

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

PRINTED: 07/19/2011
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 07/05/2011
--	--	--	--

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)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

<p>F 000</p> <p>F 225 SS=E</p>	<p>INITIAL COMMENTS</p> <p>A Standard Recertification Survey was initiated on 06/14/11 and concluded on 07/05/11. Deficiencies were cited at 483.13 Resident Behavior and Facility Practice, 483.15 Quality of Life, 483.20 Resident Assessment, 483.25 Quality of Care, 483.35 Dietary Services, 483.60 Pharmacy Services, and 483.65 Infection Control with the highest scope and severity being "E".</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p>	<p>F 000</p> <p>F 225</p>	<p>RECEIVED AUG 12 2011 BY: _____</p>	
------------------------------------	--	---------------------------	---	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Sister Teresa Kennedy</i>	TITLE <i>Administrator</i>	(X6) DATE <i>08-11-11</i>
---	-------------------------------	------------------------------

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.

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

PRINTED: 07/19/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186208	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/05/2011
--	--	--	--

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 225	<p>Continued From page 1</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy, it was determined the facility failed to ensure all alleged violations of abuse were reported immediately to the Administrator. This failure to report, prevented the facility from initiating an abuse investigation, protecting the resident from the perpetrator, and reporting to the State Agencies as required.</p> <p>On 05/02/11, facility staff was made aware of Resident #7's allegation that "a man named Mark put a stick in my vagina." Staff failed to immediately report the allegation to the Administrator, preventing the facility from protecting the resident and initiating the investigation of the allegation.</p> <p>On 05/06/11 and 05/07/11 facility staff was made aware of Resident #7's allegation of abuse that Certified Nursing Assistant (CNA) #4 pushed the resident out of bed. The staff failed to immediately report the allegation to the Administrator, preventing the facility from protecting residents from the alleged perpetrator.</p>	F 225		
-------	--	-------	--	--

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

PRINTED: 07/19/2011
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 07/05/2011
--	--	--	--

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)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 225	<p>Continued From page 2 The findings include:</p> <p>Review of the facility's policy, "Subject: Adult Abuse Identification and Reporting", undated, revealed it was the facility's policy for all staff members to report any allegation of abuse of a resident to a supervisor, for the facility to notify all concerned parties (including the State Licensing and Certification Agency), and for that allegation to be investigated immediately with any alleged perpetrator removed from resident care during the investigation.</p> <p>Interview with the Nurse Manager, the Administrator and the Assistant Administrator on 07/02/11 at 3:30 PM revealed the facility's policy and procedure for allegations of abuse was to do an internal investigation of that allegation immediately, suspend any alleged perpetrator(s) during the investigation, and report the allegation to the State Licensing Agency (OIG) and other concerned parties. The Administrator stated the nurses did the investigations and the criteria for an investigation was any allegation of abuse, regardless of the resident's mental status.</p> <p>1. Review of Resident #7's medical record revealed the facility admitted the resident on 07/07/09 with diagnoses which included Dementia and Depression.</p> <p>Review of the quarterly Minimal Data Set (MDS) Assessment, dated 04/12/11, revealed the facility assessed Resident #7's cognitive status as being intact. Review of the MDS revealed the facility assessed the resident as having Personality Disorder, Anxiety, Restlessness and Behaviors (sometimes refusing care). Further review of the</p>	F 225	<p>The facility will continue to report and investigate any allegations of abuse regardless of resident level of cognition.</p> <p>Policy and procedure on Abuse reviewed and revised immediately by the Assistant Administrator.</p> <p>An in-service for all staff will be conducted by the Education Director on abuse and the procedures for reporting abuse on 07/14,19,21,26,27,28/2011.</p> <p>A quality assurance monitor will be developed by the Assistant Administrator. The monitor will be conducted twice weekly for four weeks beginning 08/08/2011, weekly for four weeks, monthly for 4 months; then quarterly thereafter by the Assistant Administrator or Social Services Director. Monitors will be reviewed by the Quality Assurance Committee weekly as conducted. See Quality Assurance audit F-225.</p> <p>LPN #6 counseled regarding abuse and reporting of abuse by Nurse Manager on 07/06/2011.</p> <p>Random sampling of six residents on unit were interviewed regarding safety, care and treatment by staff on 07-06-11. Conducted by Assistant Administrator and Nurse Manager, no negative findings were identified.</p>	8/12/2011
-------	---	-------	--	-----------

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

PRINTED: 07/19/2011
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 07/05/2011
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 225	<p>Continued From page 3</p> <p>MDS revealed the facility assessed the resident as requiring two person assist for bed mobility and most Activities of Daily Living (ADL's).</p> <p>Review of the Clinical Notes revealed a note written on 05/02/11 by Licensed Practical Nurse (LPN) #6 in which Resident #7 stated "that man Mark came in here last night, said he was going to put a stick up in my vagina and take it out, then put a Foley catheter in me, I told him no, he was not going to do that, I don't want a cath in me no more." The nurse's note further revealed the nurse informed the resident she would monitor, there is no man named Mark here working, stated all male names to the resident who are working here, resident stated "NO, it was Mark, you are not putting a cath in me. I'm urinating just fine."</p> <p>Interview with LPN #6 on 07/02/11 at 8:35 AM revealed the nurse stated, "Objectively, knowing the resident as I do, I tried to reassure him/her there was no one named Mark here to harm him/her". The LPN stated the resident could blow things out of proportion and she would reapproach at a later time to try to complete care. She stated, "I did look at his/her perineal area; no bruising noted. If I thought he/she had been abused in any way, I would have reported it." LPN#6 stated she did not think Resident #7 had been abused because there was no harm inflicted. The LPN stated she was unable to remember if she told the Charge Nurse about Resident #7's allegation of a man named Mark saying he was going to put a stick up the resident's vagina. LPN #6 stated, "I will no longer make judgment calls regarding anything."</p> <p>Interview on 07/01/11 at 2:40 PM with the Social</p>	F 225	<p>Quality assurance monitor will be developed by Assistant Administrator. Monitor will be conducted twice weekly for four weeks beginning 08/08/2011, weekly for four weeks, monthly for four months, quarterly thereafter by Assistant Administrator or Social Services Director. Monitors will be reviewed by the Quality Assurance Committee weekly as conducted. Please see attached F-225.</p> <p>When told by resident #7 of alleged incident on 05/02/2011, nurse #6 examined and assessed resident #7 on 05/02/2011 and documented in resident #7's chart that there were no signs of abuse.</p> <p>Resident #7 interviewed by Director of Nursing on 07/02/2011 regarding incident of alleged abuse of 05/02/2011. Resident denied making allegation.</p> <p>CNA #4 re-inserviced on 06/21/2011 on the need for having another CNA assist in turning residents and counseled and re-inserviced concerning abuse and neglect by Director of Nursing and Nurse Manager on 06/21/2011.</p>	8/12/2011

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

PRINTED: 07/19/2011
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 07/05/2011
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)	(X5) COMPLETION DATE
F 225	<p>Continued From page 4</p> <p>Services Director revealed she did not know about Resident #7's allegation that a man named Mark told the resident he would put a stick up his/her vagina and then insert a catheter.</p> <p>Interview with the Nurse Manager on 07/01/11 at 3:30 PM revealed the Nurse Manager never knew about Resident #7's allegation that a man named Mark told the resident he was going to put a stick up the resident's vagina. The Nurse Manager said she had not seen LPN #6's note about this in the Clinical Notes but said if she had, it would have been investigated as alleged abuse.</p> <p>Interview with the Nurse Manager, the Administrator and the Assistant Administrator on 07/02/11 at 3:30 PM revealed the facility did not investigate or report Resident #7's allegation of abuse because they were not aware of them. They stated that staff did not report the allegations to them even though staff was regularly in-serviced to report all abuse allegations to the charge nurse, the Nurse Manager, the Director of Nursing, the Administrator--any manager--as soon as they were aware of that allegation. They had no explanation for why LPN #6 did not report Resident #7's allegations.</p> <p>2. Review of the Clinical (Nurses's) Notes, entered by RN #4, on 05/06/11 at 10:00 PM, revealed: "CNA's stated that during a bed change Resident #7 slid part way out of bed and was lowered onto the floor by the CNAs at 20:30. Resident suffered three lacerated toes on the right foot and c/o (complaints of) right knee pain. Cleaned area on toes with soap and water and</p>	F 225		

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

PRINTED: 07/19/2011
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 07/05/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CARMEL MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 100 CARMEL MANOR ROAD FORT THOMAS, KY 41078
---	---

(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 225	<p>Continued From page 5</p> <p>applied direct pressure to toes to stop the bleeding. Lacerated toes may require stitches. Sent resident to the hospital. POA (Power of Attorney) notified."</p> <p>Review of the Fall Investigation Report and the Incident/Accident Report, both completed by RN #4, revealed the facility determined Resident #7 "slid out of bed" on 05/06/11 at 8:30 PM during a bed change (for incontinence care).</p> <p>However, interview, on 06/16/11 at 5:20 PM, with Resident #7 revealed the resident believed Certified Nursing Assistant (CNA) #4 pushed him/her out of bed during incontinence care. The resident said two aides, CNA #3 and CNA #4, were cleaning him/her up after a bowel movement when CNA #3 went to the bathroom to get more washcloths. The resident said CNA #4 then pushed him/her out of bed, resulting in a fall to the floor and a cut on the resident's right foot. The resident stated he/she told "everybody" that he/she had been pushed out of bed by the aide but could not remember specifically the staff and nurses he/she told. The resident stated, on 06/16/11 at 5:30 PM, that CNA #4 still was not allowed to enter his/her room.</p> <p>Interview, on 06/17/11 at 9:30 AM, with CNA #3 revealed Resident #7 told her on 05/06/11 at 8:45 PM that she/he (the resident) had been pushed out of bed during incontinence care by CNA #4 while CNA #3 was in the bathroom getting more washcloths. CNA #3 said she told Registered Nurse (RN) #4 about the resident's allegation after she and the nurse lifted the resident off the floor back into bed and the nurse assessed the resident for injuries. CNA #3 stated they found a</p>	F 225	<p>The facility will continue to report and investigate any allegations of abuse regardless of resident level of cognition.</p> <p>Policy and procedure on Abuse reviewed and revised immediately by the Assistant Administrator.</p> <p>An in-service for all staff will be conducted by the Education Director on abuse and the procedures for reporting abuse on 07/14,19,21,26,27,28/2011.</p> <p>A quality assurance monitor will be developed by the Assistant Administrator. The monitor will be conducted twice weekly for four weeks beginning 08/08/2011, weekly for four weeks, monthly for 4 months, then quarterly thereafter by the Assistant Administrator or Social Services Director. Monitors will be reviewed by the Quality Assurance Committee weekly as conducted. See Quality Assurance audit F-225.</p> <p>CNA #3 and CNA #4 counseled on 06/21/2011 regarding abuse and reporting of abuse by Nurse Manager and Director of Nursing.</p> <p>CNA #4 was re-inserviced on the need for having another CNA assist in turning residents on 6/21/2011 and counseled regarding use of resident care sheets by Director of Nursing on 06/21/2011.</p>	8/12/2011
-------	--	-------	---	-----------

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

PRINTED: 07/19/2011
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 07/05/2011
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 225	<p>Continued From page 6</p> <p>cut to the resident's right foot, under the toes, and the resident was sent to the hospital for treatment and sutures to his/her foot. CNA #3 stated she did not believe the resident was capable of turning his/her body and causing his/her fall from bed.</p> <p>Interview, on 06/17/11 at 11:00 AM, with CNA #4 revealed she was aware Resident #7 had accused her of pushing him/her out of bed on 05/06/11 at 8:30 PM because the resident confronted her with the accusation the day after the fall and told the her he/she did not want her back in the resident's room to provide care for him/her. CNA #4 said she immediately asked the Nurse Manager about going back into Resident #7's room, but did not tell the Nurse Manager the resident accused her of pushing him/her out of bed. CNA #4 revealed the Nurse Manager assigned her to another hall for about a week, then allowed her to resume caring for Resident #7, provided she always worked with a partner. CNA #4 stated she had been and was still providing care for Resident #7 (on 06/17/11).</p> <p>Continued interview, on 06/17/11 at 11:10 AM, with CNA #4 revealed the CNA denied pushing the resident out of bed on 05/06/11 at 8:30 PM. CNA #4 stated after CNA #3 went to the resident's bathroom for more washcloths, she was holding the resident on her side when the resident grabbed the siderail, the resident twisted his/her body over and flipped over the side of the bed.</p> <p>Interview with Resident #7, on 07/01/11 at 3:00 PM, revealed he/she stated again he/she "was pushed out of bed, he/she did not fall out of bed."</p>	F 225	<p>Immediately post fall resident was assessed for injuries by nurse #4 and sent to ER for treatment. Nurse #4 completed incident report, investigated fall and no allegation or suspicion of abuse were noted at that time.</p> <p>Random sampling of six residents on unit were interviewed regarding safety, care and treatment by staff on 07/06/2011. Conducted by Assistant Administrator and Nurse Manager with no negative findings.</p> <p>Resident was interviewed by the Director of Nursing regarding potential abuse allegations, for abuse investigation on 07/05,06/2011. All staff involved in abuse allegations were interviewed for abuse investigation on 06/16,17,18/2011.</p> <p>Quality assurance monitor will be developed by Assistant Administrator. Monitor will be conducted beginning 08-08-11 twice weekly for four weeks, weekly for four weeks, monthly for four months, quarterly thereafter by Assistant Administrator or Social Services Director. Monitors will be reviewed by the Quality Assurance Committee weekly as conducted. Please see attached F-225.</p>	8/12/2011

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

PRINTED: 07/19/2011
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 07/05/2011
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 225	<p>Continued From page 7</p> <p>The resident stated CNA #3 "caught her head, she is a good worker". The resident stated she didn't see CNA #4 push him/her, but CNA #4 "had her hands on him/her and gave him/her a good push". The resident said he/she could not move himself/herself and can only use his/her arms; therefore he/she could not have fallen out of bed on his/her own.</p> <p>Interview with the Resident #7's daughter, on 07/02/11 at 10:30 AM, revealed she had met the resident at the hospital after the resident's fall. She stated the resident required sutures to his/her right foot. The resident's daughter stated Resident #7 told her he/she was pushed out of bed during care by an aide. The Resident's daughter, who is a Medical Assistant at the facility, stated she, as well as all other staff, have been in-serviced to report all allegations of abuse to management and she would have reported an allegation such as her mother's/father's to her supervisor or other manager.</p> <p>Interview with RN #4 on 06/16/11 at 4:40 PM revealed he denied ever being told Resident #7 had accused CNA #4 of pushing him/her out of bed. The RN stated that he believed the nurse's aide was trying to turn the resident over to clean him/her and the resident rolled out of bed. RN #4 stated he did not have reason to believe there was any intention to abuse the resident so he did not report the incident to the managers as alleged abuse. RN #4, who investigated this fall and completed the Incident Report, said he interviewed Resident #7 about his/her fall on 05/06/11 at 8:30 PM and revealed the the resident never told him he/she was pushed out of bed by CNA #4; however, review of the Incident</p>	F 225		

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

PRINTED: 07/19/2011
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 07/05/2011
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 225	<p>Continued From page 8</p> <p>Report did not include an interview with Resident #7. RN #4 also denied that CNA #3 told him about Resident #7's allegation that he/she was pushed out of bed on 05/06/11 at 8:30 PM. RN #4 stated that he never heard the word "pushed" in regard to Resident #7's fall.</p> <p>Interview with the Nurse Manager, the Administrator and the Assistant Administrator on 07/02/11 at 3:30 PM revealed the facility did not investigate or report Resident #7's allegation of abuse because they were not aware of them. They stated that staff did not report the allegations to them even though staff was regularly in-serviced to report all abuse allegations to the charge nurse, the Nurse Manager, the Director of Nursing, the Administrator--any manager--as soon as they were aware of that allegation. They had no explanation for why CNA #3, or CNA #4 did not report Resident #7's allegations.</p> <p>Furthermore, interview with the Administrator 07/05/11 at 4:00 PM revealed the Administrator did not consider Resident #7 as being reliable and therefore did not report the resident's allegations of abuse to the appropriate agencies or investigate the resident's allegations of physical abuse.</p> <p>There was no documented evidence the facility initiated the abuse policy despite Resident #7's abuse allegations made to CNA #3, CNA #4 and LPN #6. There was no evidence the facility initiated abuse investigations. Additionally, interview with CNA #4 revealed she continued to provide direct care for Resident #7 after the allegation of abuse was made. The facility could</p>	F 225		

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

PRINTED: 07/19/2011
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 07/05/2011
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)	(X5) COMPLETION DATE
F 225	Continued From page 9 provide no evidence that action was taken to protect the resident and others from the alleged perpetrator.	F 225		
F 226 SS=E	483.13(c) DEVELOP/IMPLEMENT ABUSE/NEGLECT, ETC POLICIES 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 interview, record review, and review of the facility's policy, it was determined the facility failed to follow their Abuse Policy by failing to immediately report allegations of abuse to a Supervisor. The facility's failure to report allegations of abuse prevented the facility from initiating an abuse investigation and reassigning an employee (during an abuse investigation) to non-resident care duties or suspending that employee after an allegation of abuse for one (1) of fifteen (15) sampled residents (Resident #7). Resident #7 made an allegation of abuse on 05/02/11 to Licensed Practical Nurse (LPN) #6 that was not reported to the per the facility's policy. Again on 05/06/11 Resident #7 made an allegation of abuse to Certified Nursing Assistant (CNA) #3 that was not reported per the facility's policy. The findings include: Review of the facility's policy "Subject: Abuse Investigation and Protection" revealed the facility must implement their written policies that prevent	F 226		

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

PRINTED: 07/19/2011
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 07/05/2011
--	---	--	---

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)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 226	<p>Continued From page 10</p> <p>abuse of residents. Further review of this policy revealed all allegations of abuse would be investigated immediately; the employees who had been accused of resident abuse would be reassigned to non-resident care duties or suspended without pay until the result of the investigation had been reviewed by the Administrator. Further review of the policy revealed all staff members should report any allegation of abuse of a resident to a supervisor and for the facility to inform all concerned parties including the State Licensing and Certification Agency.</p> <p>In and interview conducted with the Administrator, Nurse Manager, and the Assistant Administrator on 07/02/11 at 3:30 PM they stated the facility's policy and procedure for allegations of abuse was to do an internal investigation of that allegation immediately, suspend any alleged perpetrator(s) during the investigation, and report the allegation to the State Licensing Agency (OIG) and other concerned parties. The Administrator stated the nurses did the investigations and the criteria for an investigation was any allegation of abuse, regardless of the resident's mental status.</p> <p>1. Review of Resident #7's record revealed a note written on 05/02/11 by Licensed Practical Nurse (LPN) #6 in which Resident #7 stated "that man Mark came in here last night, said he was going to put a stick up in my vagina and take it out, then put a Foley catheter in me, I told him no, he was not going to do that, I don't want a cath in me no more." The nurse's note further revealed the nurse informed the resident she would monitor, there is no man named Mark here working, stated all male names to the resident.</p>	F 226	<p>The facility will continue to report and investigate any allegations of abuse regardless of resident level of cognition.</p> <p>Policy and procedure on Abuse reviewed and revised immediately by the Assistant Administrator.</p> <p>An in-service for all staff will be conducted by the Education Director on abuse and the procedures for reporting abuse on 07/14,19,21,26,27,28/2011.</p> <p>A quality assurance monitor will be developed by the Assistant Administrator. The monitor will be conducted twice weekly for four weeks beginning 08/08/2011, weekly for four weeks, monthly for 4 months, then quarterly thereafter by the Assistant Administrator or Social Services Director. Monitors will be reviewed by the Quality Assurance Committee weekly as conducted. See Quality Assurance audit F-225.</p> <p>LPN #6 counseled regarding abuse and reporting of abuse by Nurse Manager on 07/06/2011.</p> <p>Random sampling of six residents on unit were interviewed regarding safety, care and treatment by staff on 07-06-11. Conducted by Assistant Administrator and Nurse Manager, no negative findings were identified.</p>	8/12/2011
-------	---	-------	--	-----------

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

PRINTED: 07/19/2011
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 07/05/2011
--	---	--	---

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 226	<p>Continued From page 11</p> <p>who are working here, resident stated "NO, it was Mark, you are not putting a cath in me. I'm urinating just fine."</p> <p>On 07/02/11 at 8:35 AM an interview was conducted with LPN #6 which revealed the nurse stated, "Objectively, knowing the resident as I do, I tried to reassure him/her there was no one named Mark here to harm him/her". The LPN stated the resident could blow things out of proportion and she would reapproach the resident at a later time to try to complete care. She stated, "I did look at his/her perineal area; no bruising noted. If I thought he/she had been abused in any way, I would have reported it." LPN#6 stated she did not think Resident #7 had been abused because there was no harm inflicted. The LPN stated she was unable to remember if she told the Charge Nurse about Resident #7's allegation of a man named Mark saying he was going to put a stick up the resident's vagina. LPN #6 stated, "I will no longer make judgment calls regarding anything." Refer to F-225</p> <p>2. Review of the Clinical (Nurses's) Notes, entered by RN #4, on 05/06/11 at 10:00 PM, revealed: "CNA's stated that during a bed change Resident #7 slid part way out of bed and was lowered onto the floor by the CNAs at 20:30. Resident suffered three lacerated toes on the right foot and c/o (complaints of) right knee pain. Cleaned area on toes with soap and water and applied direct pressure to toes to stop the bleeding. Lacerated toes may require stitches. Sent resident to the hospital. POA (Power of Attorney) notified."</p>	F 226	<p>Quality assurance monitor will be developed by Assistant Administrator. Monitor will be conducted twice weekly for four weeks beginning 08/08/2011, weekly for four weeks, monthly for four months, quarterly thereafter by Assistant Administrator or Social Services Director. Monitors will be reviewed by the Quality Assurance Committee weekly as conducted. Please see attached F-225.</p> <p>When told by resident #7 of alleged incident on 05/02/2011, nurse #6 examined and assessed resident #7 on 05/02/2011 and documented in resident #7's chart that there were no signs of abuse.</p> <p>Resident #7 interviewed by Director of Nursing on 07/02/2011 regarding incident of alleged abuse of 05/02/2011. Resident denied making allegation.</p> <p>CNA #4 re-inserviced on 06/21/2011 on the need for having another CNA assist in turning residents and counseled and re-inserviced concerning abuse and neglect by Director of Nursing and Nurse Manager on 06/21/2011.</p>	8/12/2011
-------	---	-------	---	-----------

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

PRINTED: 07/19/2011
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 07/05/2011
--	--	--	--

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 226	<p>Continued From page 12</p> <p>Review of the Fall Investigation Report and the Incident/Accident Report, both completed by RN #4, revealed the facility determined Resident #7 "sld out of bed" on 05/06/11 at 8:30 PM during a bed change (for incontinence care).</p> <p>However, interview, on 06/16/11 at 5:20 PM, with Resident #7 revealed the resident believed Certified Nursing Assistant (CNA) #4 pushed him/her out of bed during incontinence care. The resident said two aides, CNA #3 and CNA #4, were cleaning him/her up after a bowel movement when CNA #3 went to the bathroom to get more washcloths. The resident said CNA #4 then pushed him/her out of bed, resulting in a fall to the floor and a cut on the resident's right foot. The resident stated he/she told "everybody" that he/she had been pushed out of bed by the aide but could not remember specifically the staff and nurses he/she told. The resident stated, on 06/16/11 at 5:30 PM, that CNA #4 still was not allowed to enter his/her room.</p> <p>interview, on 06/17/11 at 9:30 AM, with CNA #3 revealed Resident #7 told her on 05/06/11 at 8:45 PM that she/he (the resident) had been pushed out of bed during incontinence care by CNA #4 while CNA #3 was in the bathroom getting more washcloths. CNA #3 said she told Registered Nurse (RN) #4 about the resident's allegation. CNA #3 stated she did not believe the resident was capable of turning his/her body and causing his/her fall from bed.</p> <p>Interview, on 06/17/11 at 11:00 AM, with CNA #4 revealed she was aware Resident #7 had accused her of pushing him/her out of bed on 05/06/11 at 8:30 PM because the resident</p>	F 226	<p>The facility will continue to report and investigate any allegations of abuse regardless of resident level of cognition.</p> <p>Policy and procedure on Abuse reviewed and revised immediately by the Assistant Administrator.</p> <p>An in-service for all staff will be conducted by the Education Director on abuse and the procedures for reporting abuse on 07/14,19,21,26,27,28/2011.</p> <p>A quality assurance monitor will be developed by the Assistant Administrator. The monitor will be conducted twice weekly for four weeks beginning 08/08/2011, weekly for four weeks, monthly for 4 months, then quarterly thereafter by the Assistant Administrator or Social Services Director. Monitors will be reviewed by the Quality Assurance Committee weekly as conducted. See Quality Assurance audit F-225.</p> <p>CNA #3 and CNA #4 counseled on 06/21/2011 regarding abuse and reporting of abuse by Nurse Manager and Director of Nursing.</p> <p>CNA #4 was re-inserviced on the need for having another CNA assist in turning residents on 6/21/2011 and counseled regarding use of resident care sheets by Director of Nursing on 06/21/2011.</p>	8/12/2011
-------	--	-------	---	-----------

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

PRINTED: 07/19/2011
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 07/05/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CARMEL MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 100 CARMEL MANOR ROAD FORT THOMAS, KY 41076
---	---

(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 226	<p>Continued From page 13</p> <p>confronted her with the accusation the day after the fall and told the her he/she did not want her back in the resident's room to provide care for him/her. CNA #4 said she immediately asked the Nurse Manager about going back into Resident #7's room, but did not tell the Nurse Manager the resident accused her of pushing him/her out of bed. CNA #4 revealed the Nurse Manager assigned her to another hall for about a week, then allowed her to resume caring for Resident #7, provided she always worked with a partner. CNA #4 stated she had been and was still providing care for Resident #7 (on 08/17/11).</p> <p>Interview with RN #4 on 06/16/11 at 4:40 PM revealed he denied ever being told Resident #7 had accused CNA #4 of pushing him/her out of bed. The RN stated that he believed the nurse's aide was trying to turn the resident over to clean him/her and the resident rolled out of bed. RN #4 stated he did not have reason to believe there was any intention to abuse the resident so he did not report the incident to the managers. He stated he completed the Incident Report and investigation following the fall, however, review of the Incident Report/Investigation revealed no evidence of an interview with Resident #7 or witness statements. Refer to F-225</p> <p>Interview with the Nurse Manager, the Administrator and the Assistant Administrator on 07/02/11 at 3:30 PM revealed the facility did not investigate or report Resident #7's allegations of abuse because they were not aware of them. They stated that staff did not report the allegations to them even though staff was regularly in-serviced and trained to report all abuse allegations to the Supervisor as soon as</p>	F 226	<p>Immediately post fall resident was assessed for injuries by nurse #4 and sent to ER for treatment. Nurse #4 completed incident report, investigated fall and no allegation or suspicion of abuse were noted at that time.</p> <p>Random sampling of six residents on unit were interviewed regarding safety, care and treatment by staff on 07/06/2011. Conducted by Assistant Administrator and Nurse Manager with no negative findings.</p> <p>Resident was interviewed by the Director of Nursing regarding potential abuse allegations, for abuse investigation on 07/05,06/2011. All staff involved in abuse allegations were interviewed for abuse investigation on 06/16,17,18/2011.</p> <p>Quality assurance monitor will be developed by Assistant Administrator. Monitor will be conducted beginning 08-08-11 twice weekly for four weeks, weekly for four weeks, monthly for four months, quarterly thereafter by Assistant Administrator or Social Services Director. Monitors will be reviewed by the Quality Assurance Committee weekly as conducted. Please see attached F-225.</p>	8/12/2011
-------	--	-------	---	-----------

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

PRINTED: 07/19/2011
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 07/05/2011
--	---	--	---

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)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 226	<p>Continued From page 14</p> <p>they were aware of that allegation. They further stated if they would have been made aware of the allegations of abuse, they would have conducted investigations and suspended the perpetrator during the investigation.</p> <p>Furthermore, interview with the Administrator 07/05/11 at 4:00 PM revealed the Administrator did not consider Resident #7 as being reliable and therefore did not report the resident's allegations of abuse to the appropriate agencies or investigate the resident's allegations of physical abuse.</p>	F 226		
F 241 SS=E	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure each resident's dignity was enhanced during dining. Dietary staff failed to serve meals to all residents at one table at the same time. In addition, one (1) unsampled resident (Unsampled Resident B) was</p>	F 241	<p>Facility will continue to promote care for residents in a manner that promotes each resident's dignity and individuality.</p> <p>Dietary Director will conduct in-service of dietary staff on serving of residents in a timely manner, and serving all residents seated at a table at the same time on 06/23,24/2011.</p>	8/12/2011

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

PRINTED: 07/19/2011
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 07/05/2011
--	---	--	---

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 241	<p>Continued From page 15</p> <p>observed, on three (3) consecutive days, to be seated alone in the dining room for meal service. Unsampld Resident B expressed distress at not having any tablemates.</p> <p>The findings include:</p> <p>Observation of the evening meal on 06/15/11 at 5:10 PM revealed five (5) unsampled residents sitting at Table #4. Two (2) residents had already been served and were eating. Continued observation revealed two (2) more residents were served at 5:20 PM. The fifth resident was not served until 5:35 PM. Further observation at an adjacent table revealed a resident arrived to the dining room at 5:25 PM and requested food items in place of the stated menu items. The special order was served at 5:32 PM, before the last resident at Table #4 was served. Continued observation of Table #4 revealed two (2) residents had their hands up. The residents were overheard complaining, to residents at another table, their friend did not have any food. Further observation revealed the last plate was served before the residents reported to staff. Interview with the residents at Table #4 revealed similar incidents happened "sometimes". When questioned, Unsampld Resident A shrugged his/her shoulders but did not respond otherwise.</p> <p>Continued observation of the meal, at 6:00 PM, revealed an Unsampld Resident B sitting and eating alone at Table #7. The resident was positioned with his/her back to the dining room. Interview with the resident on 06/15/11 at 6:05 PM revealed he/she used to sit with someone, but they hadn't been there in a while and the resident did not know what happened to them.</p>	F 241	<p>Dietary Director will develop and implement a Quality Assurance monitor on serving residents in a timely manner, and serving all residents seated at a table at the same time. Conducted twice weekly for one month, weekly thereafter by Dietary Director, Diet Tech, or Dietician beginning 07/12/2011. Monitor will be reviewed by the Quality Assurance Committee weekly as conducted. Please see F-241 attached.</p> <p>Un-sampled resident B's tablemate expired 06/12/2011. Dietary staff were inserviced by the Dietary Director on 06/23,24 /2011 that residents will be asked if they want to eat alone or be joined by other residents at their table. Dietary Director will create and implement a Quality Assurance monitor on Resident seated alone in the dining room. Monitor will be conducted daily for two weeks, twice weekly for one month, weekly there after by the Dietary Director, Diet Tech or Dietician beginning 08/08/2011. Monitor will be reviewed by the Quality Assurance Committee weekly as conducted.</p> <p>On 06/15/2011 Dietary Director evaluated seating arrangement in dining room to assure all residents are seated with other residents unless resident does not desire to do so. Un-sampled resident B was moved to an alternate table on 06/16/2011.</p> <p>Random sampling of 6 other residents was conducted on 06/15/2011 by Dietary Director regarding eating alone. No negative findings were identified.</p>	8/12/2011
-------	---	-------	---	-----------

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

PRINTED: 07/19/2011
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 07/05/2011
--	---	--	---

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 241	<p>Continued From page 16</p> <p>The resident further stated, "I always eat by myself now."</p> <p>Interview with Certified Nursing Assistant (CNA) #1 on 06/15/11 at 6:10 PM revealed staff usually serve one table at a time. She stated she did not know what happened at Table #4.</p> <p>Further interview with CNA #1 on 06/15/11 at 6:15 PM revealed Unsampld Resident B did have a tablemate who had passed away several days ago. She stated residents sat at assigned tables but she did not know who was responsible for making the assignments.</p> <p>Continued observation, on 06/15/11 at 6:20 PM, revealed Unsampld Resident B and one other resident at another table were the only ones left in the dining. Dietary staff were observed to bus the other tables, pushing carts and clanging dishes. All liquids left on the tables were poured in a large open bucket, causing a very unpleasant smell. During thirty (30) minutes of observation, no social interaction between the residents and any other resident or staff member was noted.</p> <p>Observation of the noon meal on 06/16/11 at 12:45 PM revealed Unsampld Resident B sitting and eating alone at Table #7. The resident stated, "I used to sit with my good friend, but they moved me." Further observation, on 06/17/11 at 12:30 PM, revealed Unsampld Resident B, again sitting and eating alone at Table #7.</p> <p>During interview on 06/17/11 at 3:45 PM, the Dietary Manager stated she stressed feeding all residents at one table at the same time. She further stated staff should not bus tables</p>	F 241	<p>Dietary Director will conduct in-service of dietary staff on end of meal service and appropriate busing of tables 06/23,24/2011.</p> <p>Dietary Director will develop and implement a quality assurance monitor on busing tables. Conducted twice weekly for one month, weekly thereafter beginning 07/12/2011. Monitor will be reviewed by Quality Assurance Committee weekly as conducted. See F-241 attached.</p> <p>Dietary Director will review and revise policy on Dining on 06/30/2011. Dietary Director will inservice all dietary staff of changes or revisions to policy on dining by 07/12/2011.</p> <p>Dietary Director will develop and implement a Quality Assurance monitor on resident seating in dining room. Conducted twice weekly for one month, weekly thereafter by Dietary Director, Diet Tech or Dietician beginning 07/23/2011. Monitors will be reviewed by Quality Assurance Committee weekly as conducted. Please see F-241 attached.</p>	8/12/2011
-------	--	-------	---	-----------

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

PRINTED: 07/19/2011
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 07/05/2011
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 241	Continued From page 17 Immediately surrounding residents who were still eating. She agreed the liquids in the bucket smelled bad. Continued interview revealed she should have been informed by staff in the dining room that Unsampled Resident B, at Table #7 had no tablemate.	F 241		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to ensure a Care Plan was developed to describe the services necessary to attain or maintain the	F 279		

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

PRINTED: 07/19/2011
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 07/05/2011
--	---	--	---

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 279	<p>Continued From page 18</p> <p>resident's highest practicable physical well-being, for two (2) of fifteen (15) sampled residents, (Residents #1 and #6). Residents #1 and #6 had recently been hospitalized for respiratory infections and were receiving oxygen therapy on re-admission to the facility. Record review revealed no evidence care Care Plans had been developed related to the infections or the oxygen therapy.</p> <p>The findings include:</p> <ol style="list-style-type: none"> Review of the Clinical Record revealed Resident #1 was admitted to the facility on 05/06/11 with diagnoses which included Congestive Heart Failure and status post Pneumonia. Review of the Admission Minimum Data Set (MDS) Assessment dated 05/18/11 revealed the resident was receiving oxygen therapy. Review of the nurse's Clinical Note dated 05/06/11 at 5:32 PM revealed Resident #1 required oxygen PRN (as needed) for shortness of breath on exertion. <p>Observation on 06/14/11 at 8:15 PM revealed an oxygen concentrator and a nasal cannula were in the resident's room. The oxygen was not in use. During interview on 06/14/11 at 8:20 PM the resident stated "they test me" and tell me when I need it.</p> <p>Review of the Comprehensive Care Plan, dated 05/19/11, revealed no evidence a Care Plan was developed and interventions were in place to address the resident's recent Pneumonia or for the use of oxygen therapy.</p> <p>Observation on 06/17/11 at 10:30 AM revealed</p>	F 279	<p>The facility will continue to use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>An acute care plan outlining the plan of care, for respiratory infection care and oxygen use were implemented for resident #1 and resident #6 by Nurse Manager on 06/16/2011.</p> <p>All residents with respiratory infections and with oxygen in use were reviewed by Nurse Manager and Director of Nursing to make sure appropriate care plans, acute or chronic, were in place for the respiratory infections and for the use of oxygen on 06/22/2011 with no other residents identified without care plans.</p> <p>All resident care plans reviewed to assure all physician orders in place on care plan on 06/22/2011 by Director of Nursing. Remaining care plans found to be in compliance.</p> <p>Policy and procedure regarding the initiation, continuation and updating of care plans for residents with acute or chronic respiratory infections and acute use of oxygen were reviewed and revised by Director of Nursing on 06/21/2011.</p> <p>An in-service regarding the implementation of acute care plans for respiratory infections and acute or chronic care plans for the use of oxygen were conducted with LPN responsible for the admission for resident #1 and #6 by Director of Nursing on 07/19/2011.</p>	8/12/2011
-------	---	-------	--	-----------

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

PRINTED: 07/19/2011
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 07/05/2011
NAME OF PROVIDER OR SUPPLIER CARMEL MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 100 CARMEL MANOR ROAD FORT THOMAS, KY 41076		
(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 279	<p>Continued From page 19</p> <p>Resident #1 was in bed. The resident was receiving oxygen by nasal cannula at two (2) liters per minute.</p> <p>Interview with Registered Nurse (RN) #1 on 06/17/11 at 10:50 AM revealed she did not know when the oxygen was applied to the resident.</p> <p>Interview with RN #10 on 06/17/11 at 11:00 AM revealed Resident #1 returned from the hospital on oxygen. She stated at the present time, the resident was only using the oxygen at night. Continued interview revealed the facility should have developed a Care Plan for Resident #1 for the use of the oxygen and for the recent Pneumonia.</p> <p>During interview with the Nurse Manager on 06/17/11 at 2:20 PM, she confirmed the resident did not have a Care Plan for the use of oxygen. She stated there should have been interventions in place for oxygen therapy.</p> <p>2. Clinical Record review revealed Resident #6 was re-admitted to the facility from the hospital on 06/03/11 with diagnoses which included Congestive Heart Failure, probable Aspiration Syndrome and status post Pneumonia. Review of the Annual MDS Assessment, dated 06/08/11, revealed the resident was receiving oxygen therapy.</p> <p>Observation on 06/14/11 at 9:00 PM revealed Resident #6 was receiving oxygen therapy at three (3) liters per minute by nasal cannula. Continued observation revealed the resident used the call bell for assistance, stating "I can't breathe". The nurse, on arrival, assisted the</p>	F 279	<p>An all nurse staff in-service will be conducted by the Education Director on 07/27/2011, 08/02,04,10/2011 regarding acute care plan initiation for residents with acute respiratory infections and acute initiation for oxygen therapy or chronic care plans and care plans revisions.</p> <p>A Quality Assurance monitor will be developed and initiated on Comprehensive Care Plans to monitor for acute care plans for residents with acute respiratory infections and for new onset use of oxygen beginning 08/08/2011. It will be conducted by Director of Nursing or Unit Manager. It will be conducted weekly x 8 weeks, biweekly x 16 weeks and then monthly. Monitor will be reviewed by the Quality Assurance Committee weekly as conducted. Please see F-279 a,b,c attached.</p>	8/12/2011	

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

PRINTED: 07/19/2011
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 07/05/2011
--	---	--	---

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 279	<p>Continued From page 20</p> <p>resident with coughing and deep breathing, and applied a nebulizer mask for the administration of an inhaled albuterol treatment. (Albuterol is a bronchodilating drug used to treat shortness of breath.) Further observation revealed a portable suction machine was at the bedside for use as needed to help the resident remove respiratory secretions.</p> <p>Review of the Comprehensive Care Plan, last revised on 06/11/11, revealed no evidence the facility had developed a Care Plan related to Pneumonia or a Care Plan related to the use of oxygen therapy and the need for suctioning.</p> <p>Interview with the MDS coordinator on 06/16/11 at 11:50 AM revealed no Care Plan for oxygen administration or suctioning had been developed.</p> <p>Interview with LPN #4 on 06/16/11 at 5:05 PM confirmed Resident #6 had no written plan of care for respiratory care. The LPN stated floor staff could initiate an acute Care Plan at any time. The nurse further stated a Care Plan for oxygen therapy, respiratory infection, and suctioning of lung secretions should be expected.</p> <p>Interview with the Nurse Manager on 06/17/11 at 2:20 PM revealed she had been made aware of the lack of a Care Plan related to oxygen therapy and suctioning for Resident #6. She stated one should have been developed when the resident returned from the hospital.</p>	F 279		
F 281 SS=D	<p>483.20(k)(3)(I) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p>	F 281		

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

PRINTED: 07/19/2011
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 07/05/2011
--	---	--	---

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 281	<p>Continued From page 21</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to ensure professional standards of quality were met when two (2) of fifteen (15) sampled residents received oxygen therapy without a Physician's Order (Residents #1 and #6). In addition, Resident #6 was required periodic suctioning of the upper airway with no Physician's Order.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical Record review revealed Resident #1 was re-admitted to the facility from the hospital on 05/06/11 with diagnoses which included Congestive Heart Failure and status post Pneumonia. Review of the Admission Minimum Data Set (MDS) Assessment dated 05/18/11 revealed the resident was receiving oxygen therapy. Review of the nurse's Clinical Note dated 05/06/11 at 5:32 PM revealed Resident #1 required oxygen PRN (as needed) for shortness of breath with exertion. <p>Observation of Resident #1 on 06/14/11 at 8:15 PM revealed an oxygen concentrator and administration setup were present in the room but were not in use at that time. Interview with the resident on 06/14/11 at 8:20 PM revealed staff tested the resident and administered the oxygen when needed.</p> <p>Observation on 06/17/11 at 10:30 AM revealed Resident #1 was in bed. Oxygen was being administered to the resident via nasal cannula at</p>	F 281	<p>The facility will continue to ensure professional standards of quality.</p> <p>Residents #1's physician was called by floor nurse on 06/17/2011. The physician reviewed an order for oxygen therapy.</p> <p>All resident's with oxygen equipment present in room, or known to use oxygen, were reviewed by Director of Nursing and Unit Manager to assure current, detailed orders for the use of oxygen were in place on 06/21/2011:</p> <p>Policy and procedure for obtaining and initiating oxygen orders were reviewed and revised by Director of Nursing on 06/20/2011.</p> <p>Nurse that admitted resident #1 was in-serviced regarding obtaining proper orders for the use of oxygen for any resident admitted requiring oxygen therapy either continuous or as needed, by Director of Nursing on 07/09/2011.</p> <p>An in-service with all staff nurses will be completed by the Education Director on 07/27/2011,08/02,08/04,8/10/2011 outlining proper procedure to obtain orders from physician for the use of oxygen.</p>	8/12/2011
-------	--	-------	--	-----------

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

PRINTED: 07/19/2011
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 07/05/2011
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 281	<p>Continued From page 22 two (2) liters per minute.</p> <p>Review of the Physician's Orders for the months of May and June 2011 revealed no order for oxygen administration.</p> <p>Interview with Registered Nurse (RN) #1 on 06/17/11 at 10:50 AM revealed she did not know when the oxygen was applied to the resident. Continued interview revealed when an order for oxygen was placed in the computer system, a prompt was generated to the electronic Medication Administration Record (MAR) to remind the nurse to check the resident's oxygen saturation level and ensure the oxygen was administered as ordered. Review of the MAR with RN #1 revealed no order for the oxygen had been placed in the system.</p> <p>Interview with RN #10 on 06/17/11 at 11:00 AM revealed Resident #1 returned from the hospital on oxygen. She stated the resident was only using the oxygen at night. Continued interview revealed there should have been a Physician's Order for oxygen administration.</p> <p>During interview with the Nurse Manager on 06/17/11 at 2:20 PM, she confirmed Resident #1 did not have a Physician's Order in place for the administration of oxygen. She stated an order should have been obtained when the resident was re-admitted to the facility from the hospital.</p> <p>2. Review of the Clinical Record for Resident #6 revealed he/she was re-admitted to the facility from the hospital on 06/03/11 with diagnoses which included Congestive Heart Failure, Probable Aspiration Syndrome and status post</p>	F 281	<p>A Quality Assurance monitor will be developed and implemented on professional standards to obtain and initiate oxygen orders for residents requiring oxygen therapy. It will be conducted by Director of Nursing or Unit Manager weekly x 8 weeks, bi-weekly x 16 weeks and then monthly beginning 08/08/2011. Monitor will be reviewed by Quality Assurance Committee weekly as conducted. See F-281 attached.</p> <p>Residents #6's physician was called by floor nurse on 06/16/2011. The physician reviewed an order for oxygen therapy.</p> <p>All resident's with oxygen equipment present in room or known to use oxygen or require suctioning were reviewed by Director of Nursing and Unit Manager to assure current, detailed orders for the use of oxygen were in place on 06/22/2011.</p> <p>Policy and procedure for obtaining and initiating oxygen orders or orders for suctioning were reviewed and revised by Director of Nursing on 06/20/2011</p>	8/12/2011

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

PRINTED: 07/19/2011
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 07/05/2011
--	---	--	---

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)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 281	<p>Continued From page 23</p> <p>Pneumonia. Review of the Annual MDS Assessment dated 06/08/11 revealed the resident was receiving oxygen therapy.</p> <p>Observation of Resident #6 on 06/14/11 at 9:00 PM revealed oxygen was being administered at three (3) liters per minute by nasal cannula. Continued observation of the resident's room revealed a portable suction machine and related equipment was on the bedside table. Interview with Licensed Practical Nurse #4 on 06/14/11 at 9:10 PM revealed staff suctioned Resident #6 as need to assist him/her in removing respiratory secretions.</p> <p>Review of the Physician's Orders for the month of June 2011 revealed no order was in place for oxygen administration or suctioning of respiratory secretions.</p> <p>During interview on 06/16/11 at 11:50 AM the MDS Coordinator confirmed there was no order for the oxygen or the suctioning for Resident #6. She stated an order would be expected for both treatments.</p> <p>Subsequent interview with LPN #4 on 06/16/11 at 5:05 PM revealed the resident should have a Physician's Order for the oxygen and the suctioning.</p> <p>Interview with the Nurse Manager on 06/17/11 at 2:20 PM revealed she had been made aware of the lack of a Physician's Order for the oxygen and suctioning. She stated an order should have been obtained when the resident was re-admitted to the facility.</p>	F 281	<p>Nurse that admitted resident #6 was in-serviced regarding obtaining proper orders for the use of oxygen or suctioning for any resident admitted requiring oxygen therapy either continuous or as needed, by Director of Nursing on 07/09/2011. Nurse that performed suctioning on Resident #6 was in-serviced that a MD needs to be notified and an order obtained for suctioning a resident on 07/09/2011.</p> <p>An in-service with all staff nurses will be completed by the Education Director on 07/27/2011,08/02,08/04,8/10/2011 outlining proper procedure to obtain and record physician orders for the use of oxygen therapy or suctioning.</p> <p>A Quality Assurance monitor will be developed and implemented on professional standards to obtain and initiate oxygen orders for residents requiring oxygen therapy and suctioning treatment. It will be conducted by Director of Nursing or Unit Manager weekly x 8 weeks, bi-weekly x 16 weeks and then monthly beginning 08/08/2011. Monitor will be reviewed by the Quality Assurance Committee weekly as conducted. See F-281A attached.</p>	8/12/2011
F 282	483.20(k)(3)(ii) SERVICES BY QUALIFIED	F 282		

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

PRINTED: 07/19/2011
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 07/05/2011
--	---	--	---

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)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 282 SS=D	<p>Continued From page 24 PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure the care plan was followed for one (1) of fifteen (15) sampled residents (Resident #7). The Staff did not ensure a two person assist during incontinence care as required by the resident's assessment and Comprehensive Care Plan.</p> <p>The findings include:</p> <p>Review of Resident #7's medical record revealed the facility admitted the resident on 07/07/09 with diagnoses which included Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Osteoporosis, Arthritis, Obesity and Dementia.</p> <p>Review of the Comprehensive Care Plan, initiated on 07/20/09, for Assistance with Daily Living (ADL's) revealed Resident #7 required extensive assistance with all ADL's except locomotion in a wheelchair off unit. The Care Plan stated that some ADL's require two people for assistance such as toilet use, bathing, transfers and bed mobility. Review of Minimal Data Sets (MDS) Assessments, dated 01/11/11 and 04/12/11 revealed Resident #7 required two-person assist with bed mobility and toilet use.</p>	F 282	<p>The facility will continue to assure resident care plans are followed by all staff.</p> <p>Resident # 7 was assessed by nurse #7 and assisted per 3 staff members, and aide(s) involved were in-serviced and supervised to use two staff members when caring for resident by nurse #7 on 05/06/2011.</p> <p>Unit manager reviewed all other residents and identified other residents that require assist of 2 staff members to ensure that care is properly rendered by 2 staff members with no negative findings. All residents were reviewed with Director of Nursing, Unit Manager, Director of Therapy Services and Restorative Director to identify all residents that require 2 person assist and assure all care plans are up to date and accurate for care status on 06/29/2011.</p> <p>Policy and procedure regarding incontinence care of a resident were reviewed and revised including proper initiation and following care plan to care for each individual resident by Director of Nursing on 06-20-2011.</p> <p>Certified Nurse Aide # 4 and Certified Nurse Aide # 3 were counseled and re-educated regarding proper following of each residents care plan by Director of Nursing and Nurse Manager on 06/21/2011.</p>	8/12/2011
---------------	--	-------	---	-----------

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

PRINTED: 07/19/2011
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 07/05/2011
--	--	--	--

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)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 282	<p>Continued From page 25</p> <p>Interview with CNA #4 on 06/16/11 at 4:05 PM revealed she was left holding the resident during incontinence care while CNA #3 went to the resident's bathroom for more wet washcloths. The CNA stated that in a matter of seconds, the resident grabbed the right siderail, twisted himself/herself all the way around and his/her legs went over the side of the bed, resulting in a fall from the bed and laceration on the bottom of the resident's right foot.</p> <p>Interview with Certified Nurse Assistant (CNA) #3 on 06/16/11 at 5:15 PM revealed she was working with CNA #4 on 05/06/11 at 8:15 PM providing incontinence care to Resident #7. CNA #3 stated she left the resident and CNA #4 to go to the resident's bathroom to get more wet washcloths, telling CNA #4 to hold the resident until she returned. The resident was lying on his/her side in the middle of the bed. She stated soon she heard the resident yell and when she returned to the room, she saw the resident had fallen over the side of the bed and was on her knees on the floor between the two beds, holding onto the side rail with his/her left hand.</p> <p>Interview with the Director of Nursing (DON) on 06/18/11 at 11:30 AM revealed Resident #7 required the assistance of two persons to provide incontinence care, as this would relate directly to the resident's bed mobility, which was assessed as requiring two person assistance.</p>	F 282	<p>An in-service for all nurses and aides will be conducted by Education Director on 07/27/11, 08/02,04,10/2011 regarding proper implementation of care guidelines and use and following of residents' care plan including following guidelines for any resident requiring 2 person assistance, including resident #7.</p> <p>A Quality Assurance monitor regarding services by qualified personnel regarding the implementation and following of resident care plan by care staff will be developed and implemented by the Director of Nursing. It will be conducted by the Director of Nursing or Unit Manager beginning 08/08/2011, weekly x 8 weeks, biweekly x 8 weeks, then monthly thereafter. Monitor will be reviewed by the Quality Assurance Committee weekly, biweekly, and monthly as conducted. See F-282/F-323 attached.</p>	8/12/2011
F 323 SS=D	<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</p>	F 323		

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

PRINTED: 07/19/2011
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 07/05/2011
--	---	--	---

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)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 323	<p>Continued From page 26 adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure each resident received adequate supervision to prevent accidents for one (1) of fifteen (15) samples residents (Resident #7). On 05/06/11, one (1) staff person attempted to complete incontinence care independently even though Resident #7 was assessed and care planned for assist of two (2) for bed mobility. As a result, the resident fell out of bed and sustained a cut to his/her right foot, requiring a hospital visit and sutures.</p> <p>The findings include:</p> <p>Review of Resident #7's medical record revealed the facility admitted the resident on 07/07/09 with diagnoses which included Congestive Heart Failure, Chronic Obstructive Pulmonary disease, Osteoporosis, Arthritis, Obesity and Dementia.</p> <p>Review of the Comprehensive Care Plan, initiated on 07/20/09, for Assistance with Daily Living (ADL's) revealed Resident #7 required extensive assistance with all ADL's. The Care Plan states that some ADL's require two people: toilet use, bathing, transfers and bed mobility. Continued review of the Care Plan for Falls Risk, initiated on 07/20/09, revealed Resident #7 was at risk for falls due to a history of falls. The Care Plan</p>	F 323	<p>The facility will continue to assure resident care plans are followed by all staff.</p> <p>Resident # 7 was assessed by nurse #7 and assisted per 3 staff members, and aide(s) involved were in-serviced and supervised to use two staff members when caring for resident by nurse #7 on 05/06/2011.</p> <p>Unit manager reviewed all other residents and identified other residents that require assist of 2 staff members to ensure that care is properly rendered by 2 staff members with no negative findings. All residents were reviewed with Director of Nursing, Unit Manager, Director of Therapy Services and Restorative Director to identify all residents that require 2 person assist and assure all care plans are up to date and accurate for care status on 06/29/2011.</p> <p>Policy and procedure regarding incontinence care of a resident were reviewed and revised including proper initiation and following care plan to care for each individual resident by Director of Nursing on 06-20-2011.</p> <p>Certified Nurse Aide # 4 and Certified Nurse Aide # 3 were counseled and re-educated regarding proper following of each residents care plan by Director of Nursing and Nurse Manager on 06/21/2011.</p>	8/12/2011
-------	---	-------	---	-----------

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

PRINTED: 07/19/2011
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 07/05/2011
--	---	--	---

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 323	<p>Continued From page 27</p> <p>revealed the resident needed assistance with ADLs, took psychotropic drugs routinely and had diagnoses of dementia and poor balance. Further review revealed an intervention for two (2) person assistance for toileting and perineal care while in bed.</p> <p>Review of the quarterly Minimal Data Sets (MDS) dated 04/12/11 revealed Resident #7 was assessed as requiring the assistance of two (2) persons for bed mobility and toilet use. The resident was also assessed on the MDS as a falls risk and a Care Plan for falls was developed.</p> <p>Review of the Clinical Notes entered on 05/06/11 at 10:01 PM by Registered Nurse (RN) #3 revealed "CNA's stated that during a bed change (the resident) slid part way out of the bed and was lowered onto the floor by the CNAs at 20:30. Resident suffered three lacerated toes on right foot and complained of right knee pain. Cleaned area on toes with soap and water and applied direct pressure to toes to stop the bleeding. Lacerated toes may require stitches. Sent resident to (hospital)."</p> <p>Reviews of the Incident Report and Fall Investigation, both completed by RN #3, revealed the resident "slid out of bed" during a bed change (incontinence care).</p> <p>Interview with CNA #4 on 06/16/11 at 4:05 PM revealed she was left holding the resident during incontinence care while CNA #3 went to the resident's bathroom to get more wet washcloths. CNA #4 stated that in a matter of seconds, the resident grabbed the siderall, twisted himself/herself all the way around and his/her</p>	F 323	<p>An in-service for all nurses and aides will be conducted by Education Director on 07/27/11, 08/02, 08/04, 08/10/2011 regarding proper implementation of care guidelines and use and following of residents' care plan including following guidelines for any resident requiring 2 person assistance, including resident #7.</p> <p>A Quality Assurance monitor regarding services by qualified personnel regarding the implementation and following of resident care plan by care staff will be developed and implemented by the Director of Nursing. It will be conducted by the Director of Nursing or Unit Manager beginning 08/08/2011, weekly x 8 weeks, biweekly x 8 weeks, then monthly thereafter. Monitor will be reviewed by the Quality Assurance Committee weekly as conducted. See F-282/F-323 attached.</p>	8/12/2011
-------	---	-------	--	-----------

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

PRINTED: 07/19/2011
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 07/05/2011
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)	(X5) COMPLETION DATE
F 323	Continued From page 28 legs went over the side of the bed, resulting in a fall from the bed and a cut to the resident's right foot. The fall required a trip to the hospital emergency room and sutures to the resident's foot. Interview with Certified Nurse Assistant (CNA) #3 on 06/16/11 at 5:15 PM revealed she was working with CNA #4 on 05/06/11 at 8:15 PM providing incontinence care to Resident #7. CNA #3 left the resident lying on his/her side in the middle of the bed with CNA #4 and went to the resident's bathroom to get more wet washcloths. CNA #3 stated she heard the resident yell and CNA #4 yell. When she returned to the room, she saw the resident had fallen over the side of the bed and was on his/her knees on the floor between the two beds, holding the side rail of the bed with his/her left hand. Interview with the Director of Nursing (DON) on 06/18/11 at 11:30 AM revealed Resident #7 required the assistance of two (2) persons to provide incontinence care, as this would relate directly to the resident's bed mobility, which was assessed to require the assistance of two (2) persons.	F 323		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning;	F 328		

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

PRINTED: 07/19/2011
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 07/05/2011
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 328	<p>Continued From page 29 Respiratory care; Foot care; and Prostheses.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to ensure proper care and treatment for respiratory needs for two (2) of fifteen (15) sampled residents, (Residents #1 and #6). Resident #1 had an oxygen concentrator with a dirty filter and the administration tubing was not stored properly when not in use. The tubing was lying on the floor behind the concentrator. Resident #6 had a mask for the administration of Intermittent Inhalation therapy. The mask was observed lying uncovered on the foot pedal of the resident's wheelchair.</p> <p>The findings include:</p> <p>Review of the Nursing Department policy titled "Oxygen", (no date), revealed the intake filter on the oxygen concentrator "must be checked daily and cleaned whenever dirty". The policy did not address how resident equipment was to be stored when not in use.</p> <p>1. Review of the Clinical Record revealed Resident #1 was admitted to the facility on 05/06/11 with diagnoses which included Congestive Heart Failure and status post Pneumonia. Review of the Admission Minimum data Set (MDS) Assessment, dated 05/18/11, revealed the resident was receiving oxygen therapy.</p>	F 328	<p>Facility will continue to provide proper care and treatment for respiratory needs of residents.</p> <p>Plastic bags to contain tubing for oxygen and nebulizer equipment were obtained immediately by the Director of Nursing. New tubing was put in place for resident #1's oxygen concentrator and resident #6's nebulizer machine by the Director of Nursing on 06/14/2011. Plastic bags were put in place for resident #1 to store oxygen tubing and resident #6 to store nebulizer tubing by the Director of Nursing on 06/14/2011. The oxygen concentrator filter was removed from resident #1's concentrator, cleaned and put back into place by the Director of Nursing on 06/15/2011.</p> <p>All residents with oxygen equipment and nebulizer equipment present were identified by Director of Nursing on 06/21/2011. All residents were checked to assure proper storage bags were in place for tubing for oxygen concentrators, oxygen tanks and nebulizer treatment machines by the Director of Nursing on 06/21/2011. All other residents had storage bag present. All oxygen concentrator filters were checked for cleanliness by the Director of Nursing and cleaned on 06/21/2011.</p> <p>Policy and procedure for oxygen use were reviewed and revised by Director of Nursing to include proper storage of unused oxygen tubing and nebulizer tubing for infection control purposes on 06/20/2011. Policy and procedure for oxygen concentrators reviewed and revised by Director of Nursing to include proper cleaning of oxygen concentrator filters</p>	8/12/2011

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

PRINTED: 07/19/2011
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 07/05/2011
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 328	<p>Continued From page 30</p> <p>Observation of Resident #1 on 06/14/11 at 8:15 PM revealed the filter on the oxygen concentrator was heavily coated with dust. In addition, the oxygen administration tubing, which was not in use at the time, was lying on the floor behind the concentrator.</p> <p>Interview with LPN #1 on 06/15/11 at 10:50 AM revealed she had not been instructed to clean or change oxygen concentrator filters. She stated "someone" came and checked the equipment periodically but she did not know how often. She further stated there was probably a policy about it.</p> <p>2. Clinical Record review for Resident #6 revealed he/she was re-admitted to the facility from the hospital on 06/03/11 with diagnoses which included Congestive Heart Failure, probable Aspiration Syndrome and status post Pneumonia. Review of the Annual MDS Assessment, dated 06/08/11, revealed the resident was receiving oxygen therapy.</p> <p>Observation of Resident #6 on 06/14/11 at 9:00 PM revealed the mask used for intermittent inhalation therapy was lying uncovered on the foot pedal of the resident's wheelchair. Continued observation revealed the nurse entered the room and applied the mask to the resident's face and administered a breathing treatment.</p> <p>Interview with Licensed Practical Nurse #4 on 06/14/11 at 9:10 PM revealed oxygen therapy supplies should be stored in a plastic bag when not in use.</p>	F 328	<p>Nurses on duty were inserviced regarding proper storage of oxygen tubing and nebulizer tubing and checking and maintaining air filters for oxygen concentrators by the Director of Nursing on 07/09/2011.</p> <p>An in-service with all nurses will be conducted by the Education Director by 07/27/2011, 08/02,08/04,08/10/2011 regarding policy for policy and procedure for proper storage of oxygen tubing when not in use, and proper observation and cleaning of external filters on oxygen concentrators.</p> <p>A Quality Assurance monitor will be developed by the Director of Nursing and implemented regarding the storage of oxygen tubing and nebulizer tubing, and observation and maintenance of external filters on oxygen concentrators. Monitor conducted by Director of Nursing or Unit Manager beginning 08/08/2011- 1x weekly x 12 weeks, bi-weekly x 8 weeks, then monthly. Monitor will be reviewed by the Quality Assurance Committee weekly as conducted. See F-328 and F-328A attached.</p> <p>Quality Assurance monitor for monitoring tube feed supplies, ostomy supplies and injection procedure will continue to be completed monthly by Director of Nursing or Unit Manager. Monitor will be reviewed by the Quality Assurance Committee weekly as conducted.</p>	8/12/2011

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

PRINTED: 07/19/2011
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 07/05/2011
--	---	--	---

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 328	Continued From page 31 Interview with the Unit Manager on 06/15/11 at 11:20 AM revealed Central Supply was responsible for changing out equipment and cleaning the filters weekly.	F 328		
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure hot foods were maintained at the proper temperature at point-of-service. The findings include: Review of the facility policy titled "Subject: Food Temperatures" revealed it was the policy of the facility that food be served to all residents at the proper temperature. The policy stated "hot foods are served hot and cold foods are served cold. The purpose of this policy is to enhance the enjoyment of the meal by residents and to prevent food borne illnesses." The facility's procedure was that the person serving the food would check temperatures of food at the point of service. Review of the facility's policy stated the meat or main dish will be above 140 degrees at point of service. Vegetables will be above 140 degrees at	F 364	The facility will continue to provide resident meals at proper temperature. Dietary Director to review and revise policy "Food Temperatures" on June 30, 2011. Dietary Director will create and implement a Quality Assurance monitor on food temperature at point of service. Dietary Director, Diet Tech or Dietician will conduct monitor one time daily for one month, every other day for 1 month, then two times weekly thereafter beginning 08/05/2011 to assure temperatures are 140 degrees or above at point of service. Cooks will continue to check temperature of food at each meal and post temperature to log. Monitor will be reviewed by Quality Assurance Committee weekly as conducted. See F 364 A attached. Dietary Director, Diet Tech and Dietician to interview residents regarding temperature of food at point of service. Interviews conducted 07/12/2011. No negative findings. Dietary Director to in-service all dietary staff regarding food temperatures and proper use of steam table on 06/23/2011. In-service conducted by Dietary Director with all dietary staff regarding proper use of covers during meal service on 06/23/2011.	8/12/2011

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

PRINTED: 07/19/2011
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 07/05/2011
NAME OF PROVIDER OR SUPPLIER CARMEL MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 100 CARMEL MANOR ROAD FORT THOMAS, KY 41076	
(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 364	Continued From page 32 the point of service and the starch will be above 140 degrees at the point of service. Observation of the trayline on 06/13/11 at 6:30 PM revealed some of the hot foods did not meet the facility policy at point-of-service temperature requirements. The chicken was 140 degrees, the mashed potatoes were 139 degrees and the cooked carrots were 122 degrees; none of these foods were served at "above 140 degrees". Interview with the Dietary Manager on 06/13/11 at 6:35 PM revealed the food service equipment (trayline) was not turned up on high. The dietary manager revealed Kitchen Aide #13 told her she turned the equipment just past medium for the supper meal. Observation revealed Kitchen Aide #13 did not re-cover the hot food on the trayline at any point during the trayline service. Further observation revealed several times that filled plates sat in the pass-through window uncovered for several minutes before aides picked up the meals to be served to the residents. Interview with the Dietary Manager on 06/13/11 at 7:00 PM revealed the small covers should have been placed over hot foods on the trayline to keep those foods hot. She also revealed plate covers should have been placed on residents' meals setting in the pass-through waiting for aides to serve them to residents. She stated this would have held some heat in the food.	F 364	Dietary Director will create and implement a Quality Assurance monitor on use of covers during meal service. Monitor will be conducted daily for 2 weeks, twice weekly for one month, weekly thereafter by Dietary Director or designee beginning 08/08/2011. Monitor will be reviewed by the Quality Assurance Committee weekly as conducted. See F-364 attached.	8/12/2011
F 371 SS=E	483.35(l) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must -	F 371		

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

PRINTED: 07/19/2011
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 07/05/2011
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 371	<p>Continued From page 33</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to store, prepare, distribute and serve food under sanitary conditions.</p> <p>The findings include:</p> <p>Review of the facility's policy (Subject: Storage) revealed it was the policy of the facility to store and issue foods, nonfood items, and supplies in a safe, clean and appropriate environment. The policy stated that left over foods are put in the refrigerator covered, dated, and labeled. Further review revealed, the policy stated that all food items in refrigerators are properly dated, labeled, and placed in containers with lids, or are loosely wrapped. All frozen food is dated, labeled and wrapped. Produce items such as oranges, apples, and cabbage are stored for two (2) weeks before being discarded.</p> <p>Observation on initial tour, on 06/14/11 at 11:00 AM, revealed several items in the walk-in refrigerator to be undated. Observation revealed boiled eggs in a bag, a plate of left-over doughnuts, left-over bacon, a ham, a bag of</p>	F 371	<p>The facility will continue to store, prepare, distribute and serve food under sanitary conditions.</p> <p>Dietary Director will immediately assure dating, labeling and proper storage of all current refrigerator/freezer items. Any undated items were discarded 06/15/2011.</p> <p>Dietary Director will review and revise policy on "Storage" 06/30/2011.</p> <p>In-service will be conducted by Dietary Director for all dietary staff regarding dating, labeling and storage of all food items in refrigerators and freezer on 07/12/2011.</p> <p>A Quality Assurance monitor on dating, labeling and storage of all food items will be developed by the Dietary Director. Monitor will be conducted by the Dietary Director, Diet Tech or Dietician beginning twice weekly for four weeks, weekly thereafter beginning 07/12/2011. Monitor will be reviewed by Quality Assurance Committee weekly as conducted. See 371A – attached.</p> <p>Dietary Director will review and revise policy "Cleaning/Sanitation of Dietary Equipment" 06/30/2011.</p> <p>In-service will be conducted by Dietary Director for all dietary staff regarding cleaning/sanitation of dietary equipment on 07/12/2011.</p>	8/12/2011

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

PRINTED: 07/19/2011
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 07/05/2011
--	---	--	---

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 371	<p>Continued From page 34 carrots, bags of onions, one pound packages of butter, a box of bags of grapes, and boxes of apples and oranges were undated.</p> <p>Observation on initial tour on 06/14/11 at 11:00 AM revealed several items in the walk-in freezer to be undated. A bag of pork chops, bags of frozen cauliflower and succotash, coconut cream pies, angel food cakes, and cheese cakes were undated.</p> <p>Interview with the Dietary Manager at 11:30 AM on 06/14/11 revealed the items should have been labeled and dated when they were received into stock or put into the refrigerator or freezer as left-overs.</p> <p>Observation in the kitchen on 06/14/11 at 11:35 AM revealed a mop bucket containing dirty water and a used mop that were left sitting in the food service area. Further observation of the clean storage closet revealed a damp mop stored on the floor of the closet.</p> <p>Interview with the Dietary Manager on 06/14/11 at 11:35 AM revealed that whoever had been mopping the kitchen must have forgotten to put away the mop bucket and mop. She also revealed that the mop head should have been taken off and hung up to dry.</p> <p>Observation of the trayline on 06/15/11 at 5:30 PM revealed both trayline servers--one to serve hot foods and the other cold drinks and desserts--left trayline repeatedly to do other tasks and did not wash their hands before returning to the tray line to serve food. Both trayline servers left the trayline to get food items out of the oven,</p>	F 371	<p>A Quality Assurance monitor will be developed by the Dietary Director. Monitor will be conducted by the Dietary Director, Diet Tech or Dietician beginning 08/08/2011 monitor will be conducted twice weekly for four weeks, weekly thereafter. Monitor will be reviewed by Quality Assurance Committee weekly as conducted. See F-371 attached</p> <p>Dietary Director to immediately evaluate current procedures during serving of trayline.</p> <p>In-service for all dietary staff regarding new trayline procedures will be conducted by Dietary Director on 07/12/2011.</p> <p>In-service for all dietary staff regarding proper hand washing and use of gloves will be conducted by Dietary Manager on 07/12/2011.</p> <p>Dietary Director will review and revise policy regarding "Hand washing" on 06/30/2011.</p> <p>Quality Assurance monitor will be developed by Dietary Director. Monitor to be performed twice weekly for one month, weekly thereafter, conducted by Dietary Director, Diet Tech or Dietician beginning on 07/12/2011. Monitor will be reviewed by Quality Assurance Committee weekly as conducted.</p>	8/12/2011
-------	--	-------	---	-----------

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

PRINTED: 07/19/2011
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 07/05/2011
--	--	--	--

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 371	<p>Continued From page 35</p> <p>the refrigerator, the cabinets and to heat soup in the microwave--and their hands came in contact with numerous unsanitized handles and other items. The servers did not change gloves.</p> <p>Interview with the Dietary Manager on 06/15/11 at 6:15 PM revealed she did not realize their method of service was a problem or unsanitary. She stated this was the way they had always done it.</p> <p>Interview with Kitchen Aide #13 on 06/15/11 at 6:20 PM revealed they had always served food this way and did not realize it was unsanitary.</p> <p>Interview with the Dietary Manager on 06/15/11 at 6:30 PM revealed the kitchen staff had been in-serviced on 04/07/11 on proper handwashing, use of gloves and labeling and dating items. However, the Dietary Manager admitted the staff had not always practiced these procedures and would be re-educated and procedures re-evaluated.</p>	F 371		
F 431 SS=E	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary</p>	F 431		

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

PRINTED: 07/19/2011
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 07/05/2011
--	--	--	--

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 431	<p>Continued From page 36 instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy it was determined the facility failed to ensure medication carts were maintained in sanitary condition. Spills were noted in the drawers and on the outside of multi-dose bottles of liquid medications. In addition, an expired bottle of Tums remained on the cart.</p> <p>The findings include: Review of the Nursing Department Policy titled "Medication Administration" (no date), revealed when residents are discharged, or if medication is placed on hold or discontinued, the medication is</p>	F 431	<p>Facility will continue to store all drugs and biologicals in sanitary condition.</p> <p>Medication drawers cleaned by staff nurse, all liquid bottles were cleaned and restocked by staff nurse immediately. The bottle of "Tums" was removed by staff nurse from medication cart immediately 06/16/2011.</p> <p>All medication carts were reviewed by staff nurses and Director of Nursing for cleanliness of drawers in medication cart 06/16/2011. All liquid bottles were checked and cleaned as needed 06/16/2011. Medication carts were checked for discharged residents medications and removed as needed by staff nurses and Director of Nursing 06/16/2011.</p> <p>Policy and procedure for care of medication cart and medication administration were reviewed and revised by Director of Nursing on 06/21/2011.</p> <p>Nurse on duty was in-serviced on medication cart care and cleanliness by unit manager on 06/23/2011.</p> <p>An in-service regarding keeping medication cart and medication bottles clean and organized and prompt removal of all discharged residents medications will be conducted by the Education Director on 07/2,08-2,4,10/11 for all nurses and medication aides.</p>	8/12/2011
-------	--	-------	--	-----------

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

PRINTED: 07/19/2011
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 07/05/2011
--	---	--	---

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 431	<p>Continued From page 37 removed from cart and returned to pharmacy. The policy did not address how the cart itself was to be maintained.</p> <p>Observation of Medication Cart #2 on 06/16/11 at 11:05 AM revealed the drawers contained dust and spilled liquids that had dried. In addition, a dried white substance was noted on the outside of a multi-dose bottle of Milk of Magnesia and a dried red substance was observed on the lid and down the sides of a bottle of Tums antacids. Continued observation revealed the Tums expired on 01/10/11 and were labeled for a resident no longer living at the facility.</p> <p>Interview with Registered Nurse #1, on 06/16/11 at 11:10 AM, revealed she tried to scrub the outside top of the cart every day. She stated she did not know if anyone was assigned to clean the inside of the carts regularly.</p> <p>Interview with the Director of Nursing on 06/17/11 at 2:20 PM revealed the medication nurses were responsible for ensuring the carts were clean on their shifts. She further stated the outdated medication should have been discarded.</p>	F 431	<p>Quality Assurance monitors will be developed by the Director of Nursing regarding labeling and storage of drugs and biologicals; cleanliness of cart and medication bottles and prompt removal of discharged resident medications. They will be conducted by Director of Nursing, Unit Manager or computer nurse weekly x 6 weeks, biweekly x 6 weeks and then monthly beginning 08/08/2011. Monitors will be reviewed by the Quality Assurance Committee weekly as conducted. See F-431 and F-431A attached.</p>	8/12/2011
F 441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it -</p>	F 441		

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

PRINTED: 07/19/2011
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 07/05/2011
--	---	--	---

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)	(X5) COMPLETION DATE
F 441	<p>Continued From page 38</p> <p>(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.</p> <p>(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.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure all sterile supplies were stored in a manner to maintain product integrity. A urinary catheter was observed to have torn packaging. In addition, a nasal cannula was stored in an opened packaged.</p>	F 441	<p>The facility will continue to provide proper storage of sterile supplies.</p> <p>Catheter with torn packaging and nasal cannula in torn packaging were disposed of immediately by nurse on duty.</p> <p>All catheter and nasal cannula supplies were checked by Director of Nursing and staff nurse for damaged packaging on 06/22/2011.</p> <p>Policies and procedures regarding stocked sterile supplies were reviewed and revised by Director of Nursing on 06/21/2011.</p> <p>Desk nurse on duty was in-serviced by Director of Nursing regarding stocked sterile supplies and monitoring of packaging at least weekly and before use by visualizing all supplies that require sterile packing stored on unit, looking for compromised packaging and removal of items from stock if package is damaged on 07/19/2011.</p> <p>An in-service regarding the proper storage and weekly and monthly checking of sterile supply packages and removal from stock if identified damaged packaging will be conducted by Education Director on 07/27,08-2,4,10/11 for all nurses.</p>	8/12/2011

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

PRINTED: 07/19/2011
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 07/05/2011
--	---	--	---

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 441	<p>Continued From page 39</p> <p>The findings include:</p> <p>Observation of the medication room on 06/16/11 at 11:05 AM revealed sterile urinary catheters were stored in a drawer. Continued observation revealed one package was dilapidated and torn. Observation of the respiratory supplies revealed a nasal cannula package had been opened and placed back in storage.</p> <p>Interview with Registered Nurse #1, on 06/16/11 at 11:10 AM, revealed the items could not be used and should have been removed from the supply stock.</p> <p>Interview with the Unit Manager on 06/17/11 at 2:20 PM revealed the medication nurses were responsible, on the shifts they worked, for maintaining the medication room and supplies in a manner that preserved product integrity.</p>	F 441	<p>A Quality Assurance monitor will be developed and implemented regarding infection control and stock supply packaging and inspection by the Director of Nursing. It will be conducted by Director of Nursing, Unit Manager or desk nurse weekly x 16 weeks, biweekly x 16 weeks, then monthly beginning 08/08/2011. Monitor will be reviewed by the Quality Assurance Committee weekly as conducted. See F-441 attached.</p>	8/12/2011
-------	--	-------	--	-----------

QUALITY ASSURANCE AUDIT

ADMINISTRATION

(Indicate Discipline)

F225/226

INDICATOR: _____ Audit Date: _____

Unit (if applicable): _____

N= _____

Threshold: _____ %

<u>Target</u>	<input type="checkbox"/> <u>Population:</u>	<input type="checkbox"/> <u>Site:</u>	<input type="checkbox"/> <u>Data:</u>
---------------	---	---------------------------------------	---------------------------------------

Methodology: <input type="checkbox"/> Observation <input type="checkbox"/> Interview <input type="checkbox"/> Record Review

Pre-established Criteria	YES	NO	N/A	COMMENT
Is there evidence of: Q1 Staff knowledge regarding types of abuse?				
Q2. Employee able to name 3 different types of abuse.				
Q3. Staff able to recognize signs of abuse. Name 2 examples.				
Q4. Staff aware of how to report abuse?				

Root Cause Analysis and, trends, patterns, variance from threshold.

	Q1	Q2	Q3	Q4	Total #	Total %
Total # Oppor. For "yes"						-----
Total # of "yes"						-----
% Accuracy/ Question					-----	

Threshold Met Variance From Threshold Exceeded by ____%
 Unmet by ____%

Plan of Correction:

EDA * (of plan): _____ Signature/Title/Date _____

QUALITY ASSURANCE AUDIT

ADMINISTRATION

(Indicate Discipline)

F225/226

INDICATOR: _____ **Audit Date:** _____

Unit (if applicable): _____

N= _____

Threshold: _____ %

<u>Target</u>	<input type="checkbox"/> <u>Population:</u>	<input type="checkbox"/> <u>Site:</u>	<input type="checkbox"/> <u>Data:</u>
---------------	---	---------------------------------------	---------------------------------------

Methodology: <input type="checkbox"/> Observation <input type="checkbox"/> Interview <input type="checkbox"/> Record Review

Pre-established Criteria	YES	NO	N/A	COMMENT
Is there evidence of: Q1 Resident feels in a secure environment.				
Q2. Resident finds staff caring and compassionate.				
Q3. Resident feels comfortable reporting issues or concerns.				
Q4. Resident feels any concerns are answered in a timely manner.				

Root Cause Analysis and, trends, patterns, variance from threshold.

	Q1	Q2	Q3	Q4	Total #	Total %
Total # Oppor. For "yes"						-----
Total # of "yes"						-----
% Accuracy/ Question					-----	

Threshold Met Variance From Threshold Exceeded by ____%
 Unmet by ____%

Plan of Correction:

EDA * (of plan): _____ Signature/Title/Date _____

QUALITY ASSURANCE AUDIT

DIETARY

(Indicate Discipline)

F-241

INDICATOR: Table Seating & Table Service

Audit Date: _____

Unit (if applicable): _____

N= _____

Threshold: _____ %

<u>Target</u>	<input type="checkbox"/> <u>Population:</u>	<input type="checkbox"/> <u>Site:</u>	<input type="checkbox"/> <u>Data:</u>
---------------	---	---------------------------------------	---------------------------------------

Methodology: <input type="checkbox"/> Observation <input type="checkbox"/> Interview <input type="checkbox"/> Record Review

Pre-established Criteria	YES	NO	N/A	COMMENT
Is there evidence of: Q1. Residents happy with table seating.				
Q2. If resident requests an alternate meal item, their wait will be no longer than 15 minutes.				
Q3. All residents seated at one table are served at the same time.				
Q4..				

Root Cause Analysis and, trends, patterns, variance from threshold.

	Q1	Q2	Q3	Q4	Total #	Total %
Total # Oppor. For "yes"						-----
Total # of "yes"						-----
% Accuracy/ Question					-----	

Threshold Met
 Variance From Threshold
 Exceeded by ____%
 Unmet by ____%

Plan of Correction:

EDA * (of plan): _____ Signature/Title/Date _____

QUALITY ASSURANCE AUDIT

F241A

DIETARY

(Indicate Discipline)

INDICATOR: Resident seating

Audit Date: _____

Unit (if applicable): _____

N= _____

Threshold: _____ %

<u>Target</u>	<input type="checkbox"/> <u>Population:</u>	<input type="checkbox"/> <u>Site:</u>	<input type="checkbox"/> <u>Data:</u>
---------------	---	---------------------------------------	---------------------------------------

Methodology:	<input type="checkbox"/> Observation	<input type="checkbox"/> Interview	<input type="checkbox"/> Record Review
--------------	--------------------------------------	------------------------------------	--

Pre-established Criteria	YES	NO	N/A	COMMENT
Is there evidence of: Q1. Resident will always have a tablemate if they desire.				
Q2. If resident does not have tablemate, is there documentation that resident is content and not isolated?				
Q3. Dining environment fosters pleasant social experience.				
Q4.				

Root Cause Analysis and, trends, patterns, variance from threshold.

	Q1	Q2	Q3	Q4	Total #	Total %
Total # Oppor. For "yes"						-----
Total # of "yes"						-----
% Accuracy/ Question					-----	

Threshold Met
 Variance From Threshold
 Exceeded by ____%
 Unmet by ____%

Plan of Correction:

EDA * (of plan): _____ Signature/Title/Date _____

QUALITY ASSURANCE AUDIT

DIETARY

(Indicate Discipline)

F241B

INDICATOR: Clean up of tables

Audit Date: _____

Unit (if applicable): _____

N= _____

Threshold: _____ %

<u>Target</u>	<input type="checkbox"/> <u>Population:</u>	<input type="checkbox"/> <u>Site:</u>	<input type="checkbox"/> <u>Data:</u>
---------------	---	---------------------------------------	---------------------------------------

Methodology: <input type="checkbox"/> Observation <input type="checkbox"/> Interview <input type="checkbox"/> Record Review

Pre-established Criteria	YES	NO	N/A	COMMENT
Is there evidence of: Q1. Tables are being cleared when all residents have Left that table.				
Q2. When residents are still present in dining room Bus carts are not visible.				
Q3. Residents do not feel as if they are being rushed out of dining area.				
Q4.				

Root Cause Analysis and, trends, patterns, variance from threshold.

	Q1	Q2	Q3	Q4	Total #	Total %
Total # Oppor. For "yes"						-----
Total # of "yes"						-----
% Accuracy/ Question					-----	

Threshold Met Variance From Threshold Exceeded by ____%
 Unmet by ____%

Plan of Correction:

EDA * (of plan): _____ Signature/Title/Date _____

QUALITY ASSURANCE AUDIT

DIETARY

(Indicate Discipline)

F364

INDICATOR: Food Temperature

Audit Date: _____

Unit (if applicable): _____

N= _____

Threshold: _____ %

<u>Target</u>	<input type="checkbox"/> <u>Population:</u>	<input type="checkbox"/> <u>Site:</u>	<input type="checkbox"/> <u>Data:</u>
---------------	---	---------------------------------------	---------------------------------------

Methodology: <input type="checkbox"/> Observation <input type="checkbox"/> Interview <input type="checkbox"/> Record Review

Pre-established Criteria	YES	NO	N/A	COMMENT
Is there evidence of: Q1. Proper use of plate covers.				
Q2. Correct steam table setting-10.				
Q3. Food on steam table appropriately covered to conserve temperature.				
Q4. Temperature checked: 1. Before delivery to steam tables. 2. Before serving. 3. Test tray 1 x a week to assure temperature holding at time of service to resident.				

Root Cause Analysis and, trends, patterns, variance from threshold.

	Q1	Q2	Q3	Q4	Total #	Total %
Total # Oppor. For "yes"						-----
Total # of "yes"						-----
% Accuracy/ Question					-----	

Threshold Met Variance From Threshold Exceeded by ____%
 Unmet by ____%

Plan of Correction:

EDA * (of plan): _____ Signature/Title/Date _____

QUALITY ASSURANCE AUDIT

DIETARY

(Indicate Discipline)

F371

INDICATOR: Dating food in walk in and freezer _____

Audit Date: _____

Unit (if applicable): _____

N= _____

Threshold: _____ %

Target _____	<input type="checkbox"/> Population: _____	<input type="checkbox"/> Site: _____	<input type="checkbox"/> Data: _____
--------------	--	--------------------------------------	--------------------------------------

Methodology: _____	<input type="checkbox"/> Observation	<input type="checkbox"/> Interview	<input type="checkbox"/> Record Review
--------------------	--------------------------------------	------------------------------------	--

Pre-established Criteria	YES	NO	N/A	COMMENT
Is there evidence of: Q1. All freezer items dated upon arrival.				
Q2. All open items in freezer are dated.				
Q3. All items in the Refrigerators are dated.				
Q4.				

Root Cause Analysis and, trends, patterns, variance from threshold.

	Q1	Q2	Q3	Q4	Total #	Total %
Total # Oppor. For "yes"						-----
Total # of "yes"						-----
% Accuracy/ Question						-----

Threshold Met
 Variance From Threshold
 Exceeded by ____ %
 Unmet by ____ %

Plan of Correction:

EDA * (of plan): _____ Signature/Title/Date _____

QUALITY ASSURANCE AUDIT

DIETARY

(Indicate Discipline)

F371A

INDICATOR: SJT tray line

Audit Date: _____

Unit (if applicable): _____

N= _____

Threshold: _____ %

<u>Target</u>	<input type="checkbox"/> <u>Population:</u>	<input type="checkbox"/> <u>Site:</u>	<input type="checkbox"/> <u>Data:</u>
---------------	---	---------------------------------------	---------------------------------------

Methodology: <input type="checkbox"/> Observation <input type="checkbox"/> Interview <input type="checkbox"/> Record Review

Pre-established Criteria	YES	NO	N/A	COMMENT
Is there evidence of: Q1. When leaving tray line staff exhibits proper hand hygiene.				
Q2. General education on importance hand hygiene in a dietary setting.				
Q3.				
Q4.				

Root Cause Analysis and, trends, patterns, variance from threshold.

	Q1	Q2	Q3	Q4	Total #	Total %
Total # Oppor. For "yes"						-----
Total # of "yes"						-----
% Accuracy/ Question					-----	

Threshold Met Variance From Threshold Exceeded by ____ %
 Unmet by ____ %

Plan of Correction:

EDA * (of plan): _____ Signature/Title/Date _____

QUALITY ASSURANCE AUDIT

DIETARY

(Indicate Discipline)

F371B

INDICATOR: Proper Storage of mop bucket

Audit Date: _____

<u>Target</u>	<input type="checkbox"/> <u>Population:</u>	<input type="checkbox"/> <u>Site:</u>	<input type="checkbox"/> <u>Data:</u>
---------------	---	---------------------------------------	---------------------------------------

Unit (if applicable): _____

N= _____

Threshold: _____ %

Methodology: <input type="checkbox"/> Observation <input type="checkbox"/> Interview <input type="checkbox"/> Record Review

Pre-established Criteria	YES	NO	N/A	COMMENT
Is there evidence of: Q1. Mop bucket stored in proper place.				
Q2. Used mop heads stored in proper place.				
Q3.				
Q4.				

Root Cause Analysis and, trends, patterns, variance from threshold.

	Q1	Q2	Q3	Q4	Total #	Total %
Total # Oppor. For "yes"						-----
Total # of "yes"						-----
% Accuracy/ Question					-----	

Threshold Met Variance From Threshold Exceeded by ____%
 Unmet by ____%

Plan of Correction:

EDA * (of plan): _____ Signature/Title/Date _____

QUALITY ASSURANCE AUDIT

NURSING

(Indicate Discipline)

F279

INDICATOR: Acute/Chronic Suctioning of Residents

Audit Date: _____

Unit (if applicable): _____

N= _____

Threshold: 100 %

<u>Target</u>	<input type="checkbox"/> <u>Population:</u>	<input type="checkbox"/> <u>Site:</u>	<input checked="" type="checkbox"/> <u>Data:</u>
---------------	---	---------------------------------------	--

Methodology:	<input type="checkbox"/> Observation	<input type="checkbox"/> Interview	<input checked="" type="checkbox"/> Record Review
--------------	--------------------------------------	------------------------------------	---

Pre-established Criteria	YES	NO	N/A	COMMENT
Is there evidence of:				
Q1. An acute issue, current or past				
Q2. An acute care plan initiated, timely.				
Q3. An acute care plan being completely/accurately filled out.				
Q4. Adequate daily documentation by day shift.				
Q5. Adequate, daily documentation by evening shift.				
Q6. Adequate, daily documentation by night shift.				

Root Cause Analysis and, trends, patterns, variance from threshold.

	Q1	Q2	Q3	Q4	Total #	Total %
Total # Oppor. For "yes"						-----
Total # of "yes"						-----
% Accuracy/ Question					-----	

Threshold Met
 Variance From Threshold
 Exceeded by ____%
 Unmet by ____%

Plan of Correction:

EDA * (of plan): _____ Signature/Title/Date _____

QUALITY ASSURANCE AUDIT

NURSING

(Indicate Discipline)

F279 F281

INDICATOR: Resident Assessment (Oxygen Orders and Care Plans)

Audit Date: _____

Unit (if applicable): _____

N= _____

Threshold: 90 %

<u>Target</u>	<input type="checkbox"/> <u>Population:</u>	<input checked="" type="checkbox"/> <u>Site:</u>	<input checked="" type="checkbox"/> <u>Data:</u>
---------------	---	--	--

Methodology:	<input checked="" type="checkbox"/> Observation	<input type="checkbox"/> Interview	<input checked="" type="checkbox"/> Record Review
--------------	---	------------------------------------	---

Pre-established Criteria	YES	NO	N/A	COMMENT
Is there evidence of:				
Q1. An order is present for resident to receive oxygen.				
Q2. The order being written completely including rate, method of delivery, duration and reason.				
Q3. An oxygen monitor is in place on MAR.				
Q4. Oxygen therapy is acutely care planned for new onset of oxygen or new admission on oxygen.				
Q5. An oxygen concentrator present in room.				
Q6. The concentrator tubing being changed within the past 7 days, dated properly.				
Q7. The tubing is stored properly in a plastic bag, off of the ground and other objects when not in use.				
Q8. An oxygen tank present on residents wheelchair.				
Q9. The tubing being changed in the last 7 days, dated properly.				

Root Cause Analysis and, trends, patterns, variance from threshold.

	Q1	Q2	Q3	Q4	Total #	Total %
Total # Oppor. For "yes"						-----
Total # of "yes"						-----
% Accuracy/ Question					-----	

Threshold Met
 Variance From Threshold
 Exceeded by _____%
 Unmet by _____%

Plan of Correction:

EDA * (of plan): _____ Signature/Title/Date _____

QUALITY ASSURANCE AUDIT

NURSING

(Indicate Discipline)

F281

INDICATOR: Acute/Chronic Suctioning of Residents

Audit Date: _____

Unit (if applicable): _____

N= _____

Threshold: 100 %

<u>Target</u>	<input checked="" type="checkbox"/> <u>Population:</u>	<input type="checkbox"/> <u>Site:</u>	<input checked="" type="checkbox"/> <u>Data:</u>
---------------	--	---------------------------------------	--

Methodology:	<input checked="" type="checkbox"/> Observation	<input type="checkbox"/> Interview	<input checked="" type="checkbox"/> Record Review
--------------	---	------------------------------------	---

Pre-established Criteria	YES	NO	N/A	COMMENT
Is there evidence of: Q1. The resident experiencing difficulty expelling respiratory secretions or choking episode.				
Q2. The order is obtained to suction resident; order is complete.				
Q3. An acute care plan is initiated indicating reason for suctioning and use of suctioning.				
Q4. Episodes of suctioning being adequately documented in nurses notes.				

Root Cause Analysis and, trends, patterns, variance from threshold.

	Q1	Q2	Q3	Q4	Total #	Total %
Total # Oppor. For "yes"						-----
Total # of "yes"						-----
% Accuracy/ Question					-----	

Threshold Met
 Variance From Threshold
 Exceeded by ____%
 Unmet by ____%

Plan of Correction:

EDA * (of plan): _____ Signature/Title/Date _____

QUALITY ASSURANCE AUDIT

NURSING

(Indicate Discipline)

F 323

INDICATOR: Resident Assessment (Following Care Plan ADL's)

Audit Date: _____

Unit (if applicable): _____

N= _____

Threshold: 100 %

<u>Target</u>	<input type="checkbox"/> <u>Population:</u>	<input checked="" type="checkbox"/> <u>Site:</u>	<input checked="" type="checkbox"/> <u>Data:</u>
---------------	---	--	--

Methodology:	<input checked="" type="checkbox"/> Observation	<input type="checkbox"/> Interview	<input checked="" type="checkbox"/> Record Review
--------------	---	------------------------------------	---

Pre-established Criteria	YES	NO	N/A	COMMENT
Is there evidence of: Q1. Aide properly followed care plan for transferring resident.				
Q2. Aide properly followed toileting care plan for ADL status to toilet.				
Q3. Aide properly followed Ambulation Care plan (MDS) for ambulating resident.				
Q4. Aide properly followed bathing care plan (MDS) for bathing resident.				
Q5. Aide properly followed dressing care plan (MDS) for dressing resident.				

Root Cause Analysis and, trends, patterns, variance from threshold.

	Q6	Q7	Q8	Q9	Total #	Total %
Total # Oppor. For "yes"						-----
Total # of "yes"						-----
% Accuracy/ Question					-----	

Threshold Met
 Variance From Threshold
 Exceeded by _____%
 Unmet by _____%

Plan of Correction:

EDA * (of plan): _____ Signature/Title/Date _____

QUALITY ASSURANCE AUDIT

NURSING

(Indicate Discipline)

F328

INDICATOR: Quality of Care- Oxygen Concentrator Filters

Audit Date: _____

Unit (if applicable): _____

N= _____

Threshold: 100 %

<u>Target</u>	<input type="checkbox"/> Population:	<input checked="" type="checkbox"/> Site:	<input type="checkbox"/> Data:
---------------	--------------------------------------	---	--------------------------------

Methodology:	<input checked="" type="checkbox"/> Observation	<input type="checkbox"/> Interview	<input type="checkbox"/> Record Review
--------------	---	------------------------------------	--

Pre-established Criteria	YES	NO	N/A	COMMENT
Is there evidence of: Q1. An oxygen concentrator present in resident's room.				
Q2. The concentrator having an external air filter.				
Q3. The air filter being clean, free of dust and debris.				
Q4. The air filter being monitored daily and documented.				

Root Cause Analysis and, trends, patterns, variance from threshold.

	Q1	Q2	Q3	Q4	Total #	Total %
Total # Oppor. For "yes"						-----
Total # of "yes"						-----
% Accuracy/ Question					-----	

Threshold Met
 Variance From Threshold
 Exceeded by _____%
 Unmet by _____%

Plan of Correction:

EDA * (of plan): _____ Signature/Title/Date _____

QUALITY ASSURANCE AUDIT

NURSING

(Indicate Discipline)

F328

INDICATOR: Quality of Care- Storage of Oxygen and Nebulizer Tubing

Audit Date: _____

Unit (if applicable): _____

N= _____

Threshold: 90 %

<u>Target</u>	<input type="checkbox"/> <u>Population:</u>	<input type="checkbox"/> <u>Site:</u>	<input type="checkbox"/> <u>Data:</u>
---------------	---	---------------------------------------	---------------------------------------

Methodology:	<input checked="" type="checkbox"/> Observation	<input type="checkbox"/> Interview	<input type="checkbox"/> Record Review
--------------	---	------------------------------------	--

Pre-established Criteria	YES	NO	N/A	COMMENT
Is there evidence of: Q6. The tubing is stored properly in a plastic bag, off the ground when not in use.				
Q7. A nebulizer machine present in resident's room.				
Q8. The tubing being changed in the last 7 days, dated properly.				
Q9. The tubing is stored properly, in a plastic bag when not in use.				

Root Cause Analysis and, trends, patterns, variance from threshold.

	Q6	Q7	Q8	Q9	Total #	Total %
Total # Oppor. For "yes"						-----
Total # of "yes"						-----
% Accuracy/ Question					-----	

Threshold Met
 Variance From Threshold
 Exceeded by ____%
 Unmet by ____%

Plan of Correction:

EDA * (of plan): _____ Signature/Title/Date _____

QUALITY ASSURANCE AUDIT

NURSING

(Indicate Discipline)

F 4 3 1

INDICATOR: Pharmacy Services: (Med. Cart Cleanliness & Organization)

Audit Date: _____

Unit (if applicable): _____

N= _____

Threshold: 90 %

<u>Target</u>	<input type="checkbox"/> <u>Population:</u>	<input checked="" type="checkbox"/> <u>Site:</u>	<input type="checkbox"/> <u>Data:</u>
---------------	---	--	---------------------------------------

Methodology:	<input checked="" type="checkbox"/> Observation	<input type="checkbox"/> Interview	<input type="checkbox"/> Record Review
--------------	---	------------------------------------	--

Pre-established Criteria	YES	NO	N/A	COMMENT
Is there evidence of: Q1. No personal items present on medicine cart.				
Q2. Cart supplies stocked adequately.				
Q3. A water pitcher in place and clean/sanitary.				
Q4. All edible supplies on cart are properly dated.				
Q5. The medication drawers are neat, organized, and there is no evidence of medication remnants.				
Q6. The narcotic drawer is neatly organized.				
Q7. The liquid drawer is neat and organized. No evidence of spilled medications in the drawer.				
Q8. The liquid medication bottles are maintained properly. No spilled medication on bottle exterior.				

Root Cause Analysis and, trends, patterns, variance from threshold.

	Q1	Q2	Q3	Q4	Total #	Total %
Total # Oppor. For "yes"						-----
Total # of "yes"						-----
% Accuracy/ Question					-----	

Threshold Met
 Variance From Threshold
 Exceeded by ____%
 Unmet by ____%

Plan of Correction:

EDA * (of plan): _____ Signature/Title/Date _____

NURSING

(Indicate Discipline)

INDICATOR: Storage Room Supplies Packaging

Audit Date: _____

Unit (if applicable): _____

N= _____

Threshold: 90 %

Target Population: Site: Data:

Methodology: Observation Interview Record Review

Pre-established Criteria	YES	NO	N/A	COMMENT
Is there evidence of: Q1. All catheter supplies are checked, no damaged packages present.				
Q2. All oxygen supplies checked and no damaged packages present.				
Q3. All nebulizer supplies checked and no damaged packages noted.				
Q4. All colostomy supplies checked and no damaged packages noted.				
Q5. All irrigation and tube feed supplies checked and no damaged packages noted.				
Q6. At least weekly monitoring of supplies for damaged packaging and accurate documentation.				

Root Cause Analysis and, trends, patterns, variance from threshold.

	Q1	Q2	Q3	Q4	Total #	Total %
Total # Oppor. For "yes"						-----
Total # of "yes"						-----
% Accuracy/ Question					-----	

Threshold Met
 Variance From Threshold
 Exceeded by ____%
 Unmet by ____%

Plan of Correction:

EDA * (of plan): _____ Signature/Title/Date _____

NURSING

F431A

(Indicate Discipline)

INDICATOR: Pharmacy Services: Removal of expired, discontinued, discharged residents medications

Audit Date: _____

Unit (if applicable): _____

<input type="checkbox"/> Target	<input type="checkbox"/> Population:	<input checked="" type="checkbox"/> Site:	<input type="checkbox"/> Data:
---------------------------------	--------------------------------------	---	--------------------------------

N= _____

Threshold: 180 %

Methodology:	<input checked="" type="checkbox"/> Observation	<input type="checkbox"/> Interview	<input type="checkbox"/> Record Review
--------------	---	------------------------------------	--

Pre-established Criteria	YES	NO	N/A	COMMENT
Is there evidence of: Q1. All ordered medications are available in the medication cart.				
Q2. All discontinued medications are removed from medication cart.				
Q3. All expired medications are removed from medication cart.				
Q4. All discharged residents medications are removed from medication cart.				
Q5. All discontinued, expired and discharged resident medications are removed from medication refrigerator.				
Q6. At discontinued, expired and discharged residents medications are removed from medication cabinet.				

Root Cause Analysis and, trends, patterns, variance from threshold.

	Q1	Q2	Q3	Q4	Total #	Total %
Total # Oppor. For "yes"						-----
Total # of "yes"						-----
% Accuracy/ Question					-----	

Threshold Met
 Variance From Threshold
 Exceeded by ____%
 Unmet by ____%

Plan of Correction:

EDA * (of plan): _____ Signature/Title/Date _____

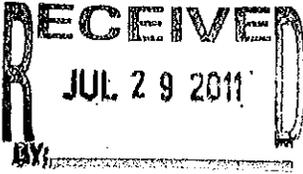
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/19/2011
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 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 06/15/2011
--	---	---	---

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
--------------------	--	---------------	---	----------------------

K 000	<p>INITIAL COMMENTS</p> <p>42 CFR 483.70(a)</p> <p>K3 BUILDING: 0101 K6 PLAN APPROVAL: 8/9/1989 K7 SURVEY UNDER: 2000 Existing K8 SNF</p> <p>A Life Safety Code survey was initiated and concluded on 06/15/11. The facility failed to meet the minimal requirements with 42 Code of the Federal Regulations, Part 483.70. The highest scope and severity deficiency identified was an "F".</p>	K 000		
K 056 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview on 06/15/11 at 11:00 AM, it was determined the facility failed to ensure the building had a complete sprinkler system, according to NFPA standards. The</p>	K 056	<p>The facility will continue to provide buildings conducive to the safety of its residents, staff and visitors.</p> <p>Director of Maintenance to initiate contract for installation of sprinklers under overhangs located at the Terrace Exit and the Physical Therapy Exit.</p> <p>Director of Maintenance to inspect and ensure compliance at all exits.</p> <p>Selected contractor to install sprinklers.</p>	8/15/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Sister Anne Kennedy, Administrator* TITLE: *Madeline Selton, Cost Admin* (X6) DATE: *7/28/11*

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.

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

PRINTED: 07/19/2011
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 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 06/15/2011
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	
K 056	<p>Continued From page 1</p> <p>deficient practice has the potential to affect all residents, staff and visitors. The facility is licensed for sixty-five (65) beds with a census of fifty-eight (58) the day of the survey.</p> <p>The findings include:</p> <p>Observation on 06/15/11 at 11:00 AM with the Maintenance Supervisor, revealed two overhangs with no sprinklers. The overhangs are located at the Terrace Exit and the Physical Therapy Exit. Both overhangs are over four (4) feet in width.</p> <p>Interview, on 06/15/11 at 11:00 AM, with the Maintenance Supervisor revealed he was not aware the overhangs needed to be sprinkled.</p> <p>Reference: NFPA 13 (1999 Edition) 5-13 8.1 Sprinklers shall be installed under exterior roofs or canopies exceeding 4 Ft. (1.2 m) in width. Exception: Sprinklers are permitted to be omitted where the canopy or roof is of noncombustible or limited combustible construction.</p>	K 056			