

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

SEP 18 2014

PRINTED: 08/21/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185208	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/07/2014
NAME OF PROVIDER OR SUPPLIER CARMEL MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 100 CARMEL MANOR ROAD FORT THOMAS, KY 41075		
(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 A Recertification Survey was initiated on 08/05/14 and concluded on 08/07/14. Deficiencies were cited with the highest scope and severity of an "E".	F 000	Preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state laws.	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) 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). 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 §483.16(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	F 157	1) Physician notified of resident #1's refusal, at times, to wear TED hose and Geri-sleeves. Physician saw resident #1 on 8/13/14 and adjusted orders. Charge Nurse noted and recorded changes. 2) All resident's physician orders were reviewed on 8/20/14. There were no other issues identified. All residents with orders to wear therapeutic TED Hose or Geri Sleeves were assessed for compliance on 8/20/14. Any resident that was non-compliant was interviewed and if verbalized a desire other than physician current orders, physician was notified of resident's wishes by Unit Manager and designated nurses, and changes initiated. 3) Policy and Procedure for Notification of Change, and Refusal of Medications and Treatments were reviewed and updated as needed by 8/20/14 by Director of Nursing. Nurses were educated to document each episode of refusal to comply with orders for TED Hose or Geri-sleeves and to notify	9/19/14

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

State Anne Mack

TITLE

Administrative

(X6) DATE

8-28-2014

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 157	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, interview and review of the facility's policy, it was determined the facility failed to ensure the Physician was notified when there was a significant change in a resident's physical status and/or a need to alter treatment for one (1) of fifteen (15) sampled residents (Resident #1). Observations during initial tour revealed Resident #1 without his/her Physician ordered TED (Thrombo-Embolic Deterrent) hose (used to prevent blood clots) or Geri Sleeves (protective sleeves to prevent skin injury), and no documented evidence the Physician was notified of the alteration in treatment.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Notification of Change", undated, revealed the attending Physician should be notified to discontinue an existing form of treatment due to adverse reactions, unsuccessful treatment, or non-compliant with treatment.</p> <p>Review of the facility's policy titled, "Refusal of Medications and Treatments", undated, revealed when a Physician ordered service could not be administered per order, the Physician must be notified. Further review revealed the Physician should be notified when a medication or treatment had been refused by the resident for a twenty-four (24) hour period.</p> <p>Record review revealed the facility admitted Resident #1 on 10/16/13, with diagnoses which included Cerebral Vascular Accident, Atrial</p>	F 157	<p>physician of these episodes. Nurse aides were educated to notify staff nurse of each episode of refusal, or other reasons for TED Hose or Geri-sleeves to not be in place as ordered by physician. Education to be performed by 9/15/14 by Education Director, Director of Nursing, Unit Manager or other designated nurse.</p> <p>4) Staff nurses and CNA staff educated on the need of nurse aides to notify nurses of any refusals of ordered care including the refusal to comply for orders for TED Hose or Geri-sleeves. This is to be reported per each episode. Education to be performed by 9/15/14 by Education Director, Director of Nursing, Unit Manager or other designated nurse.</p> <p>5) A QA monitor has been developed and will be initiated by 9/16/14 by Director of Nursing and Unit Manager to assess compliance of resident with orders for TED Compression Hose and Geri-sleeves. The QA will also assess staff compliance in notifying physician of any incidents of resident refusal of orders. QA will be completed for 100% of residents with an active order for TED Hose or Geri-sleeves, weekly x 4 weeks, every other week x 8 weeks, then monthly x 9 months by Director of Nursing, Unit Manager, Education nurse</p>	

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F 157	<p>Continued From page 2</p> <p>Fibrillation, Congestive Heart Failure, Dementia, Diabetic, Anxiety and Depressive Disorder. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 07/29/14, revealed the facility assessed Resident #1 as having a Brief Interview for Mental status (BIMS) score of a fifteen (15) out of fifteen (15), indicating no cognitive impairment.</p> <p>Review of Resident #1's Physician Orders, revealed an order for TED hose initiated on 10/16/13. Continued review of the Physician's order revealed the TED hose were to be applied in the morning at 6:00 AM and taken off at night at 8:00 PM. Review of the Physician's orders revealed an order for Geri Sleeves was initiated on 05/28/14. Further review of the Physician's Order revealed the Geri Sleeves were to be applied bilaterally before getting out of bed in the morning at 7:00 AM, and removed after the resident was in bed at night at 7:00 PM, to protect and maintain skin integrity.</p> <p>Observation on: 08/05/14 at 5:19 PM and 6:40 PM; 08/06/14 at 11:09 AM; and 08/07/14 at 9:23 AM and 9:41 AM, revealed Resident #1 was not wearing either the TED hose or Geri Sleeves.</p> <p>Interview with Resident #1 on 08/07/14 at 9:23 AM, revealed she had worn the TED hose and Geri Sleeves before, but reported "not in a while". Further interview revealed Resident #1 was unable to be more specific with a time frame of how long it had been since he/she had worn the TED hose and Geri Sleeves.</p> <p>Interview, on 08/07/14 at 9:30 AM, with Certified Nurse Aide (CNA) #4, who had provided care for Resident #1, revealed the resident was ordered</p>	F 157	<p>or other Desk Nurse, IT Nurse or Med Cart Team Nurse. Findings will be tracked and trended in routine and quarterly QA Committee meetings, by QA Committee Nurse. Other QA Committee members including, Administrator, Assistant Administrator, Medical Director, Consultant Physician, Social Services Director, MDS Coordinator, Director of Nursing, Dietary Director, Admissions Coordinator, Pastoral Care Coordinator, Activities Director, Business Office Director, and other representatives from the Carmelite Sisters for the Aged and Infirm will be involved in the review of these audits.</p>	

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F 157	<p>Continued From page 3</p> <p>to wear TED hose; however, indicated not being aware the resident was ordered to wear Geri Sleeves. Further interview revealed CNA #4 when caring for Resident #1 before he/she had never put Geri Sleeves on the resident.</p> <p>Interview, on 08/07/14 at 9:36 AM, with Licensed Practical Nurse (LPN) #1, who had provided care for Resident #1, revealed she did not remember Resident #1 having an order for Geri Sleeves and had not ever notified the Physician regarding a refusal for the TED hose or Geri Sleeves.</p> <p>Interview with the Unit Manager on 08/07/14 at 10:01 AM, revealed Resident #1 should have the TED hose and Geri Sleeves on if the Physician ordered those for treatment interventions. Further interview revealed should the resident or family refuse treatments or interventions, staff should notify the Physician of the refusal and document the refusal in the medical record.</p> <p>Interview with the Director of Nursing (DON) on 08/07/14 at 11:06 AM, revealed his expectations were for staff to follow the Physician's Orders. The DON revealed should a resident refuse implementation of a Physician's Order, the family and Physician should be notified and this should be documented in the resident's medical record. Further interview revealed he was unable to locate any documentation in Resident #1's medical record of notification to the Physician of the resident refusing to wear or not wearing the TED hose or Geri Sleeves.</p> <p>Attempts were made on 08/07/14 at 4:26 PM and 4:47 PM, to contact Resident #1's Physician; however, the calls were unsuccessful and messages left with no return call.</p>	F 157		

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F 280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>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.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to ensure the Comprehensive Care Plan was reviewed and revised periodically after each assessment for one (1) of fifteen (15) sampled residents (Resident #1). The facility failed to ensure Resident #1's Comprehensive Care Plan was updated on 10/18/13, to reflect the Physician's Order for TED hose, and on 05/28/14 to reflect a Physician's Order for Geri Sleeves.</p>	F 280	<p>1) Resident #1's Care Plan was updated on 8/8/14 by MDS nurse to include resident's order to TED hose and Geri-sleeves. These devices were put in place and direct nursing staff educated to apply these devices as ordered by Unit Manager. Care Plan was updated again on 8/13/14 by MDS nurse; after physician review and order changes. Staff were educated of changes in care directives by Unit Manager, and designated nurse(s).</p> <p>2) All residents physician's orders were reviewed for orders of TED Hose or Geri-sleeves for all residents with orders for these devices, all resident Care Plans were reviewed for accuracy and updated as needed by MDS Coordinator by 8/21/14.</p> <p>3) Policies and Procedures, "Comprehensive Assessment and Instrument System", and "Care Planning" were reviewed and updated, as needed, by 8/20/14 by Director of Nursing and MDS Assessment nurse.</p> <p>4) Registered and licensed nurses will be educated by 9/15/14 by Education Nurse, MDS nurse, Director of Nursing, Unit Manager, or designated nurse that any orders received for treatment devices such as TED Hose, Geri-sleeves, or other treatment modalities must be added to the residents chronic Care Plan upon receipt of the order.</p>	9/19/14
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F 280	Continued From page 5 The findings include: Review of the facility's policy titled, "Comprehensive Assessment and Instrument System", undated, revealed the care plan would be completed by day twenty-one (21) from admission and updated quarterly or with a significant change in status. Continued review revealed the care plan would show problems, measurable goals and appropriate incident specific interventions. Further review revealed between the quarterly reviews the care plan would also be updated. Review of the facility's policy titled, "Care Planning", undated, revealed all residents would have a care plan developed which would reflect all services provided to the resident to maintain or attain the resident's highest practicable physical, mental and psychological well-being. Continued review revealed the care plan would address interventions required to assist the resident to meet their goals and would be updated as needed to reflect the most current resident needs. Record review revealed the facility admitted Resident #1 on 10/16/13, with diagnoses which included Congestive Heart Failure, Diabetes, Anxiety Disorder, Cerebral Vascular Accident (stroke) and Atrial Fibrillation. Record review revealed a Quarterly Minimum Data Set (MDS) Assessment, dated 07/29/14, which noted the facility assessed Resident #1 to require total dependence with bed mobility, locomotion, dressing, toilet use, personal hygiene and extensive assist with transfers. Review of the MDS revealed the facility assessed Resident #1 to have skin tears, and to be cognitively intact.	F 280	5) A QA monitor was developed and will be initiated by 9/16/14 by Director of Nursing and Assessment Nurse to assure orders received for TED Hose and Geri-sleeves are updated timely to the residents Chronic Care Plan. This QA will be completed on 100% of census x 1, then weekly x 4 weeks on new orders received from physician, then biweekly x 8 weeks, then monthly x 9 months on any new orders for TED Hose or Geri-sleeve devices ordered by physician. This QA will be performed by MDS Nurse, Director of Nursing, Unit Manager, or desk nurse, IT nurse or medication cart nurse. Findings will be tracked and trended in the routine QA meeting and quarterly QA Committee meeting involving the members listed in F157/N019 in criteria #4.	

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F 280 | Continued From page 6

F 280

Review of the August Monthly Physician's Orders revealed a Physician's Order dated 10/16/13 for TED hose to be placed on in the morning and off at night. Additionally, review revealed a Physician's Order dated 05/28/14 for Geri Sleeves to be placed on the resident's bilateral forearms before getting out of bed and removed after the resident was in bed to protect and maintain skin integrity.

Review of Resident #1's Comprehensive Care Plan revealed Resident #1 had a care plan for at risk for skin breakdown and having fragile skin. However, review of the Comprehensive Care Plan revealed no documented evidence the care plan was updated to include the TED hose or Geri Sleeves were implemented as an intervention per the Physician's Orders.

Observation on 08/05/14 at 5:19 PM, revealed Resident #1 was propelled by wheelchair to his/her room after a shower. Continued observations revealed Resident #1 to not be wearing either TED hose or Geri Sleeves.

Observation at 5:40 PM on 08/05/14, revealed Resident #1 in the dining area sitting up in a wheel chair not wearing the TED hose or Geri Sleeves. Observation on 08/06/14 at 11:09 AM, revealed staff assisted Resident #1 to the bed from the wheelchair; however, the resident was not wearing TED hose or Geri Sleeves.

Observation on 08/07/14 at 9:23 AM, revealed Resident #1 was not wearing TED hose or Geri Sleeves.

Interview with Certified Nursing Aide (CNA) #4 on 08/07/14 at 9:30 AM, revealed Resident #1 did wear TED hose at times, but not Geri Sleeves.

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F 280	Continued From page 7 CNA #4 reported she had never assisted Resident #1 to put on and wear Geri Sleeves. Interview with Licensed Practical Nurse (LPN) #1 on 08/07/14 at 9:36 AM, revealed she was unaware Resident #1 was ordered to wear Geri Sleeves. LPN #1 indicated she was did not know if the care plan included the Geri Sleeves as an intervention. Interview with the Unit Manager on 08/07/14 at 10:01 AM, revealed Resident #1's Comprehensive Care Plan should have been updated with the TED hose and Geri Sleeves as Interventions. Interview with the MDS Coordinator on 08/07/14 at 12:23 PM, revealed it was the responsibility of all licensed nursing staff to update residents' care plans as necessary. Further interview revealed it was her department's responsibility to ensure the care plan was updated with each of the resident's assessments. Interview with the Director of Nursing (DON) on 08/07/14 at 11:06 AM, revealed Resident #1's Comprehensive Care Plan should have been updated to include the TED hose and Geri Sleeves as interventions. The DON revealed licensed nursing staff were responsible for updating residents' care plans. Continued interview revealed the resident should also have a care plan for refusal of TED hose and/or Geri Sleeves if the resident was in fact refusing to wear them.	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309	1) TED Hose and Geri-sleeves were applied to resident #1 on 8/7/14. Medical doctor notified of resident's	9/19/14

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F 309 Continued From page 8

Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to ensure each resident received the necessary care and services in regards to Physician ordered treatment for one (1) of fifteen (15) sampled residents (Resident #1). Record review revealed Resident #1 had orders to wear TED hose (anti-embolic hose) and Geri Sleeves; however, observations revealed no TED hose or Geri Sleeves were worn by the resident as per the Physicians Orders.

The findings include:

Review of the facility's policy titled, "Notification of Change", undated, revealed it was the policy of the facility to ensure each resident received quality medical care. Review of the Policy revealed if a resident was non-compliant with a treatment, experienced an adverse reaction or a treatment was unsuccessful the Physician was to be notified.

Review of the facility's policy titled, "Comprehensive Assessment and Instrument System", undated, revealed the care plan would

F 309 refusals and medical doctor saw resident on 8/13/14 and adjusted orders.

2) All residents were reviewed for orders for TED Hose or Geri-sleeves were visually monitored on 8/19/14 by Floor Nurses to assure current orders were being followed accurately. At this time, 100% compliance was observed for residents with orders to wear TED hose or Geri-sleeves.

3) Policies and Procedures were reviewed and revised as needed on or before 8/20/14 by Director of Nursing.

4) Licensed and registered nurses and CNAs were in-serviced about the need to follow medical doctor orders and apply ordered devices. Nursing Staff were educated about notifying nurses of resident refusals and nurses responsibility to notify medical doctor will be completed by 9/15/14 by Education Nurse, Director of Nursing and Unit Manager.

5) A QA monitor was developed and

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F 309	<p>Continued From page 9</p> <p>be developed and updated quarterly or with a significant change in status. Continued review revealed between quarterly reviews the care plan should be updated as necessary.</p> <p>Record review revealed the facility admitted Resident #1 on 10/16/13, with diagnoses which included Diabetes, Atrial Fibrillation, Cerebral Vascular Accident (stroke), Congestive Heart Failure, Osteoporosis and Depressive Disorder. Review of the record revealed the 07/29/14 Quarterly Minimum Data Set (MDS) which noted the facility assessed Resident #1 to require total dependence dressing and personal hygiene, and to require extensive assist with transfers. Review of the MDS Assessment revealed the facility to have had skin tears. Further review revealed the facility assessed Resident #1 to have a Brief Interview for Mental Status (BIMS) score of fifteen which indicated the resident had no cognitive impairment, and to have had skin tears.</p> <p>Review of the August Monthly Physician's Orders revealed a Physician's Order dated 10/16/13, for Resident to wear TED hose which were to be placed on in the morning and off at night. Continued review of the Physician's Orders revealed an order dated 05/28/14, for Resident #1 to wear Geri Sleeves which were to be placed on his/her bilateral forearms before getting out of bed and removed at bedtime to protect and maintain the resident's skin integrity. Review of Resident #1's Comprehensive Care Plan revealed a care plan for at risk for skin breakdown which noted the resident had fragile skin. However, further review of the care plan revealed no documented evidence it had been updated to include the TED hose or Geri Sleeves as interventions when the orders were received.</p>	F 309	<p>will be initiated by 9/16/14 by Director of Nursing and Unit Manager to monitor for TED Hose & Geri-sleeves devices to be in place per medical doctor order and will be completed daily x 7 days, weekly x 7 weeks, every other week x 8 weeks, monthly x 8 months then quarterly thereafter, by Director of Nursing, Unit Manager, Education Nurse or MDS Nurse, Desk Nurse, IT Nurse or Med Cart Team Nurse. These audits will be tracked and trended in the routine QA meeting, and the quarterly QA Committee meeting that includes members listed in F157/N019 in criteria #4.</p>	

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F 309	Continued From page 10 Further record review revealed no documented evidence of the Physician having been notified if Resident #1's orders for the TED hose and Geri Sleeves were not being implemented. Observation, on 08/05/14 at 5:19 PM and 5:40 PM, on 08/06/14 at 11:09 AM and on 08/07/14 at 9:23 AM revealed Resident #1 was not wearing TED hose or Geri Sleeves as per the Physician's Orders. Interview with Certified Nursing Aide (CNA) #4, on 08/07/14 at 9:30 AM and Licensed Practical Nurse (LPN) #1 revealed they had both provided care for Resident #1, and were not aware Resident #1 was to wear Geri Sleeves. LPN #1 revealed she was not aware the resident had an order for Geri Sleeves. CNA #4 reported she had never assisted Resident #1 to wear Geri Sleeves. Interview, on 08/07/14 at 10:01 AM, with the Unit Manager, of the unit on which Resident #1 resided, revealed if the resident had orders for TED hose and Geri Sleeves the resident should be wearing them, and the care plan should indicate both as interventions. The Unit Manager stated if a resident refused a Physician ordered treatment, the Physician should be notified for further orders or discontinuation. Additionally, the Unit Manager stated Resident #1's Physician should have been notified that the resident was not wearing the TED hose or Geri Sleeves. Phone contact was attempted with Resident #1's Physician on 08/07/14 at 4:26 PM and 4:47 PM; however, were unsuccessful. Messages were left, but no return call received. Interview with the Director of Nursing (DON) on	F 309		
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F 309	Continued From page 11 08/07/14 at 11:06 AM, revealed if Resident #1 had orders for TED hose and Geri Sleeves he/she should have been wearing them, and if the resident had refused to wear them the Physician should have been notified. The DON stated if a resident refused treatments ordered the resident should be care planned for the refusal. Per interview, the Comprehensive Care Plan should have been updated for Resident #1's TED hose and Geri Sleeves as interventions. Continued Interview revealed licensed nursing staff had the responsibility of updating care plans.	F 309		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked,	F 431	1) Medication room door was locked on 8/5/14 and monitored and remained locked after this date. 2) Both door locks were inspected on 8/6/14 by Maintenance Director and in good working order. A keypad lock replacement handle was installed on each door on 8/21/14 by maintenance team. 3) Policy and Procedure: "Medication Storage" was reviewed and updated as needed by 8/20/14 by Director of Nursing and consultant pharmacist.	9/19/14

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F 431	<p>Continued From page 12</p> <p>permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's policy, it was determined the facility failed to ensure the medication room remained locked and inaccessible to residents, family, visitors and unauthorized staff.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Medication-Storage" undated, revealed medications and other drugs, including treatment items, should be stored in a locked cabinet or locked room inaccessible to residents and visitors.</p> <p>Observation during initial tour on 08/05/14 at 11:15 AM, revealed the medication room to be unlocked and accessible to residents, family, visitor and unauthorized staff. Continuous observation revealed the medication room to remain unlocked until 11:24 AM. Further observation revealed multiple medications to be stored in the medication room to include: Tylenol (pain reliever medication), Imodium (anti-diarrheal medication), Depakote (bi-polar treatment medication), Buspar (anti-anxiety</p>	F 431	<p>4) Registered and Licensed nurses will be educated regarding safety and keeping medication doors locked at all times by 9/15/14 by Education Nurse, Director of Nursing and Unit Manager.</p> <p>5) A QA monitor has been developed and will be initiated by 9/16/14 by Director of Nursing and Unit Manager. QA to be completed by Director of Nursing, Unit Manager, Education Nurse, or designated nurse(s). The (2) Medication Room doors will be checked for 2 x's per shift for 2 weeks, then daily x 1 month, 3 times a week x 1 month, weekly x 2 months, every other week x 2 months, then monthly x 5 months and quarterly afterwards. Findings will be tracked and trended in routine and quarterly QA Committee meetings, by QA Committee Nurse. Other QA Committee members including, Administrator, Assistant Administrator, Medical Director, Consultant Physician, Social Services Director, MDS Coordinator, Director of Nursing, Dietary Director, Admissions Coordinator, Pastoral Care Coordinator, Activities Director, Business Office Director, and other representatives from the Carmelite Sisters for the Aged and Infirm will be involved in the review of these audits.</p>		

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F 431	Continued From page 13 medication), Colace (stool softner), Benadryl (allergy medication), Naproxen (nonsteroidal anti-inflammatory medication), Apresoline (used to treat hypertension), Sodium Chloride (normal saline), Tums (antacid medication), Miralax (laxative medication), Milk of Magnesia (laxative medication), Mag Citrate (laxative medication), Robitussin (cough medication), Pepto Bismol (antacid medication), Liquid Potassium Chloride (a mineral supplement medication used to prevent or treat low Potassium), Lidocaine Patches (pain reliever medication), Ventolin Inhalers (asthma medication), Cholestyramine Oral Suspension (used to lower cholesterol), Flexeril (muscle relaxer medication), Glipzide (Diabetic medication), Ranexa (medication used to treat chronic chest pain), Metformin (Diabetic medication), Prilosec (acid reducing medication), Lasix (, Cefexa (depression medication), Oxybutynin (medication used to treat overactive bladder), Bentyl (medication used to treat irritable bowel syndrome), Norvasc (anti-hypertensive medication), Lisinopril (anti-hypertensive medication), Imdur (medication used to prevent chest pain), Carafate (medication used to treat and prevent ulcers), Albuterol (respiratory inhalant), Ipratropium (respiratory inhalant), URI Stat (used to treat symptoms of urinary tract irritation), Nutrisource Fiber Packs (fiber supplements), Prevalite Powder (medication used to treat high cholesterol and itching from partial biliary obstruction, Heparin (an anti-coagulant) Lock Flush and Normal Saline prefilled syringes. Interview with Licensed Practical Nurse (LPN) #1 on 08/05/14 at 11:25 AM, revealed each nurse assigned to a medication cart had a key to the medication room, and the medication room was to be kept locked due to the medications stored in	F 431		
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F 431	Continued From page 14 the room. Further interview revealed the facility did have residents who were cognitively impaired yet mobile and wandered which might access the unlocked medication room and that could be harmful to the resident. Interview with LPN #4 on 08/07/14 at 6:30 PM, revealed the medication room should be kept locked at all times. Further interview revealed and if it was unlocked this would be a safety risk for residents. Interview with Registered Nurse (RN) #1 on 08/07/14 at 6:26 PM, revealed the medication room should be kept locked at all times due to the medications that were stored in the room. Further interview revealed if it was unlocked this could be a safety risk for residents. Interview with the Unit Manager on 08/07/14 at 6:34 PM, revealed the medication room should be kept locked at all times, and if it wasn't locked this could be a safety risk for cognitively impaired residents who might gain access. Interview with the Director of Nursing (DON) on 08/07/14 at 7:00 PM, revealed the medication room should be kept locked at all times per the facility policy. The DON stated if the medication room was not locked it was a safety risk for residents. Interview with the Administrator on 08/07/14 at 12:31 PM, revealed the medication room should be locked at all times per the facility's policy. The Administrator stated the medication room should remain locked to ensure resident safety as the facility did have residents who were cognitively impaired but independently mobile. The	F 431			

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F 431	Continued From page 15 Administrator provided a list of thirteen (13) residents the facility assessed to be cognitively impaired; however, were mobile without staff assist.	F 431			
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to ensure interventions were accurately documented in the medical record for one (1) of fifteen (15) sampled residents (Resident #1). The findings include: Review of the facility's policy titled, "Charting and Documentation", undated, revealed all services provided to the resident, or any changes in the	F 514	1) Nurses identified as documenting TED Hose and Geri-sleeves, will make a late entry in nurses notes that devices were not in place for 8/5/14, 8/6/14, 8/7/14 by 8/29/14. 2) All documentation for those residents wearing Geri-sleeves and TED Hose were checked for accuracy. 3) Policy and Procedure Charting and Documentation was reviewed and revised as needed by Director of Nursing on 8/20/14. 4) Nurses and nurse aides were educated on need to follow medical doctor orders for Plan of Care, and when orders are not followed aides are to report to nurses, and nurses document and notify medical doctor/family Power of Attorney appropriately. Education will be completed by 9/15/14 by Education Nurse, Director of Nursing, or Unit Manager. 5) A QA monitor has been developed and will be initiated by 9/16/14 by	9/19/14	

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F 514	<p>Continued From page 16</p> <p>resident's condition, should be recorded in the resident's medical record. Review revealed documentation pertaining to a resident's refusal of treatment should include: the treatment attempted, date and time treatment was attempted, resident's response and reason for refusal, name of person attempting to administer the treatments, documentation that the resident was informed of the purpose of the treatment and the consequences of not receiving the care, documentation each time the resident refused treatment, the resident's conditions and any adverse effects due to the refusal, the date and time the Physician was notified and Physician's response, pertinent observation and the signature and title of the person recording the data. Continued review revealed should an error in documentation occur, erasures of any type should not be made in the medical record, and a follow up note should be completed stating that there was an error in documentation in a previous note, the date, time and name of the person completing the error should be noted in the error report note, and what error was made, then the correction of the error should be written on a new note.</p> <p>Record review revealed Resident #1 was admitted by the facility on 10/16/13, with diagnoses which included Cerebral Vascular Accident (stroke), Congestive Heart Failure, Atrial Fibrillation, Diabetes, Anxiety Disorder and Depressive Disorder. Review of the Quarterly Minimum Data Set (MDS), dated 07/29/14, revealed the facility assessed Resident #1 be cognitively intact, to require total dependence with bed mobility, locomotion, dressing, toilet use, personal hygiene and extensive assist with transfers, and to have had skin tears.</p>	F 514	<p>Director of Nursing, Unit Manager to monitor for accurate documentation of carrying out physician orders for residents with orders for TED Hose or Geri-sleeves. QA will be completed for residents with physician orders for TED Hose or Geri-sleeves. It will be completed: weekly x 4 weeks, bi-weekly x 8 weeks, then monthly x 9 months to be completed by Director of Nursing, Unit Manager, designated nurse(s) then quarterly afterwards. Findings will be tracked and trended in routine and quarterly QA Committee meetings, by QA Committee Nurse. Other QA Committee members including, Administrator, Assistant Administrator, Medical Director, Consultant Physician, Social Services Director, MDS Coordinator, Director of Nursing, Dietary Director, Admissions Coordinator, Pastoral Care Coordinator, Activities Director, Business Office Director, and other representatives from the Carmelite Sisters for the Aged and Infirm will be involved in the review of these audits.</p>	

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F 514	Continued From page 17 Review of the August Monthly Physician's Orders revealed Resident #1 an order dated 10/16/13, for TED hose to be placed on in the morning and off at night. Further review revealed an order dated 05/28/14, for Geri Sleeves to be placed on bilateral forearms before getting out of bed and removed after the resident was in bed to protect and maintain skin integrity. Review of Resident #1's Treatment Administration Record (TAR) for 08/05/14, revealed: the Geri Sleeves were initialed as applied at 6:03 AM and initialed as removed at 19:30 PM, and the TED hose were initialed as applied at 6:03 AM and initialed as removed at 19:58 PM; on 08/06/14, the Geri sleeves were documented as being applied at 6:07 AM and removed at 19:50, and the TED hose applied at 6:07 AM and removed at 19:50 PM; on 08/07/14 the Geri sleeves and TED hose were initialed as applied at 5:54 AM. However, observation on 08/05/14 at 5:19 PM and 5:40 PM, on 08/06/14 at 11:09 AM, on 08/07/14 at 9:23 AM and 9:41 AM revealed Resident #1 was not wearing the Geri Sleeves or TED hose as per the TAR documentation. Interview with Certified Nurse's Aide (CNA) #4, on 08/07/14 at 9:30 AM, revealed she was responsible for Resident #1's care, and the TED hose should be applied prior to CNA #4's scheduled shift. Continued interview revealed Resident #1 was not wearing TED hose on 08/07/14, and CNA #4 was not aware of the reason the resident was not wearing them. Further interview revealed CNA #4 had not attempted to apply the TED hose nor, did she report the resident not wearing them to the nurse.	F 514		

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F 514 Continued From page 18
Additionally, she stated she was unaware Resident #1 had Geri Sleeves ordered.

Interview with Licensed Practical Nurse (LPN) #3 on 08/07/14 at 5:27 PM, revealed she had cared for Resident #1 on the night of 08/06/07, and early morning of 08/07/14, and had documented having applied TED hose and Geri Sleeves to Resident #1. LPN #3 stated Resident #1 was asleep when she went into the room to implement the interventions, and LPN #3 did not awaken Resident #1 to apply the TED hose or Geri Sleeves. Continued interview revealed she had documented on the TAR she applied the interventions of TED hose and Geri Sleeves prior to going to the resident's room, and had forgotten to document the resident was asleep and the interventions were not implemented. Further interview revealed she should have documented accurately on the TAR to reflect the correct interventions in use.

Interview with Registered Nurse (RN) #1 on 08/07/14 at 4:01 PM, revealed she was responsible for Resident #1's care, and was aware Resident #1 had Physician's Orders for TED hose and Geri Sleeves. Further interview revealed she was not aware Resident #1 had neither of these interventions implemented for 08/07/14. RN #1 indicated the TAR should contain accurate documentation.

Interview with LPN #1 on 08/07/14 at 9:41 AM, revealed she had cared for Resident #1; however, was unaware Resident #1 had an order for Geri Sleeves. LPN #1 indicated she was also unaware that Resident #1 was not wearing the TED hose as per the Physician's Order and as documented on the TAR. LPN #1 revealed

F 514

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F 514	Continued From page 19 should a resident refuse a treatment, it should be noted on the TAR. Further interview revealed documentation of a treatment should not be completed until the treatment was completed, and indicated the TAR should contain accurate documentation. Interview with the Unit Manager on 08/07/14 at 10:01 AM, revealed the TAR should accurately reflect the treatment interventions for each resident. Further interview revealed should a resident refuse a treatment, the refusal should be documented on the TAR and the Physician and family notified of the refusal. Interview with the Director of Nursing (DON) on 08/07/14 at 11:06 AM, revealed his expectation of his staff would be to follow the Physician's Orders and document treatments accurately on the TAR. The DON revealed a treatment that was not done or not completed should not be documented as completed. Further interview revealed should a resident refuse a treatment it should be documented accurately on the TAR, with the Physician and family notified of the refusal.	F 514			

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NAME OF PROVIDER OR SUPPLIER CARMEL MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 100 CARMEL MANOR ROAD FORT THOMAS, KY 41075		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 000	INITIAL COMMENTS CFR: 42 CFR 483.70(a) BUILDING: 01 PLAN APPROVAL: 1989 SURVEY UNDER: 2000 Existing FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: Two (2) story with a basement Type III (211) SMOKE COMPARTMENTS: Three (3) smoke compartments FIRE ALARM: Complete fire alarm system with one hundred forty two (142) heat and sixty (60) smoke detectors SPRINKLER SYSTEM: Complete automatic wet and dry sprinkler system. GENERATOR: Type II generator. Fuel source is diesel. A standard Life Safety Code survey was conducted on 08/06/14. The facility was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for sixty-five (65) beds with a census of sixty-three (63) on the day of the survey. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from	K 000			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Steve Alton Mack</i>			TITLE <i>Administrator</i>		(X6) DATE <i>8-28-2014</i>

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

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K 000	Continued From page 1 Fire)	K 000	Preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state laws.	
K 047 SS=F	NFFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exit signs were maintained in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect three (3) of three (3) smoke compartments, all residents, staff and visitors. The facility has the capacity for sixty-five (65) beds and at the time of the survey, the census was sixty-three (63). The findings include: Observation, on 08/06/14 at 2:40 PM with the Maintenance Director, revealed the facilities exit signage was the photoluminescent type. The exit signage did not have a light illuminating the face. Interview, on 08/06/14 at 2:41 PM with the Maintenance Director, revealed he was unaware of the requirements for the illumination of egress. The census of sixty-three (63) was verified by the Administrator on 08/06/14. The findings were	K 047	The Director of Maintenance, Maintenance and Security Personnel have been in-serviced by the Assistant Administrator regarding the illumination of egress requirements on 8/29/14. Replacement illuminated exit signs have been ordered for the areas identified and will be installed by Denier Electric. All exit signs will be connected to the generator for back up illumination in the event of a power outage. A QA audit regarding proper illumination of exit signs will be completed monthly by the Director of Maintenance with results forwarded to Administration to assure compliance.	9/19/14

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K 047	Continued From page 2 acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 08/06/14. Actual NFPA Standard: 7.8 ILLUMINATION OF MEANS OF EGRESS 7.8.1 General. 7.8.1.1* Illumination of means of egress shall be provided in accordance with Section 7.8 for every building and structure where required in Chapters 11 through 42. For the purposes of this requirement, exit access shall include only designated stairs, aisles, corridors, ramps, escalators, and passageways leading to an exit. For the purposes of this requirement, exit discharge shall include only designated stairs, aisles, corridors, ramps, escalators, walkways, and exit passageways leading to a public way. 7.8.1.2 Illumination of means of egress shall be continuous during the time that the conditions of occupancy require that the means of egress be available for use. Artificial lighting shall be employed at such locations and for such periods of time as required to maintain the illumination to the minimum criteria values herein specified. Exception: Automatic, motion sensor-type lighting switches shall be permitted within the means of egress, provided that the switch controllers are equipped for fail-safe operation, the illumination timers are set for a minimum 15-minute duration, and the motion sensor is activated by any occupant movement in the area served by the lighting units. 7.8.1.3* The floors and other walking surfaces within an exit and within the portions of the exit access and	K 047		
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K 047	<p>Continued From page 3</p> <p>exit discharge designated in 7.8.1.1 shall be illuminated to values of at least 1 ft-candle (10 lux) measured at the floor.</p> <p>Exception No. 1: In assembly occupancies, the illumination of the floors of exit access shall be at least 0.2 ft-candle (2 lux) during periods of performances or projections involving directed light.</p> <p>Exception No. 2*: This requirement shall not apply where operations or processes require low lighting levels.</p> <p>7.8.1.4*</p> <p>Required illumination shall be arranged so that the failure of any single lighting unit does not result in an illumination level of less than 0.2 ft-candle (2 lux) in any designated area.</p> <p>7.8.1.5</p> <p>The equipment or units installed to meet the requirements of Section 7.10 also shall be permitted to serve the function of illumination of means of egress, provided that all requirements of Section 7.8 for such illumination are met.</p> <p>7.8.2 Sources of Illumination.</p> <p>7.8.2.1*</p> <p>Illumination of means of egress shall be from a source considered reliable by the authority having jurisdiction.</p> <p>7.8.2.2</p> <p>Battery-operated electric lights and other types of portable lamps or lanterns shall not be used for primary illumination of means of egress.</p> <p>Battery-operated electric lights shall be permitted to be used as an emergency source to the extent permitted under Section 7.9.</p> <p>7.10.7.2* Photoluminescent Signs.</p> <p>The face of a photoluminescent sign shall be continually illuminated while the building is occupied. The illumination levels on the face of</p>	K 047		
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K 047	Continued From page 4 the photoluminescent sign shall be in accordance with its listing. The charging illumination shall be a reliable light source as determined by the authority having jurisdiction. The charging light source shall be of a type specified in the product markings.	K 047		
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4	K 052	Director of Maintenance was in-serviced by the Assistant Administrator on 8/7/14 regarding the necessity of timely Fire Alarm testing and the NFPA requirements. The Fire Alarm testing schedule has been reviewed with the Director of Maintenance and testing dates set in advance of quarterly deadlines. Fire Alarm testing company has been notified. QM audit will be completed by the Assistant Administrator or assignee on a quarterly basis to ensure compliance.	9/19/14
	This STANDARD is not met as evidenced by: Based on fire alarm testing record review and interview, it was determined the facility failed to ensure the fire alarm system was inspected and tested in accordance with National Fire Protection Association (NFPA) Standards. The deficient practice had the potential to affect three (3) of three (3) smoke compartments, all residents, staff and visitors. The facility has the capacity for sixty-five (65) beds and at the time of the survey, the census was sixty-three (63).			

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K 052	Continued From page 5 The findings include: Fire alarm testing record review, on 08/06/14 at 2:00 PM with the Maintenance Director, revealed the facility failed to conduct a quarterly fire alarm test during the fourth quarter of 2013 until 01/02/14. Interview, on 08/06/14 at 2:01 PM with the Maintenance Director revealed he was not aware the fire alarm testing company had missed the fourth quarter by two (2) days. The census of sixty-three (63) was verified by the Administrator on 08/06/14. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 08/06/14. Actual NFPA Standard: NFPA 101, 9.6.1.4. A fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm Code.	K 052		
K 072 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10	K 072	All linen carts have been removed from the paths of egress. 8/7/14 The table blocking Exit #3 has been moved. 8/7/14 The sign-in book protruding in Hall #4 has been adjusted to the required specifications. 8/7/14	9/19/14

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K 072	<p>Continued From page 6</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain exit access in accordance with NFPA standards. The deficient practice had the potential to affect three (3) of three (3) smoke compartments, all residents, staff and visitors. The facility had the capacity for sixty-five (65) beds and at the time of the survey, the census was sixty-three (63).</p> <p>The findings include:</p> <p>Observation, on 08/06/14 at 2:30 PM with the Maintenance Director, revealed a linen cart stored in the egress path by room #124.</p> <p>Interview, on 08/06/14 at 2:31 PM with the Maintenance Director, revealed the linen cart was routinely stored in this location.</p> <p>Observation, on 08/06/14 at 2:45 PM with the Maintenance Director, revealed a linen cart and an ice cart stored in the egress path of Hall #3.</p> <p>Interview, on 08/06/14 at 2:46 PM with the Maintenance Director, revealed the linen cart and ice cart were routinely stored in this location.</p> <p>Observation, on 08/06/14 at 2:47 PM with the Maintenance Director, revealed a table blocking the exit door of Hall #3.</p> <p>Interview, on 08/06/14 at 2:48 PM with the Maintenance Director, revealed the table was used for restorative dining and frequently not pushed out of the way after use.</p> <p>Observation, on 08/06/14 at 2:52 PM with the Maintenance Director, revealed a sign-in book</p>	K 072	<p>The Director of Maintenance, Maintenance Department and Security were in-serviced on 8/29/14 by the Assistant Administrator regarding NFPA standards pertaining to exit access.</p> <p>A QA monitor will be completed by the Director of Maintenance weekly for 4 weeks, then bi-weekly for 4 weeks, then monthly to assure compliance. All monitors will be forwarded to Administration.</p> <p>All staff will be in-serviced regarding maintaining clear pathways of egress through in-services conducted 9/3/14 and 9/4/14.</p>	9/19/14

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K 072	Continued From page 7 shelf projecting sixteen (16) inches out from the wall located by the entrance/exit door of Hall #4. Interview, on 08/06/14 at 2:53 PM with the Maintenance Director, revealed he was not aware of the egress requirements pertaining to projections from the wall. The census of sixty-three (63) was verified by the Administrator on 08/06/14. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 08/06/14. Actual NFPA Standard: Reference: NFPA 101 (2000 Edition) Means of Egress Reliability 7.1.10.1 Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. Reference: NFPA 101 (200 Edition) 7.3.2* Measurement of Means of Egress. The width of means of egress shall be measured in the clear at the narrowest point of the exit component under consideration. Exception: Projections not more than 3 1/2 in. (8.9 cm) on each side shall be permitted at 38 in. (96 cm) and below.	K 072			
K 144 SS=F	Reference: S&C-12-21-LSC NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144			

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K 144 Continued From page 8

This STANDARD is not met as evidenced by:
Based on interview and generator testing record review, it was determined the facility failed to maintain the generator set by National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect three (3) of three (3) smoke compartments, all residents, staff and visitors. The facility had the capacity for sixty-five (65) beds with a census of sixty-three (63) on the day of the survey.

The findings include:

Generator testing record review, on 08/06/14 at 2:05 PM with the Maintenance Director, revealed the facility did not document the transfer times monthly when the power was transferred during the monthly testing of the generator transfer switch.

Interview, on 08/06/14 at 2:06 PM with the Maintenance Director, revealed he was not aware of the requirement.

The census of sixty-three (63) was verified by the Administrator on 08/06/14. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 08/06/14.

K 144 The Generator Log has been revised 9/19/14 to reflect documentation of transfer times during monthly testing.

The Director of Maintenance was inserviced on 8/29/14 by the Assistant Administrator regarding the requirement.

A copy of the completed log will be forwarded to Administration for QA monitoring on a monthly basis to assure compliance.

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K 144	Continued From page 9 Actual NFPA Standard: Reference: NFPA 99 (1999 Edition) 3-4.1.1.15 + Alarm Annunciator. A remote annunciator, storage battery powered, shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station (see NFPA 70, National Electrical Code, Section 700-12.) The annunciator shall indicate alarm conditions of the emergency or auxiliary power source as follows: a. Individual visual signals shall indicate the following: 1. When the emergency or auxiliary power source is operating to supply power to load 2. When the battery charger is malfunctioning b. Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate the following: 1. Low lubricating oil pressure 2. Low water temperature (below those required in 3-4.1.1.9) 3. Excessive water temperature 4. Low fuel - when the main fuel storage tank contains less than a 3-hour operating supply 5. Overcrank (failed to start) 6. Overspeed Where a regular work station will be unattended periodically, an audible and visual derangement signal, appropriately labeled, shall be established at a continuously monitored location. This derangement signal shall activate when any of the conditions in 3-4.1.1.15(a) and (b) occur, but need not display these conditions individually. [110: 3-5.5.2]	K 144			

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K 144 Continued From page 10
Reference: NFPA 110 (1999 Edition) 5-3.1 The Level 1 or Level 2 EPS equipment location shall be provided with battery-powered emergency lighting. The emergency lighting charging system and the normal service room lighting shall be supplied from the load side of the transfer switch.

Reference: NFPA 99 (1999 Edition) 3-5.4.1.1 Maintenance and Testing of Alternate Power Source and Transfer Switches.
(a) Maintenance of Alternate Power Source. The generator set or other alternate power source and associated equipment, including all appurtenant parts, shall be so maintained as to be capable of supplying service within the shortest time practicable and within the 10-second interval specified in 3-4.1.1.8 and 3-5.3.1.
(b) Inspection and Testing. Generator sets shall be inspected and tested in accordance with 3-4.4.1.1(b).
Actual Standard: NFPA 110, 6-4.5 Level 1 and Level 2 transfer switches shall be operated monthly. The monthly test of a transfer switch shall consist of electrically operating the transfer switch from the standard position to the alternate position and then a return to the standard position.
Actual Standard: NFPA 99, 3-4.4.1.1 Maintenance and Testing of Alternate Power Source and Transfer Switches.
(a) Maintenance of Alternate Power Source. The generator set or other alternate power source and associated equipment, including all

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K 144	<p>Continued From page 11</p> <p>appurtenant parts, shall be so maintained as to be capable of supplying service within the shortest time practicable and within the 10-second interval specified in 3-4.1.1.8 and 3-4.3.1. Maintenance shall be performed in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Chapter 6.</p> <p>(b) Inspection and Testing.</p> <p>1. Test Criteria. Generator sets shall be tested twelve (12) times a year with testing intervals between not less than 20 days or exceeding 40 days. Generator sets serving emergency and equipment systems shall be in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Chapter 6.</p> <p>2. Test Conditions. The scheduled test under load conditions shall include a complete simulated cold start and appropriate automatic and manual transfer of all essential electrical system loads.</p> <p>3. Test Personnel. The scheduled tests shall be conducted by competent personnel. The tests are needed to keep the machines ready to function and, in addition, serve to detect causes of malfunction and to train personnel in operating procedures.</p> <p>Actual Standard: NFPA 99, 3-3.4.4.2. A written record of inspection, performance, exercising period, and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction.</p> <p>Reference: NFPA 99 (1999 Edition) 6-1.1* The routine maintenance and operational testing program shall be based on the manufacturer's recommendations, instruction manuals, and the</p>	K 144			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185208	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 08/06/2014
NAME OF PROVIDER OR SUPPLIER CARMEL MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 100 CARMEL MANOR ROAD FORT THOMAS, KY 41075	
(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)
K 144	<p>Continued From page 12</p> <p>minimum requirements of this chapter and the authority having jurisdiction</p> <p>Reference: NFPA 99 (1999 Edition) 6-3.3 A written schedule for routine maintenance and operational testing of the EPSS shall be established</p> <p>Reference: NFPA 99 (1999 Edition) 6-4.1* Level 1 and Level 2 EPSSs, including all appurtenant components, shall be inspected weekly and shall be exercised under load at least monthly.</p> <p>Reference: NFPA 99 (1999 Edition) 6-4.5 Level 1 and Level 2 transfer switches shall be operated monthly. The monthly test of a transfer switch shall consist of electrically operating the transfer switch from the standard position to the alternate position and then a return to the standard position.</p> <p>Reference: NFPA 101 (2000 edition) 7.9.1.2 Where maintenance of illumination depends on changing from one energy source to another, a delay of not more than 10 seconds shall be permitted.</p> <p>Reference: NFPA 110 (1999 ed.) 5-7 Heating, Cooling, and Ventilating. 5-7.1* Consideration shall be given to properly sizing the ventilation or air-conditioning systems to remove all the heat rejected to the EPS equipment room by the energy converter, uninsulated or insulated exhaust pipes, and other heat-producing equipment. 5-7.2 Adequate ventilation shall be provided to prevent temperatures or temperature rises in the EPS and related</p>	K 144	

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accessory equipment that exceed the recommendations of the manufacturer.
5-7.3 For the EPS equipment room, the ventilation or cooling equipment, or both, shall be sized so that the ambient temperature shall not exceed the EPS equipment manufacturer's criteria or allowable maximum temperatures.

Reference: NFPA 110 (1999 Edition) 5-2.1 The EPS shall be installed in a separate room for Level 1 installations. EPSS equipment shall be permitted to be installed in this room. The room shall have a minimum 2-hour fire rating or shall be located in an adequate enclosure located outside the building capable of resisting the entrance of snow or rain at a maximum wind velocity required by local building codes. No other equipment, including architectural appurtenances, except those that serve this space, shall be permitted in this room.

Reference: NFPA 110 (1999 Edition) 5-12.6 The starting battery units shall be located as close as practicable to the prime mover starter to minimize voltage drop. Battery cables shall be sized to minimize voltage drop in accordance with the manufacturers' recommendations and accepted

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engineering practices.
Battery charger output wiring shall be permanently connected. Connections shall not be made at the battery terminals.

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