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

PRINTED: 08/31/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185208		C 08/19/2011

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)	(X6) COMPLETION DATE
F 000	INITIAL COMMENTS An abbreviated survey was initiated on 08/17/11 to investigate three abuse complaints: #KY00016740, #KY00016903 and #KY00016739. The survey was concluded on 08/19/11 with #KY00016740 and #KY00016903 unsubstantiated with no deficiencies and #KY00016739 substantiated with a deficiency cited.	F 000		
F 224 SS=D	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. 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 implement polies and procedures that prohibit neglect for one (1) of three (3) sampled residents, (Resident #1). On 07/12/11 Resident #1 was not checked or changed and left sitting up in his/her wheelchair from approximately 7:00 PM until 3:45 AM. The findings include: Review of the facility's policy "Adult Abuse Identification and Reporting, , undated, reveal the facility requires all staff members to be aware and observant to signs of abuse and neglect and will not condone resident abuse by anyone, including	F 224	RECEIVED SEP 09 2011 BY: Issue identified by CNA #2 & #3, LPN #1 notified. Resident was assisted to bed by CNA #2, CNA #3, LPN #1, and another RN. Incontinence care was provided to resident #1 and resident #1 was dressed appropriately in bedclothes by CNA #2 and CNA #3 immediately LPN #1 assessed resident #1 for	9/26/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sister Teresa Kennedy — TITLE: Administrator — (X6) DATE: 09-08-11

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 224	Continued From page 1 all staff members. Further review revealed neglect was defined as failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. Review of the facility's policy "Incontinent Resident- Care of", undated, revealed care of incontinent residents: the incontinent resident will be cared for on a timely basis to promote good skin integrity and to promote good health. Review of Resident #1's medical record reveals the resident was admitted to the facility on 06/03/11 with diagnoses which included dementia, depression, osteoporosis, arthritis, involuntary movements and atopic dermatitis. Observation of Resident #1, on 08/17/2011 at 4:15 PM, revealed the resident in his/her room in his/her wheelchair and unable to answer any questions about care. The resident did not engage or connect with the interviewer in any way and softly spoke to himself/herself. It was observed that the resident could only made needs known with signs of distress such as facial expressions, whimpering or crying out. Review of the resident's admission Minimum Data Set (MDS) Assessment, dated 06/16/11, revealed Resident #1 was assessed as being severely impaired in regard to mental status, incontinent of bowel and bladder and to require extensive assistance with all activities of daily living (ADL's). Review of the current Nurse's Aid Care Plan, dated 06/16/11, revealed Resident #1 was "alert with severe confusion due to dementia", could	F 224	pain/discomfort, and medicated as ordered, and performed a full body skin assessment immediately on 7-12-11. RN removed NCA assigned to resident's care, from resident care, as soon as incident was identified and immediately notified Nursing Director, CNA was interviewed by LPN #1 & RN per instruction from Director Of Nursing and sent home, immediately, and remained off schedule, pending completion of investigation, by Director of Nursing on 7-12-11 at 3:50 AM. Incident was reported to OIG, Adult Protective as per facility polity. Director of Nursing investigated incident, interviewing LPN #1 & RN, CNA #1, CNA #2, CNA #3 and aide assigned to care for resident. Director of Nursing attempted to interview resident but resident was not interviewable due to severe cognitive deficits. Results of investigation were reviewed with administer and assistant administrator, and decision was made to terminate the aide responsible for residents direct care. CNA was notified of termination. LPN #1 responsible for care of resident on 7-12-2011 was counciled by Nursing Director and unit manager. Results of investigation were forwarded to OIG. Policy and procedure for incontinent residents, care of, was reviewed and updated on 7-15-2011 by Director of Nursing.	9/26/11

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F 224	Continued From page 2 make some needs known with 1-2 words or gestures, but generally all needs must be anticipated and met...needs feeding assistance, and is dependent for most to all ADL's. Interview, on 08/18/11 at 7:20 PM, with Certified Nurse Assistant (CNA)#1 revealed she and another aide were assigned to check and change the resident and put him/her to bed on the evening of 07/12/11. CNA #1 revealed that she agreed to wash the resident's face and hands and take off his/her top and put on his/her gown while the other aide would later remove the resident's pants, provide incontinence care and transfer the resident to bed with the assistance of another aide. CNA #1 stated that she did the first part of the resident's care, left him/her in his/her wheelchair and then went to work with resident showers until 10:00 PM when her shift was over. Interview with CNA #2, on 08/19/11 at 11:00 AM, revealed she answered a call light for Resident #1's roommate at 3:45 AM on 07/12/11 and heard Resident #1 whimpering behind the privacy curtain, which was drawn all the way around Resident #1's bed. CNA #2 revealed she and CNA #3 found Resident #1 sitting up in his/her wheelchair with his/her gown on his/her upper body with pants and shoes still on. The resident was wet with urine. The aides called for the nurses on duty that night and the resident was assessed (by the nurses), changed, cleaned, undressed and put to bed. Interview with the aide assigned to put the resident to bed and check him/her every two hours was not possible because he was dismissed by the facility due to this incident and	F 224	Aide responsible for residents care during incident was terminated. It was discussed with him/her that rounds are done every 2 hours and that this was not done, resulting in resident neglect. This was completed on 7-15-2011 All nursing staff will be/was inserviced on providing timely incontinence care and routine rounds on all residents under their care while in facility. Inservices completed by education director on/by 9-22-2011. Quality Assurance monitor was developed by Nursing Director to monitor for evidence of provision of timely care. Quality Assurance will be completed by Director of Nursing, Unit Manager, or charge nurse. Quality Assurance will be completed three times a week, representing each shift x 4 weeks then weekly x 9 weeks, then every other week by 8 weeks, then monthly by 9-25-2011	9/26/11

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F 224	Continued From page 3 his phone was no longer in service. Interview with Licensed Practical Nurse (LPN) #1, on 08/19/11 at 11:30 AM, revealed she was the nurse assigned to supervise care after 11:00 PM on 07/12/11. She revealed she was in Resident #1's room multiple times that night taking care of the resident's roommate. LPN #1 stated that the curtain was pulled completely around Resident #1's bed and the aide assigned to her had been reporting the resident's needs, so she assumed Resident #1 was in bed and fine. LPN #1 stated that she had no explanation for why Resident #1 was not checked and changed at 10:00 PM, 12:00 midnight and 2:00 AM. LPN #1 stated that when she asked the aide assigned why he didn't check Resident #1, the aide stated, "I have no excuse". LPN #1 further stated that she was in charge of supervising the aide and she normally did checks every 1-2 hours. She stated, "I was spot checking and I did not peek around the curtain and check on Resident #1 that night. I can't give an explanation". Interview with the Director of Nursing (DON), on 08/19/11 at 2:00 PM, revealed he had interviewed the aide assigned to Resident #1's care on 07/12/11 and found that the aide did not provide care for the resident because he did not want to disturb the resident's new roommate who had just gone to sleep and was not adjusting well to the facility. The DON revealed the aide stated Resident #1 was a "light wetter" and if you checked and changed him/her, he/she might yell out and awaken the roommate. The aide said he felt like Resident #1 wouldn't need incontinence care until after 4:00 AM.	F 224		

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F 224	Continued From page 4 The DON revealed the aides are to check and change the residents every two (2) hours and supervisors are to go into several rooms at night to make sure residents are dry and turned. He stated, "This was not done with Resident #1".	F 224		