

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

PRINTED: 06/28/2012
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 C 06/14/2012
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 332	<p>Continued From page 1</p> <p>required to use the three-step rule to ensure the correct dose of medication was administered. The three-step rule included reading the medication label before removing the medication from the container, before administering the medication, and following administration of the medication.</p> <p>Review of the Adverse Drug Reaction policy (dated 09/14/07) revealed tablets and capsules listed on the "Medication Guidelines List" would not be crushed unless a specific physician's order to crush a non-crushable medication was obtained. The policy noted the physician's order must include a statement from the physician to justify the medical necessity of crushing the medication and the degree of risk to the resident. According to the "Medication Guidelines List," Potassium Chloride Extended Release should not be crushed prior to administration.</p> <p>1. Observations of a medication administration on 06/13/12, at 9:10 AM, revealed Registered Nurse (RN) #2 administered one 50 milligram (mg) tablet of Zoloft (anti-depressant medication) to Resident #16. However, a review of the current physician's orders dated June 2012 revealed the attending physician had prescribed Zoloft 150 mg to be administered daily to Resident #16.</p> <p>Interview with RN #2 on 06/13/12, at 11:00 AM, revealed she was required to "double check" the medication administration record (MAR) to ensure the correct dose of medication was administered to Resident #16. RN #2 stated she overlooked the additional Zoloft 100 mg dose to be administered to Resident #16.</p>	F 332	<p>medications and how to handle situation if a resident requires a medication to be crushed, that is not approved to be crushed, and also on the proper three check method to assure proper dose is administered to residents.</p> <p>DON, and unit manager, and designee(s) will review all residents, and for residents that require medications to be crushed, will review all medications for orders of medications that cannot be crushed. Any medications that cannot be crushed will be reviewed by DON, Unit Manager, or designee, with a physician for an alternative acceptable mode of delivery, or if physician approves to crush, physician will write order to crush, a non-crushable medication and include rational, by 7/12/12. All residents medications will be reviewed by DON, Unit Manager or designee, for orders that require more than one tablet or capsule to make the correct dose. Any orders requiring more than one tablet/capsule will be reviewed with physician by DON, Unit Manager, or designee for possible order clarification to a different dose or medication, that requires one tablet/capsule to make correct dose. Medications that continue to require</p>	7/24/12	

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

PRINTED: 06/28/2012
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 C 06/14/2012
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 332	Continued From page 2 2. Additional medication administration observation conducted on 06/13/12, at 9:20 AM, revealed RN #2 administered Potassium Chloride Extended Release (potassium supplement) 20 meq, which was listed on the facility's "Medication Guidelines List" of medications that were not to be crushed unless specifically ordered by the physician, to Resident #17. RN #2 was observed to crush the tablet and mix the medication with applesauce prior to administration. A review of the June 2012 physician's orders revealed a physician's order (originally dated 04/20/12) noting "crush medications by mouth." However, the order failed to include a statement from the physician to justify the medical necessity of crushing the medication and the degree of risk to the resident as required by facility policy. Continued interview with RN #2 on 06/13/12, at 11:00 AM, revealed she had talked with Resident #17's physician "in general" regarding crushing the resident's medication, but not specifically about the Potassium Chloride. RN #2 further stated she had not discussed the possibility of a liquid form of Potassium Chloride to be administered to Resident #17. Interview conducted with the Director of Nurses on 06/14/12, at 4:45 PM, revealed nurses were responsible to administer the correct dose of medication at the correct time to residents. The DON stated nurses were required to utilize the Medication Guidelines List to determine if a medication could be crushed prior to administration. The DON further stated medication observation audits were randomly conducted one to two times per quarter to	F 332	more than one tablet/capsule will have order on electronic medication administration record clarified and each tablet will be listed separately, on its own line, to indicate each individual dose. Computer nurse or designee will complete this. This will be completed by 7/12/12. DON, Unit Manager, or designee will review all residents, and any resident that is frequently off the unit for long periods of time, during med pass times. DON, Unit Manager, or designee will consult the physician regarding residents that are identified, and make acceptable adjustments to medication pass times to fit residents personal schedule, and physicians treatment plans, by 7/12/12. RN #1 and RN #2 will be observed doing medication pass by 7/23/12 by consulting pharmacist or designee. DON reviewed policy and procedure regarding medication delivery and updated as needed on 7/4/12. Lifeline Pharmacy was consulted regarding medication pass procedure and will in-service all staff nurses regarding general procedures for performing a medication pass by 7/23/12 by Pharmacy representative and DON, Unit Manager, or education nurse.	7/24/12	

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

PRINTED: 06/28/2012
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 C 06/14/2012
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 332	Continued From page 3 monitor accuracy and competency during medication administration. The DON stated no problems had been identified during the facility's medication observations. 3. A review of the current physician's orders for Resident #18, dated June 2012, revealed the resident's attending physician had prescribed Humalog (insulin) to be administered to Resident #18 per "sliding scale" three times per day at 8:00 AM, 1:00 PM, and 6:00 PM. However, observations of a medication administration on 06/13/12, revealed RN #1 administered Humalog (insulin) 3 units subcutaneously to Resident #18 at 9:45 AM, one hour and forty-five minutes past the time requested by the physician and forty-five minutes past the timeframe established by the facility. Interview with RN #1 on 06/13/12, at 12:09 PM, revealed a volunteer had taken Resident #18 to the church service without asking staff if Resident #18 had received his/her medication and, as a result, RN #1 failed to administer Resident #18's insulin in accordance with the physician's orders and/or facility policy.	F 332	Med pass observation audits will be performed by consulting pharmacist, Education Nurse, DON or Unit Manager beginning 7/23/12. These will be done weekly x 8 weeks, every other week x 8 weeks, then monthly x 10 months.	7/24/12
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	The facility will continue to: Procure food from sources approved or considered satisfactory by Federal, State or Local Authorities and store, prepare and serve food under sanitary conditions. Paper towel dispenser relocated to avoid possible contamination when moving from dirty to clean supplies/surfaces immediately 6/14/12.	7/24/12

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

PRINTED: 06/28/2012
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 C 06/14/2012
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 371	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on review of the facility policy, observation, and interview, it was determined the facility failed to distribute and serve food under sanitary conditions. Dietary staff was observed at the evening meal on 06/12/12, to wash their hands at the kitchen sink (only sink available) and reach to the left of the sink above the countertop for paper towels while water was observed dripping from the employee's hands onto a covered (plastic wrap) pan of combread, a clean steam table pan, and a clean food serving scoop. The findings include: A review of the facility's dietary policy/procedure for Infection Control/Exposure Control (revised 11/17/11) revealed the policy/procedure stated all staff was educated in the importance of hand hygiene through hand washing and hand sanitizing. According to the policy, staff was to cleanse/sanitize their hands. Those would include times at the start of their shift, after restroom use, after smoking, eating, or other personal acts, and when there was resident or resident item contact. In addition, the policy indicated the times for staff to cleanse/sanitize hands included but was not limited to, when moving from dirty to clean supplies/surfaces. However, the policy/procedure did not indicate the location of the employee's designated hand washing sink. Observation of the tray line at the evening meal at 5:45 PM on 06/12/12, revealed the facility had a	F 371	Policy regarding Infection control/exposure control reviewed 6/14/12. Monitor developed and conducted on sinks used for hand washing in the kitchen/pantry areas. Monitor conducted 6/15/12 x 1, then added to weekly infection control monitors.	7/24/12

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

PRINTED: 06/28/2012
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 C 06/14/2012
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 371	Continued From page 5 kitchen pantry on the nursing unit containing a steam table where the residents' food was stored for each meal service. Observation of dietary staff preparing residents' food trays to be served revealed staff washed their hands at the kitchen sink, and the paper towels were located to the left of the sink above the countertop. Staff was observed to wash their hands nine times during the observation period at the kitchen sink, and reached to the left of the sink for the paper towels. Water was observed to drip from the employees' hands onto the top of a pan of cornbread (covered with plastic wrap), a clean steam table pan, and a clean food serving scoop. An interview was conducted with a dietary employee at 10:15 AM on 06/14/12. The dietary worker stated she worked in the kitchen pantry area on the nursing unit. The employee stated staff had to wash their hands at the kitchen sink in the pantry area because it was the only sink in the pantry area. The employee stated there was not a designated hand washing sink in the kitchen pantry area. Interview with the Dietary Manager (DM) at 6:05 PM on 06/12/12, revealed the kitchen pantry on the nursing unit only had the one sink for staff to use including to wash their hands. The DM stated the majority of the residents ate their meals in the dining area of the nursing unit.	F 371			
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a	F 441	Resident #18's individual glucometer was located, performance check done, and placed back into assigned storage area in resident's room on 6/13/12 by staff	7/24/12	

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

PRINTED: 06/28/2012
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 C 06/14/2012
--	---	--	---

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 441	Continued From page 6 safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by:	F 441	nurse. DON and Unit Manger met with RN #2 and in-serviced on use of personal glucometers and on proper sanitation per facility policy, if a different glucometer is used for a resident, other than their individual glucometer on 6/13/12. Unit nurse checked all rooms to verify that each resident that had orders for finger stick blood glucose monitoring, had a personal glucometer labeled with their name, present in the assigned storage area in the residents room, and each glucometer was in good working order on 6/14/12. DON reviewed policy and procedure for glucometer use and care and updated as needed on 6/28/12. All nursing staff was in-serviced regarding proper use, care, of individual/personal glucometers, and the parameters for using a glucometer, other than the residents personal glucometer, along with proper sanitation of common use glucometer by 7/23/12. DON created a Quality Indicator monitor sheet to monitor use/care of individual glucometers and proper use and sanitation of facility monitors on 7/4/12. This monitored system will be initiated on 7/23/12 and completed weekly x 6 weeks, then every other week x 6 weeks, then monthly x 9 months by DON, Unit Manager, or infection control nurse.	7/24/12
-------	---	-------	---	---------

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

PRINTED: 06/28/2012
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 C 06/14/2012
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 441	<p>Continued From page 7</p> <p>Based on observation, interview, and review of facility policy, it was determined the facility failed to maintain an Infection Control Program designed to provide a safe and sanitary environment to prevent the development and transmission of disease and infection for one of twenty sampled residents (Resident #18). Observation of a glucose monitoring test on 06/13/12, revealed facility staff failed to properly clean/sanitize the multi-use resident glucometer machine prior to or after obtaining a blood specimen to check Resident #18's blood glucose level.</p> <p>The findings include:</p> <p>Review of the facility's Blood Glucose Meter, Use of policy (dated 04/15/10), under the section titled Routine Meter Care, revealed each resident is assigned an individual meter that is to be cleaned twice a month with a Dispatch (bleach) wipe. The policy further revealed if a meter that is not assigned to that resident is used the meter must be cleaned using a Dispatch wipe before and after each use.</p> <p>A review of the physician's orders dated June 2012 revealed facility staff was to perform fingerstick blood glucose checks for Resident #18 four times a day.</p> <p>Observations of Resident #18 on 06/13/12, at 9:23 AM, revealed Registered Nurse (RN) #1 performed a fingerstick blood glucose check on Resident #18. RN #1 was observed to look for Resident #18's individual glucometer but was unable to locate the glucometer. RN #1 was further observed to obtain a glucometer from the</p>	F 441			

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

PRINTED: 06/28/2012
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 C 06/14/2012
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 441	Continued From page 8 medication cart and to put on gloves. The RN was observed to clean the glucometer with an alcohol towelette, obtain a blood specimen from Resident #18, process the blood specimen in the glucometer, clean the glucometer with an alcohol towelette, and return the glucometer to the medication cart. Interview on 06/13/12, at 9:38 AM, with RN #1 revealed Resident #18 had an individual glucometer but RN #1 was unable to find the glucometer and he/she used the multi-use glucometer that was stored on the medication cart. The interview further revealed RN #1 did not recall being trained by the facility to clean the glucometer with anything other than an alcohol towelette. Interview on 06/13/12, at 4:30 PM, with the Infection Control Registered Nurse revealed the company that provided the glucometers had also provided an in-service to staff on how to clean and sanitize the glucometers. According to the Infection Control Nurse, nurses that were educated by the company were required to educate the new nurses. Review of the facility's infection control in-service that included information on how to clean and sanitize a glucometer, conducted on 07/19/10, revealed RN #1 attended the in-service.	F 441			
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRONMENT The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.	F 465	Medication Cart "A" was thoroughly cleaned by RN #2 on 6/13/12. RN #2 was in-serviced by DON, Unit Manager on his/her responsibility to check medication cart for cleanliness and to maintain acceptable cleanliness throughout shift	7/24/12	

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

PRINTED: 06/28/2012
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 C 06/14/2012
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 465	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and a review of facility policy, it was determined the facility failed to ensure the environment was sanitary for residents. Observations of the facility's medication carts revealed the "A" cart was soiled and contained pill debris and dried sticky substances. The findings include: A review of the facility's Medication Cart Policy, no date given, revealed medication cart care was the responsibility of the nurse passing medications from the individual cart. According to the policy, at shift change the oncoming nurse must assess the cart for cleanliness prior to accepting the keys. Further review of the policy revealed the cart should be clean, with no remnants of medications including residue from crushed medications or spilled liquids on the exterior of the cart or inside the medication drawers. Observations on 06/13/12, at 1:45 PM, revealed medication cart "A" was soiled with grit/pill debris and a brown, dried sticky substance inside the medication drawers. An interview with RN #2 at 1:00 PM on 06/13/12, revealed she had administered medications from medication cart "A" on 06/13/12, and acknowledged she had failed to clean the cart. An interview with the Director of Nursing (DON)	F 465	on 6/13/12. All medication carts were checked by DON and Unit Manager for cleanliness on 6/14/12. Any discrepancies were addressed with medication cart nurse and corrected at that time on 6/14/12 by medication cart nurse. A weekly cleaning schedule was created by DON to have medication carts terminally cleaned every week, along with routine cleaning in place currently, to be completed by 11-7 nurse(s) beginning 7/23/12. Policy and procedure including medication cart sanitation was reviewed by DON and updated, as needed, on 7/14/12. An in-service was created by DON on 7/4/12 and will be completed with all staff nurses by 7/23/12 per DON. DON created a Quality Assurance monitor to check routine cleanliness of all medication carts on 7/4/12. Quality Assurance monitoring will begin on 7/24/12 and be completed by DON, Unit Manager, infection control nurse, or designee. Monitoring will be done 2 times a week x 8 weeks, weekly x 8 weeks, every other week x 8 weeks, then monthly x 6 months.	7/24/12	

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

PRINTED: 06/28/2012
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 C 06/14/2012
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 465	Continued From page 10 on 06/14/12, at 1:40 PM, revealed the facility had a policy related to keeping the medication carts clean and that each nurse was responsible to ensure the cleanliness of the cart assigned to her.	F 465		

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

PRINTED: 02/25/2013
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 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 06/13/2012
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	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 08/09/89</p> <p>SURVEY UNDER: NFPA 101 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: Two stories with basement Type III (211)</p> <p>SMOKE COMPARTMENTS: 4</p> <p>FIRE ALARM: Complete fire alarm system</p> <p>SPRINKLER SYSTEM: Complete (wet and dry) sprinkler system</p> <p>GENERATOR: One Type II Diesel generator.</p> <p>A standard Life Safety Code survey was conducted on 06/13/12. Carmel Manor was found to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for 65 beds with a census of 63 on the day of the survey.</p>	K 000			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

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