

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

PRINTED: 09/28/2011  
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 09/15/2011
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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
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F 000	<p><b>INITIAL COMMENTS</b></p> <p>An Abbreviated Survey to investigate KY#00017046 was conducted on 09/09/11 through 09/12/11 and a Partially Extended Survey was conducted on 09/12/11 through 09/15/11. Immediate Jeopardy related to KY#00017046 was identified on 09/12/11 in the areas of 42 CFR 483.25 (F323) at a Scope and Severity (S/S): "K", and 42 CFR 483.75 (F490) S/S: "K". Substandard Quality of Care was identified in 42 CFR 483.25 (F323). The facility was notified of the Immediate Jeopardy and Substandard Quality of Care on 09/12/11.</p> <p>The facility failed to provide an environment free from accidental hazards, and failed to provide adequate supervision and monitoring to prevent accidents for residents requiring supervision. The facility failed to have a system in place to ensure the exit door to stairway three (3) was not accessible to residents identified as having dementia and assessed as ambulatory or mobile non-ambulatory with assistive devices. On 09/03/11, Resident #1, while being unsupervised by staff and without staff knowledge, self propelled his/her wheelchair through the exit door at stairwell #3. At approximately 3:45 PM, the facility utilities staff heard a voice calling for help through an elevator shaft, staff went into stairwell #3 and found Resident #1 lying at the bottom of a flight of six (6) stairs. Resident #1's wheelchair was at the top of the flight of six (6) stairs. Record review and interviews revealed Resident #1 sustained bruising to both palms and a skin tear to his/her left elbow. Interviews with staff and observations revealed the exit door to stairwell #3 was not equipped with any type of locking mechanism or alarming system and no staff had</p>	F 000	<p>Preparation and/or 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 or the scope or severity assigned by the regulatory agency to any alleged deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</p> <p>This Plan of Correction shall be construed as the facilities allegation of substantial compliance as of September 23, 2011.</p> <p style="text-align: center;"><b>RECEIVED</b> OCT 11 2011 BY: _____</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Sister Teresa Kennedy</i>	TITLE <i>Administrator</i>	(X8) DATE <i>10/07/11</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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F 000	<p>Continued From page 1</p> <p>been trained to provide monitoring or supervision of the exit door prior to or after the incident on 09/03/11, in order to prevent recurrence.</p> <p>The facility could provide no evidence of action taken to ensure the safety of all residents having access to the exit door at stairwell #3. Further more the facility could provide no evidence of identifying the unsecured door as being the cause of the incident with Resident #1 on 09/03/11.</p> <p>A partial extended survey was conducted from 09/12/11 through 09/15/11 which determined Immediate Jeopardy existed from 09/03/11 through 09/14/11. The facility provided an acceptable credible Allegation of Compliance (AOC) for the removal of the Immediate Jeopardy on 09/14/11. The state agency verified Immediate Jeopardy was removed prior to exit on 09/15/11, with remaining non-compliance at 42 CFR 483.25 Quality of Care (F323) and 42 CFR 483.75 (F490) Administration, at a S/S of an "E".</p> <p>KY#00017046 was determined to be substantiated with regulatory violations cited as a result of the investigation.</p>	F 000		
F 323 SS-K	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p>	F 323	<p>The facility ensures that the resident environment remains as free from accident hazards as is possible and that each resident has ongoing adequate supervision and assistance devices to prevent accidents.</p> <p>Resident #1 was assessed and sent to ER for evaluation immediately following incident 9/3/11. A Wander Guard bracelet was put in place on this resident immediately upon her return to the facility and an acute care plan was initiated on 9/3/11. This unfortunate accident occurred without warning and</p>	9/23/11

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**CARMEL MANOR**

STREET ADDRESS, CITY, STATE, ZIP CODE

**100 CARMEL MANOR ROAD  
FORT THOMAS, KY 41075**

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F 323	<p>Continued From page 2</p> <p>This <b>REQUIREMENT</b> is not met as evidenced by: Based on observation, interviews, and record reviews, it was determined the facility failed to have an effective system in place to ensure an environment free from accident hazards and failed to provide adequate supervision and monitoring for one (1) of twelve (12) sampled residents, (Resident #1). The facility failed to identify the causal factors of a fall, which prevented the facility from implementing effective interventions to prevent the recurrence of accidents.</p> <p>On 09/03/11, Resident #1, while being unsupervised by staff and without staff knowledge, self propelled his/her wheelchair through the unsecured and unalarmed exit door at stairway #3. At approximately 3:45 PM, facility utility staff heard a voice calling for help through an elevator shaft. The utility staff went into stairwell #3 and found Resident #1 lying at the bottom of a flight of six (6) stairs. Resident #1's wheelchair was at the top of the flight of six (6) stairs. Resident #1 sustained bruising to both palms and a skin tear to his/her left elbow. There was no evidence the facility identified the resident as having access to an unsupervised exit door as a causal factor resulting in the facilities failure to implement corrective action to prevent incident recurrence.</p> <p>The facility had assessed and identified five (5) residents, which included Resident #1, as being demented and ambulatory with assistive devices. After review of the facility's Roster Matrix, there were twenty four (24) residents assessed as</p>	F 323	<p>fortunately the resident received only minor injuries. No other residents were affected.</p> <p>Director of Nursing assessed all residents in the facility and those determined to be at risk for wandering related to cognition and ability/desire to propel self throughout the facility were placed on a wandering monitor and visually observed by staff member(s) every 15 minutes continuously beginning 9.10.11, or a Wander Guard was put in place. This continued until a staff member was permanently stationed at stairway 3.</p> <p>The Facility has in place a comprehensive accident prevention/fall prevention. Quality Assurance monitors conducted and documentation completed in resident charts as pertinent.</p> <p>On 9/12/11 staff supervision of stairway door 3 was initiated by placing 1 staff person, 24 hours a day, at the door to prevent egress of residents. Staff remained continually until keypad access installed and functioning properly.</p> <p>All staff monitoring door were in-serviced one (1) on (1) one by Assistant Administrator, Director of Nursing or Maintenance Director on procedures to monitor the door and residents coming to the area to promote safety of all residents. Prior to being stationed at the door, staff was instructed to observe resident activity in the area and prevent egress through the stairwell door.</p>	9/23/11

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F 323	<p>Continued From page 3 being independently ambulatory or mobile non-ambulatory with assistive devices who had access to stairwell #3 and who attended activities in the area without being supervised by staff.</p> <p>The facility failed to provide an environment free from accidental hazards and failed to thoroughly investigate the accident to determine causal factors, and implement effective action plans in response. The failure and the facility's non-compliance caused or was likely to cause Resident #1 and other residents, identified as having the potential to access the unsecured exit door, serious injury, harm, impairment, or death to a resident.</p> <p>An acceptable Allegation of Compliance was received on 09/14/11, which alleged removal of Immediate Jeopardy on 09/14/11. On 09/15/11 the State Agency verified the Immediate Jeopardy was removed on 09/14/11, prior to exit.</p> <p>The findings include:</p> <p>Record review revealed the facility admitted Resident #1 on 09/12/07, with diagnosis which included Psychosis, Dementia with Behavior Disorders, Depressive Disorder, Esophageal Reflux, Glaucoma, Anemia, Hypertension, Anxiety Disorder, and Aphasia. Review of Resident #1's Wandering Assessment, dated 05/24/11, revealed the facility assessed him/her as not being a wander risk. Review of Resident #1's Fall Assessment, dated 05/24/11, revealed the facility had assessed Resident #1 as a risk for falls. Review of Resident #1's Plan of Care, dated 06/24/11, revealed the facility had Resident #1 care planned as a fall risk, cognitive loss</p>	F 323	<p>Stairway 3 door was maglocked with keypad access and audible alarm with the door connected to fire system to automatically unlock in the event of fire. alarm. 9.14.11.</p> <p>All staff inserviced on the need of supervision of this and all doors to prevent egress of residents. In-services conducted by Education Director beginning 9.13.11. Inservices completed 9.15.11.</p> <p>A QA Monitor on doors being locked and alarmed to ensure resident safety was developed by the Maintenance Director 9.13.11. The Monitoring is being conducted by the Maintenance Director, Maintenance Staff or Security personnel, three (3) times per day at the beginning/end of each shift, for seven (7) days, once daily for seven (7) days at the beginning/end of day shift, for four (4) weeks on day shift, then monthly on day shift to monitor door being locked and alarmed.</p> <p>The results of the QA Monitors will be reviewed by the QA Committee with potential additional recommendations and a determination of the need for further ongoing formal monitoring of the doors.</p> <p>Maintenance Director immediately conducted monitoring on 9.13.11 of all stairwell and exit doors checking for security of locks and/or alarms and accessibility to assure all doors locked and/or alarmed. It was determined that all other stairway and exit doors were adequately secured.</p>	9/23/11

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F 323	<p>Continued From page 4</p> <p>related to Dementia, and Glaucoma. The facility placed the intervention to monitor for, anticipate, and intervene for factors causing prior falls, also to orient to facility and environment on admit, reorient confused resident as needed. Review of Resident #1's Minimum Data Set (MDS) Assessment, dated 08/22/11, revealed the facility had assessed Resident #1 as having short term and long term memory problems and his/her cognitive skills for daily decision making were moderately impaired. Resident #1 was unable to complete the Brief Interview for Mental Status (BIMS). Further review of the MDS revealed the facility assessed Resident #1 as having one (1) fall for that review period.</p> <p>Interview with Utilities Staff, on 09/10/11 at 6:30 PM, revealed he last saw Resident #1 in the activity room at approximately 3:10 PM when he was gathering the trash. He further stated he looked at the clock before he went to another unit to start gathering trash and it was around 3:40 PM and that was when he went to get on the elevator outside of stairwell #3. He stated he heard a voice calling for help and he proceeded to try and locate the person calling for help. Further interview with Utilities Staff revealed when he entered stairwell #3 he saw a wheelchair sitting at the top of a flight of six (6) stairs and when he turned the corner he saw Resident #1 lying at the bottom of the flight of six (6) stairs.</p> <p>Review of the Incident Report, dated 09/03/11, revealed Resident #1 sustained bruising to both palms and a laceration to the left elbow. Review of the Falls Investigation Report, dated 09/03/11, revealed Resident #1 pushed open the stairwell door after leaving the Activity Room, fell and</p>	F 323	<p>Maintenance Director immediately initiated a policy and procedure for securing all entrances/exits for resident safety with approval by the Administration. In-service for all staff regarding new policy and procedure included in in-services conducted by Education Director, 9.13.11, 9.14.11, and 9.15.11.</p> <p>Maintenance Director immediately repaired loose carpet area in stairwell # on 9.13.11. Other stairwells were inspected throughout the facility and no other loose carpet was identified.</p> <p>The Maintenance Director performs monthly rounds that include a variety of different physical plant safety issues including the safety and security of stairwell and exit doors. The results of the monthly physical plant rounds are provided to the Administrator for review and the information is provided to the QA Committee as a component of the facility's QA process.</p>	9/23/11

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F 323	<p>Continued From page 5</p> <p>sustained injury to both palms and left elbow. Further review revealed Resident #1 complained of pain was sent to the hospital via Emergency Medical Services (EMS) for evaluation.</p> <p>Observation, on 09/09/11 at 5:00 PM, revealed the door leading to stairwell #3 was able to be accessed by pushing on the door's push bar. There was no locking or securing mechanism in place to prevent the door from being opened by a resident. There was no Wander Guard alarming system in place on the door. Further observation revealed a plastic strip securing the carpet to the first stair was lose and sticking out approximately two (2) inches.</p> <p>Observation, on 09/12/11 at 1:50 PM, revealed the door leading to stairwell #3 remained unsecured and able to be opened by pushing on the push bar. Further observation revealed no staff in the area observing or supervising the unsecured door. Interviews on 09/12/11 at times ranging from 2:00 PM, revealed with License Practical Nurse (LPN) #1 at 3:00 PM, #4 at 3:15 PM, and #3 at 3:20 PM, Certified Nursing Assistant (CNA) #3 at 4:05 PM, #4 at 3:30 PM, and #7 4:30 PM, revealed at no time had Administrative Staff or Supervisors instructed them to increase observation and supervision of the unsecured door leading to stairwell #3.</p> <p>Interview with Maintenance Assistant, on 09/10/11 at 2:15 PM, revealed he had not been told about the incident until sometime later in the week by the Utilities staff who had found Resident #1. He further stated no staff from Administration notified him of the incident nor had they address what to do to secure the door to prevent further accidents</p>	F 323			

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F 323	<p>Continued From page 6</p> <p>with another resident. He further stated he felt with the door left unsecured another resident could have gained access to the area and sustain injury.</p> <p>Interview with the Maintenance Director, on 09/10/11 at 2:00 PM, revealed after the incident occurred the unsecured door should have been addressed to prevent another resident from sustaining a injury.</p> <p>Interview with Registered Nurse (RN) #2, on 09/10/11 at 3:20 PM, revealed she was the nursing supervisor the day the incident involving Resident #1 occurred. She stated no administrative staff addressed increased supervision or observation of the unsecured/unlocked door leading to stairwell #3. She stated the door being unsecured/unlocked had never been addressed with her in anyway related to this incident involving Resident #1.</p> <p>Interview with RN #1, on 09/10/11 at 4:00 PM, revealed she updated Resident #1's Care Plan with the intervention of placing the wander guard on the resident's wheelchair; however, no other interventions were discussed on the date of the incident or during Administrative staff meeting on 09/06/11 when the incident was discussed. Further interview with RN #1 revealed at no time was the unsecured door to stairwell #3 discussed or interventions placed to prevent another resident from entering the area through the unsecured door.</p> <p>Interview with Assistant Administrator, on 09/10/11 at 3:40 PM, revealed the incident had been discussed in the meeting on the following</p>	F 323		
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F 323	<p>Continued From page 7</p> <p>Tuesday, 09/06/11. She further stated the cause of the incident had not been discussed in that meeting and at no time was the unsupervised door to stairwell #3 identified as the cause of the incident. Further interview revealed at no time was the unsecured door addressed as needing to have extra supervision or observation to prevent further accidents with residents who would had access to the area. She further stated by leaving the door unsecured another resident could enter the area leading to another accident in the stairwell.</p> <p>Record review and interview with the Director of Nursing (DON), on 09/10/11 at 2:00 PM, revealed the facility had assessed and identified five (5) residents, which included Resident #1, as being demented and ambulatory with assistive devices. After review of the facility's Roster Matrix, there were twenty four (24) residents assessed as being independently ambulatory or mobile non-ambulatory with assistive devices who had access to stairwell #3 and who attended activities in the area without being supervised by staff.</p> <p>Interview with Director of Nursing (DON) and Administrator, on 09/10/11 at 4:30 PM, revealed the Administrator stated during the meeting with Administrative Staff, the unsecured door was never brought up and no interventions were discussed to be put into place to prevent another accident.</p> <p>Observation, on 09/12/11 at 3:00 PM, revealed an elastic band stretched across the door leading to stairwell #3 with a red stop sign in the middle of the band. The door leading to stairwell #3 was still unsecured and no staff was observed in the</p>	F 323		
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F 323	<p>Continued From page 8</p> <p>area for increased observation or supervision of the unsecured door.</p> <p>Record review and interview with the Director of Nursing (DON) , on 09/10/11 at 2:00 PM, revealed the facility had accessed and identified five (5) residents, which included Resident #1, as being demented and ambulatory with assistive devices. After review of the facility's Roster Matrix, there were twenty four (24) residents assessed as being independently ambulatory or mobile non-ambulatory with assistive devices who had access to stairwell #3 and who attended activities in the area without being supervised by staff.</p> <p>Interview with the DON and Administrator, on 09/12/11 at 6:10 PM, revealed the cause of the incident with Resident #1, on 09/03/11, was the unsecured door leading to stairwell #3. The DON further stated the unsecured door should have been addressed the day of the incident, with staff being in-serviced on and being placed one (1) on one (1) in front of the unsecured door until the Maintenance Director was able to set up an electrician to code and secure/lock the door. Further interview with the Administrator revealed the intervention of placing the stop sign across the unsecured door was not an appropriate intervention to prevent residents from accessing the stairwell and potentially causing another accident. The facility did not to identify the unsecured door as the cause for the incident on 09/03/11, and further failed to place appropriate interventions to prevent further injury to other residents who had access to the unsecured door, placing the residents with access to this door in danger.</p>	F 323		
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F 323	<p>Continued From page 9</p> <p>An acceptable AOC was received on 09/14/11 and the Immediate Jeopardy was found to be corrected prior to exit on 09/15/11.</p> <p>A review of the AOC revealed the following:</p> <p>Immediately on 09/12/11, the facility initiated staff supervision of Terrace level, stairway door #3 by placing staff person, twenty four (24) hours per day, at the door to stairway #3, the root cause of problem, to prevent egress of residents. Staff remained continually until the keypad access was installed and functioning properly.</p> <p>The facility recognizes that the lack of supervision of the door, and the door being unlocked, lead to the "Immediate Jeopardy" of residents.</p> <p>Security personnel and maintenance were responsible for maintaining coverage of staff at Terrace level, stairway door #3, twenty four (24) hours daily until the key pad was installed and functioning properly. All security and maintenance staff have been in serviced one (1) on one (1) by Assistant Administrator, DON, or Maintenance Director on procedures to monitor the door and residents coming to the area to promote safety of all residents. Prior to being stationed at stairway #3 door, staff was instructed to observe resident activity in the area and prevent egress through stairwell door.</p> <p>To prevent further incidents of this nature, the facility will "lock and alarm" the Terrace level, stairway door #3, work to be performed immediately. Staff members will continue to monitor door until keypad is installed and</p>	F 323		

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F 323	<p>Continued From page 10 functioning properly. Electrician installing hardware 09/13/11.</p> <p>All staff will be in-serviced on the need of supervision for this and all doors to prevent egress of residents. In-services have been conducted by the Education Director beginning 09/13/11. Staff not in-serviced will not be permitted to work until attending in-service program.</p> <p>A "Quality Assurance Monitor" which monitors all doors being locked and alarmed to ensure resident safety has been developed by the Maintenance Director, and conducted by the Maintenance Director, Maintenance Staff, or Security personnel, three (3) times per day at the beginning/end of each shift, for seven (7) days, once daily for seven (7) days at the beginning/end of day shift, weekly for four (4) weeks on day shift, then monthly on day shift to monitor door being locked and alarmed.</p> <p>Maintenance Director to immediately conduct "Quality Assurance Monitor" on 09/13/11 of all doors checking for security of locks and/or alarms and accessibility to assure all doors being locked and alarmed.</p> <p>Maintenance Director to immediately initiate on 09/13/11 a policy and procedure for securing all entrances/exits for residents safety. In-service for all staff regarding new policy and procedure included in in-services conducted on 09/13/11 by Education Director.</p> <p>Administration has coordinated installation of the keypad on 09/13/11 and any other repairs and</p>	F 323		
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F 323	<p>Continued From page 11 enhancements of the door security/alarm system.</p> <p>Administration has participated in any policy and procedure creations or revisions and had final approval for all such creations or revisions and assured staff was knowledgeable on any new or revised policies.</p> <p>The following corrective measures taken by the facility were validated as completed prior to the survey exit on 09/15/11:</p> <p>Observations made on 09/13/11 and 09/14/11 revealed staff were sitting at the door leading to stairwell #3. Interviews with those staff on 09/14/11 and 09/15/11 revealed the Maintenance Director and DON had in-serviced them on the reason for the one (1) on one (1) observation of the door. Record review of the one (1) on one (1) sign on/off sheet revealed staff was to sign, name, date, and time when they started the observation of the door and time they were relieved. Further review of the sign on/off sheet revealed instructions for staff to observe for residents in the area and to prevent egress through stairwell door.</p> <p>Record review, on 09/13/11, revealed staff were in-serviced addressing the reason for the one (1) on one (1) observation of the door leading to stairwell #3. Further review revealed signatures of staff on the form indicating they had been instructed to observe the area for residents and to prevent egress through the stairwell #3 door. Interview with the Maintenance Director, on 09/13/11 at 4:40 PM, revealed he had instructed all staff who were to do the one (1) on one (1) observation of the door, to sign in and out on the</p>	F 323		

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F 323	<p>Continued From page 12 sheet, to use the radio to call for help if a resident was trying to egress or they needed a break, and to never leave the door until another staff whom had also been in-serviced could take over the post.</p> <p>Observation and interviews, on 09/13/11, revealed the electrician for a contracted company was installing a lock/alarm mechanism for the door leading to stairwell #3. Interview with the electrician, on 09/13/11 at 3:00 PM, revealed the lock would be functioning by the end of the day; however, the parts for the alarm would not be in until the following day. He further stated the door would be a lock/alarm door, if the bar to open the door was pushed without the code being entered the alarm would sound to alert staff someone was trying to bypass the code. Observation of the door, on 9/13/11 at 5:00 PM, revealed the locking mechanism was functioning, the door was secured and a code had to be entered for the door to be opened. Interview with the Maintenance Director, on 09/14/11 at 3:00 PM, revealed the electrician was still working on the wiring for the alarm; therefore, staff continued with the one (1) on one (1) observation of the door until the electrician was done and the door was secured.</p> <p>Interview with the Education Director, on 09/14/11 at 2:00 PM, revealed she had began the in-services with staff on 09/13/11. Review of the in-service, "Resident safety-Doorway access and supervision" revealed the facility had in-serviced staff on door safety and awareness for resident safety, instructions for responding to a door alarm going off, and review of the new policy and procedure titled, "Maintenance" dated 09/13/11.</p>	F 323		
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F 323	<p>Continued From page 13</p> <p>Further interviews conducted with staff from 09/13/11 at 2:00 PM, to 09/14/11 at 4:00 PM, revealed staff was knowledgeable of the policy regarding doorway access and supervision and material covered in the in-service provided by the Education Director. Further interview with the Education Director revealed any staff not at work will be mandated to attend the in-service before returning to work. She stated she had made a list of all staff who had not attended the in-service and had forwarded a copy to their supervisor to ensure they were not permitted to work the floor until they attended the in-service.</p> <p>A review of the monitoring tool the Maintenance Director created revealed daily monitoring of the doors which were locked and/or alarmed was conducted on 09/13/11, and was on going. Interview with the Maintenance Director, on 09/14/11 at 3:30 PM, revealed he planned to continue to perform the monitors per the AOC. He further stated he had in-serviced the Maintenance Assistant and security staff to perform the monitors when he was not in the facility. The monitors will be reviewed weekly by the Administrative Staff in the weekly meetings to address if the monitors were effective and to ensure interventions placed were effective.</p> <p>On 09/14/11 at 3:30 PM, an environmental tour with the Maintenance Director revealed all doors were secured and functioning properly on Terrace level. When the door to stairwell #3 was tested and the alarm sounded, staff responded to the area in under one minute. Observation of door to stairwell #3 revealed the electrician had finished installing the alarm and it was secured and functioning at this time.</p>	F 323		

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F 323	<p>Continued From page 14</p> <p>Interviews with the Maintenance Director, DON, and Assistant Administrator, conducted on 09/14/11, revealed the monitors would be reviewed daily in Administrative Staff meetings and when determined appropriate would then be reviewed weekly in the Quality Assurance meetings.</p> <p>Interview with the DON, on 09/15/11 at 11:00 AM, revealed the Administrative Staff held a meeting and discussed the coordination of placing staff on continuous observation of the door leading to stairway #3 until the electrician could secure and alarm the door. He stated the Administrator, Assistant Administrator, and himself have been and will continue to work directly with the Maintenance Director and Education Director to continue to monitor and address issues, on a daily basis. He further stated that once the Maintenance Director and Administrator had finalized the new policy and procedure "Maintenance" they had a meeting and reviewed the final draft and then it was given to the Education Director to incorporate into the in-service.</p> <p>The State Agency determined the Immediate Jeopardy was removed on 09/14/11, prior to exit, which lowered the scope and severity to an "E" while the facility monitors the effectiveness of the systemic changes and quality assurance activities.</p>	F 323		
F 490 SS=K	<p><b>483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING</b></p> <p>A facility must be administered in a manner that enables it to use its resources effectively and</p>	F 490		

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F 490	<p>Continued From page 15</p> <p>efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of hospital records it was determined the facility failed to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental psychosocial well-being for residents in providing an environment free from accidental hazards and regarding adequate supervision to prevent accidents for one (1) of twelve (12) sampled residents, Resident #1. The facility administration failed to identify the root cause of Resident #1's accident on 09/03/11 as being the unsecured/unsupervised door leading to stairwell #3, failed to ensure residents received adequate supervision to prevent accidents, and failed to provide an environment as free from accident hazards as possible.</p> <p>Record review and interview with the Director of Nursing (DON), on 09/10/11 at 2:00 PM, revealed the facility had assessed and identified five (5) residents, which included Resident #1, as being demented and ambulatory with assistive devices. After review of the facility's Roster Matrix, there were twenty four (24) residents assessed as being independently ambulatory or mobile non-ambulatory with assistive devices who had access to stairwell #3 and who attended activities in the area without being supervised by staff.</p>	F 490	<p>The facility is administered in a manner that enables its resources to be used effectively and efficiently to assist the residents to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident.</p> <p>The facility has a well experienced administrative team and this unfortunate accident was taken seriously and interventions were put into place to address the situation and prevent future issues. Administration coordinated installation of the keypad on 9.13.11 and any other repairs and enhancements of the door security/alarm system.</p> <p>Administration has coordinated effective repairs to any hazards identified through daily inspections 9.13.11.</p> <p>Administration has participated in each policy and procedure creation or revisions and had final approval for all such creations or revisions and assured staff was knowledgeable on any new or revised policies.</p> <p>Administration has conducted daily alarm audits/checks and prescribed appropriate measures/repairs to ensure acceptable operation, and compliance with policies and procedures.</p> <p>Resident #1 was assessed and sent to ER for evaluation immediately following incident</p>	9/23/11
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F 490	<p>Continued From page 16</p> <p>On 09/03/11, Resident #1, a cognitively impaired resident, was found at the bottom of a flight of six (6) stairs by a Utilities Staff. The facility failed to recognize the unsecured/unsupervised door leading to stairwell #3 as the root cause of this incident on the day the incident occurred and again on 09/06/11, in their weekly administrative meeting. The door leading to stairwell #3 was left unsecured and unsupervised from 09/03/11 until 09/12/11 when the facility failed to identify the root cause of the incident as being the unsecured/unsupervised door. The unsecured door leading to stairwell #3 was located in the same hallway as the activity room.</p> <p>The facility had assessed and identified five (5) residents, which included Resident #1, as being demented and ambulatory with assistive devices. After review of the facility's Roster Matrix, there were twenty four (24) residents assessed as being independently ambulatory or mobile non-ambulatory with assistive devices who had access to stairwell #3 and who attended activities in the area without being supervised by staff.</p> <p>Based on the above findings, it was determined the facility failures to identify the unsecured/unsupervised door as the root cause, placed other residents with access to the unsecured door at risk for serious injury, hard, impairment, or death. The facility was informed of the Immediate Jeopardy and Substandard Quality of Care on 09/12/11 at F323 at a S/S of a "K" and F490 at a S/S of a "K".</p> <p>The facility provided an acceptable Allegation of Compliance (AOC) on 09/14/11. Immediate Jeopardy was verified to be removed prior to exit</p>	F 490	<p>9/3/11. A Wander Guard bracelet was put in place on this resident immediately upon her return to the facility and an acute care plan was initiated on 9/3/11. This unfortunate accident occurred without warning and fortunately the resident received only minor injuries. No other residents were affected.</p> <p>Director of Nursing assessed all residents on the nursing unit and those determined to be at risk for wandering related to cognition and ability/desire to propel self throughout the facility were placed on a wandering monitor and visually observed by staff member(s) every 15 minutes continuously beginning 9.10.11, or a Wander Guard was put in place. This continued until a staff member was permanently stationed at stairway 3.</p> <p>On 9/12/11 staff supervision of stairway door 3 was initiated by placing 1 staff person, 24 hours a day, at the door to prevent egress of residents. Staff remained continually until keypad access installed and functioning properly.</p> <p>All staff monitoring door were in-serviced one (1) on (1) one by Assistant Administrator, Director of Nursing or Maintenance Director on procedures to monitor the door and residents coming to the area to promote safety of all residents. Prior to being stationed at the door, staff was instructed to observe resident activity in the area and prevent egress through the stairwell door.</p>	9/23/11

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F 490	<p>Continued From page 17 on 09/15/11 with remaining non-compliance at 42 CFR 483.25 Quality of Care (F323) and 42 CFR 483.75 (F490) Administration, at a scope and severity (S/S) of an "E" while the facility monitors the effectiveness of the systemic changes and quality assurance activities.</p> <p>The findings include:</p> <p>Review of Resident #1's Clinical Notes Report revealed, on 09/03/11, Resident #1 was found by Utilities Staff at the bottom of a flight of six (6) stairs of stairwell #3. It further revealed Resident #1 was alert with confusion, and combative with staff. It was further documented the fall was unobserved, and Resident #1 had bruising to both palms and a laceration to the left elbow. Review of hospital records from the Emergency Room revealed Resident #1 was seen in their facility on 09/03/11, with diagnosis which included, Mental Health Problems, Low Potassium Level, Fall, and Open Wound.</p> <p>Record review and interview with the Director of Nursing (DON), on 09/10/11 at 2:00 PM, revealed the facility had assessed and identified five (5) residents, which included Resident #1, as being demented and ambulatory with assistive devices. After review of the facility's Roster Matrix, there were twenty four (24) residents assessed as being independently ambulatory or mobile non-ambulatory with assistive devices who had access to stairwell #3 and who attended activities in the area without being supervised by staff.</p> <p>Interview with RN #2, on 09/10/11 at 3:20 PM, revealed she was the nursing supervisor the day the incident occurred with Resident #1. She</p>	F 490	<p>Stairway 3 door was maglocked with keypad access and audible alarm with the door connected to fire system to automatically unlock in the event of fire. alarm. 9.14.11.</p> <p>All staff inserviced on the need of supervision of this and all doors to prevent egress of residents. In-services conducted by Education Director beginning 9.13.11. Inservices completed 9.15.11.</p> <p>A QA Monitor on doors being locked and alarmed to ensure resident safety was developed by the Maintenance Director 9.13.11. The Monitoring is being conducted by the Maintenance Director, Maintenance Staff or Security personnel, three (3) times per day at the beginning/end of each shift, for seven (7) days, once daily for seven (7) days at the beginning/end of day shift, for four (4) weeks on day shift, then monthly on day shift to monitor door being locked and alarmed. The results of the QA Monitors will be reviewed by the QA Committee with potential additional recommendations and a determination of the need for further ongoing formal monitoring of the doors.</p> <p>Maintenance Director immediately conducted monitoring on 9.13.11 of all stairwell and exit doors checking for security of locks and/or alarms and accessibility to assure all doors locked and/or alarmed. It was determined that all other stairway and exit doors were adequately secured.</p>	9/23/11

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F 490	<p>Continued From page 18</p> <p>stated interventions were put into place when Resident #1 returned to the facility from the hospital; however, at no time was it addressed by the Administrator on call to address any interventions regarding the unsecured door where the incident occurred to ensure safety to other residents who had access to the unsecured door.</p> <p>Interview with RN #1, on 09/09/11 at 4:00 PM, revealed she was the Administrative Staff on call the weekend the incident with Resident #1 occurred. She stated at no time was the unsecured door identified as the cause of the incident.</p> <p>Interview with the Assistant Administrator, on 09/10/11 at 4:30 PM, revealed at no time had the administrative staff identified the root cause of the incident involving Resident #1. She further stated the Administrative Staff had a meeting on 09/06/11, and the incident involving Resident #1 was discussed in the meeting, but no staff identified or brought up the cause of the incident therefore no interventions were put into place regarding the unlocked door at stairwell #3.</p> <p>Interview with the DON, on 09/12/11 at 6:10 PM, revealed the administrative Staff met every week to address any problems or issues which had occurred the week prior to the meetings. Further interview revealed the root cause of the incident involving Resident #1 was the unsecured door leading to stairwell #3 and the interventions placed by the facility were not adequate to prevent another resident from entering the stairwell and becoming injured. He further stated the only way to ensure the other residents safety would have been to place a staff member in</p>	F 490	<p>Maintenance Director immediately initiated a policy and procedure for securing all entrances/exits for resident safety with approval by the Administration. In-service for all staff regarding new policy and procedure included in in-services conducted by Education Director, 9.13.11, 9.14.11, and 9.15.11.</p> <p>Maintenance Director immediately repaired loose carpet area in stairwell # on 9.13.11. Other stairwells were inspected throughout the facility and no other loose carpet was identified.</p> <p>The Maintenance Director performs monthly rounds that include a variety of different physical plant safety issues including the safety and security of stairwell and exit doors. The results of the monthly physical plant rounds are provided to the Administrator for review and the information is provided to the QA Committee as a component of the facility's QA process. Overall compliance will be monitored by the Administrator.</p>	9/23/11

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185208</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>09/15/2011</b>
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NAME OF PROVIDER OR SUPPLIER  <b>CARMEL MANOR</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>100 CARMEL MANOR ROAD FORT THOMAS, KY 41075</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 490	<p>Continued From page 19</p> <p>constant observation of the door until the Maintenance Director could contract with a electrician to place a code/alarm on the door.</p> <p>Interview with the Administrator, on 09/12/11 at 6:20 PM, revealed at no time was the cause of the incident involving Resident #1 addressed by Administrative Staff. She stated, to her knowledge, there had never been a resident fall or get injured in the stairwell so the need to secure the door was not brought up or discussed. She further stated the Administrative Staff had a meeting on 09/06/11 and had addressed the incident involving Resident #1; however, the unsecured door was never brought up and there was no interventions implemented to prevent further accidents. Further interview revealed the only interventions the facility implemented to prevent another resident from accessing the unsecured door was a Velcro strip across the door with a stop sign in the middle of the Velcro strip. When the Administrator was asked how she felt this would keep other residents from entering the stairwell, she stated, "Because it says to stop, so they will stop and turn around." When the Administrator was asked if she felt the stop sign alone would keep all residents whom had access to the unsecured door from entering, she stated, "Maybe not all of them, but most of them would see the sign and stop." Further interview revealed the Administrative Staff should have identified the cause of the incident as the unsecured door and placed more appropriate interventions to keep all residents with access to the door safe from accidents and injury.</p> <p>There was no documented evidence the Administrative Staff had attempted to identify the</p>	F 490		

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F 490	<p>Continued From page 20</p> <p>root cause of the incident or place appropriate interventions to prevent other residents from sustaining an injury.</p> <p>An acceptable AOC was received on 09/14/11 and the Immediate Jeopardy was found to be corrected prior to exit on 09/15/11.</p> <p>The following corrective measures taken by the facility were validated as completed prior to the survey exit on 09/15/11:</p> <p>Immediately on 09/12/11, the facility initiated staff supervision of Terrace level, stairway door #3 by placing staff person, twenty four (24) hours per day, at the door to stairway #3, the root cause of problem, to prevent egress of residents. Staff remained continually until keypad access installed and functioning properly.</p> <p>The facility recognizes that the lack of supervision of the door, and the door being unlocked, lead to the "Immediate Jeopardy" of residents.</p> <p>Security personal and maintenance were responsible for maintaining coverage of staff at Terrace level, stairway door #3, twenty four (24) hours daily until key pad installed and functioning properly. All security and maintenance staff have been in serviced one (1) on one (1) by Assistant Administrator, DON, or Maintenance Director on procedures to monitor the door and residents coming to the area to promote safety of all residents. Prior to being stationed at stairway #3 door, staff were instructed to observe resident activity in the area and prevent egress through stairwell door.</p>	F 490		
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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
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F.490	<p>Continued From page 21</p> <p>To prevent further incidents of this nature, the facility will "lock and alarm" Terrace level, stairway door #3, work to be performed immediately. Staff members continue to monitor door until keypad is installed and functioning properly. Electrician installing hardware 09/13/11.</p> <p>All staff will be in-serviced on the need of supervision for this and all doors to prevent egress of residents. In-services have been conducted by the Education Director beginning 09/13/11. Staff not in-serviced will not be permitted to work until attending in-service program.</p> <p>A "Quality Assurance Monitor" which monitors all doors being locked and alarmed to ensure resident safety has been developed by the Maintenance Director, and conducted by the Maintenance Director, Maintenance Staff, or Security personnel, three (3) times per day at the beginning/end of each shift, for seven (7) days, once daily for seven (7) days at the beginning/end of day shift, weekly for four (4) weeks on day shift, then monthly on day shift to monitor door being locked and alarmed.</p> <p>Maintenance Director to immediately conduct "Quality Assurance Monitor" on 09/13/11 of all doors checking for security of locks and/or alarms and accessibility to assure all doors being locked and alarmed.</p> <p>Maintenance Director to immediately initiate on 09/13/11 a policy and procedure for securing all entrances/exits for residents safety. In-service for all staff regarding new policy and procedure included in in-services conducted on 09/13/11 by</p>	F 490		
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F 490	<p>Continued From page 22. Education Director.</p> <p>Administration has coordinated installation of the keypad on 09/13/11 and any other repairs and enhancements of the door security/alarm system.</p> <p>Administration has participated in any policy and procedure creations or revisions and had final approval for all such creations or revisions and assured staff were knowledgeable on any new or revised policies.</p> <p>The surveyor validated the corrective action taken by the facility as follows:</p> <p>Observations made on 09/13/11 and 09/14/11 revealed staff sitting at the door leading to stairwell #3. Interviews with those staff revealed the Maintenance Director and DON had in-serviced them on the reason for the one (1) on one (1) observation of the door. Record review of the one (1) on one (1) sign on/off sheet revealed staff were to sign name, date, and time they started the observation of the door and time they were relieved. Further review of the sign on/off sheet revealed instructions for staff to observe for residents in the area and to prevent egress through stairwell door.</p> <p>Record review, on 09/13/11, revealed in-service addressing the reason for the one (1) on one (1) observation of the door leading to stairwell #3. Further review revealed signatures of staff on the form indicating they had been instructed to observe the area for residents and to prevent egress through the stairwell door. Interview with the Maintenance Director, on 09/13/11 at 4:40 PM, revealed he had instructed all staff who were</p>	F 490			

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F 490	<p>Continued From page 23</p> <p>to do the one (1) on one (1) observation of the door, to sign in and out on the sheet, to use the radio to call for help if a resident was trying to egress or they needed a break, and to never leave the door until another staff whom had also been in-serviced could take over the post.</p> <p>Observation and interviews, on 09/13/11, revealed the electrician for a contracted company installing a lock/alarm mechanism for the door leading to stairwell #3. Interview with the electrician, on 09/13/11 at 3:00 PM, revealed the lock would be functioning by the end of the day; however, the parts for the alarm would not be in until the following day. He further stated the door would be a lock/alarm door, if the bar to open the door was pushed without the code being entered the alarm would sound to alert staff someone was trying to bypass the code. Observation of the door, on 9/13/11 at 5:00 PM, revealed the locking mechanism was functioning and the door was secured and a code had to be entered for the door to be opened. Interview with the Maintenance Director, on 09/14/11 at 3:00 PM, revealed the electrician was still working on the wiring for the alarm; therefore, staff continued with the one (1) on one (1) observation of the door until the electrician was done and the door was secured.</p> <p>Interview with the Education Director, on 09/14/11 at 2:00 PM, revealed she had began the in-services with staff on 09/13/11. A review of the roster for staff attending the in-service. Review of the in-service, "Resident safety- Doorway access and supervision" revealed the facility had in-serviced staff on door safety and awareness for resident safety, instructions for responding to</p>	F 490			

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F 490	<p>Continued From page 24</p> <p>a door alarm going off, and review of the new policy and procedure titled, "Maintenance" dated 09/13/11. Further interviews conducted with staff from 09/13/11 at 2:00 PM, to 09/14/11 at 4:00 PM, revealed staff were knowledgeable of the policy regarding doorway access and supervision and material covered in the in-service provided by the Education Director. Further interview with the Education Director revealed any staff not at work will be mandated to attend the in-service before returning to work. She stated she had made a list of all staff who had not attended the in-service and had forwarded a copy to their supervisor to ensure they were not permitted to work the floor until they attended the in-service.</p> <p>A review of the monitoring tool the Maintenance Director created revealed daily monitoring of the doors which were locked and/or alarmed was conducted on 09/13/11, and was on going. Interview with the Maintenance Director, on 09/14/11 at 3:30 PM, revealed he planned to continue to perform the monitors per the AOC. He further stated he had in-serviced the Maintenance Assistant and security staff to perform the monitors when he is not in the facility. The monitors will be reviewed weekly by the administrative staff in the weekly meetings to address if the monitors are effective and to ensure interventions placed are effective.</p> <p>On 09/14/11 at 3:30 PM, an environmental tour with the Maintenance Director revealed all doors were secured and functioning properly on Terrace level. When the door to stairwell #3 was tested and the alarm sounded, staff responded to the area in under one minute. Observation of door to stairwell #3 revealed the electrician had finished</p>	F 490		

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F 490	<p>Continued From page 25 installing the alarm and it was secured and functioning at this time.</p> <p>Interviews with the Maintenance Director, DON, and Assistant Administrator, conducted on 09/14/11, revealed the monitors will be reviewed daily in administrative staff meetings and when determined appropriate will then be reviewed weekly in the Quality Assurance meetings.</p> <p>Interview with the DON, on 09/15/11 at 11:00 AM, revealed the administrative staff held a meeting and discussed the coordination of placing staff on continuous observation of the door leading to stairway #3 until the electrician could secure and alarm the door. He stated the Administrator, Assistant Administrator, and himself have been and will continue to work directly with the Maintenance Director and Education Director to continue to monitor and address issues, on a daily basis. He further stated that once the Maintenance Director and Administrator had finalized the new policy and procedure "Maintenance" they had a meeting and reviewed the final draft and then it was given to the Education Director to incorporate into the in-service.</p> <p>The Immediate Jeopardy was verified removed on 09/14/11, prior to exit, with remaining non-compliance at 42 CFR 483.75 Administration, S/S of an "E" while the facility monitors the effectiveness of the systemic changes and quality assurance activities.</p>	F 490		
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