/13/10, the resident was assessed as having acquired a Stage II pressure sore. Review of the care plan dated 01/13/10 revealed a goal for resolution of the pressure sore by 03/10/10. Interventions included cleansing the wound with Normol Saline, application of Purachol and cover with foam and Tegaderm, a pressure distribution mattress, turn and reposition every two hours per clock schedule, high protein supplements and multivitamin with Zinc. Review of the care plan dated 02/15/10 included an intervention for the nurse to assess the resident's skin on admission, weekly and as needed. A review of the weekly pressure sore assessment, conducted by the Director of Nursing (DON), dated 01/13/10, revealed a Stage II pressure sore measuring 1.0 centimeter (cm.) x 0.5 cm. x 0.1 was identified on Resident #1's coccyx. On 01/25/10, the pressure sore assessment revealed the wound began having purulent (thick yellow, green or brown) drainage. A review of the wound nurse evaluation, dated 02/01/10, revealed the wound measured 1.30 cm. x 1.20 cm. and she was unable to determine the depth. There was moderate exudate with Serosanguinous (composed of serum and blood) drainage. Review of the February 2010 assessments (02/08/10, 02/15/10, 02/22/10 and 02/28/10) revealed the wound gradually increased in size (2.00 cm. x 1.00 cm). On 02/15/10, the wound assessment documentation revealed the wound had a foul odor and purulent or serosanguineous drainage. The wound was	F 314	the monitoring of wound care plans will be utilized monthly X 2 months and then quarterly as per the established CQI calendar under the supervision of the ADON	MAY 17 2010

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F 314 Continued From page 13
Identified as 75 % necrotic (dead) tissue and 25 % beefy red tissue. On 03/01/10, the wound was assessed as 2.0 cm. x 1.00 cm. with no improvement and serosanguinous drainage continued, with a moderate amount of exudate. The DON documented the bone under the wound was palpable (capable of being touched and/or felt). Further reviews of the March 2010 assessments (03/08/10, 03/12/10 and 03/18/10) revealed the wound gradually increased in size (3.0 x 1.5 cm. with a depth of 1.5 cm) and was assessed as having a foul odor with sanguineous (bloody) drainage. The wound bed was described as red, yellow-grey and gradually completely grey. The surrounding skin color ranged from red and irritated to dark and dull with thick edges. The Nursing Progress Notes, revealed the facility notified the wound nurse of the condition of the wound on 03/08/10 and on 03/18/10 and she identified the wound was not improving and had increased to 3.0 cm X 1.5 cm X 1.6cm. Record review revealed while the physician had received requests for changes in treatment, there was no documented evidence that the facility notified the physician of the worsening condition of the wound from 01/28/10 until 03/21/10.

A review of the Nurse's Notes, dated 03/18/10, revealed the resident requested to stay in bed. At 8:00 PM, the resident was assessed with an elevated temperature of 100.1 degrees. On 03/19/10 at 6:00 PM, the resident was assessed as lethargic. On 03/20/10 at 1:00 AM, the resident was assessed as lethargic, only responding by opening his/her eyes. On 03/21/10 at 7:30 PM, the resident was assessed as having his/her eyes wide open, unresponsive with a temperature of 99.8 degrees. The physician was notified on 03/21/10 at 8:45 PM, when the

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F 314	<p>Continued From page 14</p> <p>resident continued to be non-verbal with staff and the resident's temperature increased to 101.9 degrees. After physician notification, the resident was transferred to the emergency room.</p> <p>An interview with the wound nurse, on 04/08/10 at 3:00 PM, revealed she only treated the wound topically. She was trying to control the drainage, remove the slough and keep the resident comfortable. She recommended Bacitroban (antibiotic) be applied to the wound bed to help control the infection. She was not able to prescribe systemic antibiotics and she "did not know why the physician had not ordered a broad spectrum antibiotic orally to help with the wound infection."</p> <p>An interview with the MDS Coordinator/Assistant Director of Nursing (ADON), on 04/08/10 at 10:15 AM, revealed the facility addressed the potential for infection of a wound when an intervention on the care plan stated for nurses to assess the wound weekly and as needed. She stated once an infection had been identified, the care plan is revised and she received a copy of the physician's order for the antibiotic, indicating the reason for the antibiotic. She was not aware there were signs and symptoms of an infection and was not aware the pressure sore care plan needed to be revised to address the infection.</p> <p>An interview with Licensed Practical Nurse (LPN) #1 and LPN #2, on 04/07/10 at 10:00 AM and 3:15 PM, revealed LPN #1 last saw the wound on 03/19/10 and LPN #2 last saw the wound the day Resident #1 was sent to the hospital. Both revealed the wound odor was much stronger. LPN #2 revealed the wound had increased in size and depth and there was brown drainage. Both</p>	F 314			

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F 314	<p>Continued From page 15</p> <p>LPNs stated they would notify the Director of Nursing (DON) if there was any change in the wounds condition because she was responsible for the residents' wounds. They revealed the DON would then contact the wound nurse and/or physician. They both revealed neither of them had contacted the DON or physician between 03/19-03/21/10, because they saw no difference in the appearance of the wound</p> <p>An interview with the Director of Nursing (DON), on 04/07/10 at 10:00 AM and 3:15 PM revealed when the wound nurse was there for her monthly visit or when the DON updated the wound nurse by phone on the condition of the wound, the wound nurse would make a recommendation for treatment. The DON would then fax the recommendation to the physician and call the physician's office nurse. She would tell the office nurse what the wound nurse's recommendation was and the office nurse would call her back and tell her the physician approved the treatment. She stated she did not make the physician aware of the condition of the wound. She stated "I must have just missed it when it came to making the physician aware of the continued decline in condition and sign and symptoms of infection of the wound".</p> <p>A review of the Nurse's Notes, dated 03/18/10 - 3/21/10 revealed the resident became lethargic and gradually stopped responding verbally. There was no evidence the physician was made aware of the resident's change in condition. An interview with LPN #2 on 04/07/10 at 3:15 PM revealed they thought the resident's lethargy and not responding when spoken to was due to the decline in the resident's condition related to the Chronic Renal Failure.</p>	F 314			

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F 314	Continued From page 16 A review of a Nurse's Note, dated 03/21/10 at 8:45 PM, revealed the resident was assessed as having a temperature of 101.9. The family and physician were called. The physician ordered the facility to transfer the resident to the emergency room. A review of the consultant physician's hospital discharge summary, dated 03/29/10, revealed the pressure sore had a foul odor, had black eschar (thick black sloth) with some necrotic (dead) tissue with surrounding induration (raised hardened) and was tender to touch. A wound culture was ordered and revealed Proteus Mirabills and E-coli (bacteria). Merrem (antibiotic) was given intravenously to treat the infection. The wound was debrided and a wound vac was put in place. The resident was discharged with a diagnosis of Sacroiliac Decubitus (pressure sore) with Sepsis. An observation of Resident #1's pressure sore treatment, on 04/07/10 at 9:30 AM, revealed the facility assessed the wound as a Stage IV pressure sore to the coccyx, measuring 4.5 cm. x 2.0 cm. with a depth of 2.5 cm. There was tunneling at 6:00 measuring 3 cm. The wound bed was grey and the bone was exposed. There was purulent drainage. The surrounding skin color was red and irritated. The wound edges were thickened. According to the assessing nurse, the wound showed improvement. A review of the physician's orders, dated 03/30/10, revealed the resident was receiving Merem (antibiotic) 500 mg. IV every 24 hours times seven days.	F 314			
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident	F 323			

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F 323	<p>Continued From page 17</p> <p>environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to provide adequate supervision to prevent accidents for one resident (#2), in the selected sample of eight. While providing care for Resident #2 on 09/01/09, Certified Nurse Aide (CNA) #1 rolled the resident too close to the edge of the bed and the resident slid off the bed onto the floor, hitting his/her head on the floor. Findings include:</p> <p>A record review revealed Resident #2 was admitted to the facility on 08/02/07 with diagnoses to include Diabetes Type II, Dementia, Arthritis, Osteoporosis, Hypertension, Dysphagia, History of Heart Disease and Alzheimer's Disease with Anxiety/Depression.</p> <p>A review of an annual Minimum Data Set (MDS), dated 06/01/09, and a quarterly MDS, dated 02/08/10, revealed the resident required extensive assistance with bed mobility.</p> <p>A review of a "Fall Assessment Screening Tool," dated 08/17/09, revealed the resident was at high risk for falls.</p> <p>A review of the CNA care plan record, dated 08/09, revealed the resident required total assistance of two staff for all activities of daily</p>	F 323	<p>Criteria 1: Resident #2 receives the assistance of 2 staff with transfers and bed mobility in accordance with the care plan.</p> <p>Criteria 2: Resident care plans were reviewed by the ADON and MDS Coordinator to verify that they correctly identified the number of support staff needed for transfers and bed mobility.</p> <p>Criteria 3: Nursing staff have received in-service education on the provision of transfer and bed mobility assistance for residents in accordance with the care plan as provided by the ADON/designee on April 12, 2010.</p> <p>Criteria 4: The CQI indicator for the monitoring of implementation of care plan interventions will be utilized monthly X 2, and then quarterly as per the established CQI calendar, under the supervision of the Director of Nursing.</p>	<p>MAY 17 2010</p>

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F 323	<p>Continued From page 18</p> <p>living (ADLs) with the exception of feeding.</p> <p>Further review of the comprehensive care plan "ADL Function deficits," dated 08/24/09, revealed the staff was to provide assistance and support appropriate to the resident's needs ensuring the highest level of function while maintaining the safety of the resident and the staff.</p> <p>A review of the nurses' notes, dated 09/01/09, revealed the resident rolled out of bed landing on his/her left side. A slight contusion was noted to the back side of the resident's head.</p> <p>A review of the facility's investigation, dated 09/01/09, revealed CNA #1 was performing care for the resident by herself. The resident was rolled toward the CNA and was too close to the edge of the mattress. The resident slid off the mattress onto the floor. The CNA care record indicated the need for two CNAs to perform care for this resident.</p> <p>An interview with the Assistant Director of Nursing (ADON), on 04/09/10 at 1:00 PM, revealed she investigated this incident. She revealed verbal counsel was given to CNA #1, who performed care for this resident, because there should have been two staff in the room with the resident instead of one staff. She stated CNA #1 pushed the call light for assistance but did not wait long enough for help to come, instead, she tried to complete the care by herself and the resident fell onto the floor and hit his/her head. The bed was not in the lowest position at the time of the fall due to care being provided. In July 2009, there had been a CNA meeting that addressed knowing what is on the CNA care record and following through with it.</p>	F 323			

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F 323	Continued From page 19 Attempts to interview CNA #1 during the survey process were unsuccessful.	F 323		
F 363 SS=E	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was determined the facility failed to ensure residents' nutritional needs were met as evidenced by not following the menu prepared in advance. Bread was not served during the lunch meal; however, there was a container of bread on the trayline. During the supper meal, tomato, lettuce and graham crackers were supposed to be served/offered according to the menu; however, none of these food items were present on the trayline. Additionally, there were no substitutes offered for two residents (#9 and #10), not in the selected sample, who were on pureed diets. Findings include: 1. A review of the Lunch Menu for 04/06/10	F 363	Criteria 1: -Residents are served meals which adhere to the facility menu. -Substitutes are offered/provided to residents #9 and #10 as indicated. Criteria 2: -Residents are served meals which adhere to the facility menu. -Substitutes are offered/provided to all residents as indicated.	

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F 363	<p>Continued From page 20</p> <p>revealed the residents were to be served meatloaf, Au Gratin Potatoes, cabbage, drop biscuits and pineapple upside down cake.</p> <p>Observations on 04/06/10 at 12 :20 PM revealed approximately 30 residents eating in the main dining room. The facility did not provide bread on any of the residents' trays.</p> <p>Observation of Resident #9's tray revealed the facility did not provide the resident with any pureed meat.</p> <p>Observation of Resident #10's tray revealed the facility did not provide pureed potatoes or a substitute for the pureed potatoes.</p> <p>An observation of the trayline on 04/06/10 at 12:00 PM revealed there was bread in a container on the trayline; however, no bread was served during the meal.</p> <p>2. A review of the Supper Menu for 04/06/10 revealed the residents were to be served hamburgers, onion rings, lettuce and tomato, fruit cocktail and graham crackers.</p> <p>Observations of approximately 26 residents' trays revealed the facility did not provide residents lettuce, tomato and graham crackers, per the menu.</p> <p>An observation of the trayline on 04/06/10 at 5:00 PM revealed no lettuce, tomatoes or graham crackers were available on the trayline.</p> <p>Further observations on 04/06/10 revealed a pureed meat, a pureed vegetable and a pureed starch were served at each each meal; however,</p>	F 363	<p>Criteria 3: Dietary and Nursing staff have received in-service education on the need to determine that each resident is served their meal in accordance with the facility menu, and are offered substitutions as indicated, as provided by the ADON and Dietary Manager on May 3, 2010.</p> <p>Criteria 4: The CQI indicator for the monitoring of tray accuracy and the offering of substitutions will be utilized monthly X 2 months and then as per the established CQI calendar under the supervision of the dietary manager.</p>	May 17 2010	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
F 363	<p>Continued From page 21</p> <p>there was no substitute or alternate food offered the residents on the pureed diets.</p> <p>An interview with Dietary Aide #1 on 04/09/10 at 10:45 AM revealed some of the residents did not like bread; however, they should have been offered the bread. She stated Resident #9 was a vegetarian and Resident #10 disliked potatoes; however, substitutes should have been offered. She provided no explanation for the unavailability of the lettuce, tomatoes or graham crackers. She stated, "I just give what the cook fixes."</p> <p>An interview with the Dietary Manager on 04/09/10 at 11:25 AM revealed there should have been a substitute for the pureed vegetables, but the facility did not provide a substitute for the pureed meat. She stated they offered substitutes for other types of diets, but did not provide an explanation for the lack of substitutes for pureed diets. Additionally, she provided no explanation regarding the bread other than to say the Certified Nurse Aides (CNAs) usually asked residents if they wanted bread on their plates. She did not know why tomato and lettuce was not offered at supper, per menu. She stated the cook should have made sure the lettuce and tomato was provided; however, it was ultimately her responsibility to ensure the menu was followed.</p> <p>A review of the facility's policy/procedure "Menu Planning and Revision: Nutrition Services," dated 06/08, revealed "provide residents with a four week, selective menu that meets their diet order and nutritional needs. The menu is planned by the Director of Food and Nutrition Services and/or a Registered Dietician. The regular menu provides the basic pattern for planning all modified diets. Menus are planned with cost and</p>	F 363		

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NAME OF PROVIDER OR SUPPLIER CARMEL HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2501 OLD HARTFORD RD. OWENSBORO, KY 42303	
(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 363	Continued From page 22 availability of foods in mind as well as cultural needs." A review of the facility's policy/procedure "Offering Substitutes for Food Refusals," adapted 2005, revealed " the Nutritional Services Department should keep an accurate list of residents' food preferences and disllkes. When disliked foods are on the menu, a substitute of similar nutritional value will be provided. All efforts will be made to serve the menu as posted. If a substitution must be made, then a food item of similar nutritional value will be used."	F 363		
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 conditlions This REQUIREMENT is not met as evidenced by: Based on observations, interviews and review of facility policy/procedure, it was determined the facillty failed to store, prepare, distribute and serve food under sanitary conditions. Findings include: Observations of the kitchen area on 04/08/10 at 11:00 AM and on 04/07/10 at 1:05 PM revealed the walk-in refrigerator contained employees' food/drink items on the top shelf which was being	F 371	Criteria 1: -Staff personal food items are placed in the employeee refrigerator in the break room. -Dietary staff follow infection control standards for glove use and hand washing when serving food on the tray line. Criteria 2: -An audit was completed by Certified Dietary Manager on May 10, 2010. of the	

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F 371	<p>Continued From page 23</p> <p>stored alongside the food used to prepare meals for the residents.</p> <p>An interview with the Dietary Manager's assistant on 04/06/10 at 11:15 AM revealed she was unaware that the employees could not store their food in this refrigerator.</p> <p>An interview with the Dietary Manager on 04/07/10 at 1:10 PM revealed no explanation was provided regarding this issue.</p> <p>An observation of the trayline on 04/06/10 at 12:00 PM revealed Dietary Aide #1 served some of the residents' meatloaf with her gloved hand instead of a utensil. She touched her glasses on several occasions, after touching food. Additionally, she switched utensils from the vegetables to the meat and then back to the vegetables.</p> <p>An observation of the trayline on 04/06/10 at 5:00 PM revealed Dietary Aide #1 dropped the food thermometer into the pureed food twice and retrieved the thermometer from the food with her gloved hand. Additionally, she touched hamburger buns, pickles and some of the onion rings, after touching her glasses and two food carts. The tongs used for the hamburgers fell into the hamburger meat after the tongs had been observed touching the aide's apron. She continued to serve hamburgers with the same tongs.</p> <p>An interview with Dietary Aide #1 on 04/09/10 at 10:45 AM revealed she was not provided enough utensils to serve the meal at 12:00 PM, so she improvised so the residents wouldn't be kept waiting. She realized she touched her glasses</p>	F 371	<p>kitchen to identify any dietary sanitation issues. All identified issues have been addressed as indicated.</p> <p>-Hand washing/glove use competency check lists were completed on dietary Staff by Certified Dietary Manager on May 6, 2010, to determine correct implementation of infection control standards.</p> <p>Criteria 3: The dietary staff in-service education was completed on May 3, 2010, on dietary sanitation issues including but not limited to storage of employee personal food items in the employee break room refrigerator, and handwashing/glove use while serving food on the tray line as provided by the Dietary Manager.</p> <p>Criteria 4: The CQI indicator for the monitoring of dietary sanitation will be utilized monthly as per the established CQI calendar under the supervision of the Dietary Manager.</p>	<p>May 17 2010</p>	

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F 371	Continued From page 24 and food carts while serving food. A review of the facility's policy/procedure "Personnel Adherence to Sanitary Procedures," dated 03/04, revealed "food services personnel must wash their hands after touching hair, nose or mouth and at any other time when contamination could occur. If gloves are used in food preparation, food services and dietary personnel will wash hands before donning gloves. If a task is interrupted, gloves will be removed and clean gloves donned when the task is resumed."	F 371		