

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

PRINTED: 02/05/2014
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185226	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/22/2014
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NAME OF PROVIDER OR SUPPLIER CARMEL HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 2501 OLD HARTFORD RD OWENSBORO, KY 42303
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F 000	INITIAL COMMENTS	F 000		
F 241 SS=D	<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, interview, review of the Minimum Data Set (MDS) assessment, Comprehensive Care Plan and facility policy/procedure it was determined the facility failed to promote care for residents in a manner and in an environment that maintained or enhanced each residents dignity and respect for one (1) of eight (8) sampled residents (Resident #2), related to using a lift to toilet a resident while other residents were eating in the dining room.</p> <p>The findings include:</p> <p>Review of facility policy, "Resident Dignity", (undated), revealed residents would be examined and treated in a manner that maintained the privacy of their bodies.</p> <p>Review of the face sheet revealed Resident # 2 was admitted to the facility on 02/28/12 with diagnoses which include Arthritis, Cerebral</p>	F 241	<p>Criteria 1: When requiring toileting assistance during meal time, Resident #2 is assisted to her room or the whirlpool area to maintain privacy/dignity.</p> <p>Criteria 2: Residents requiring toileting assistance with a lift during meal time are assisted to their room or the whirlpool room to maintain privacy/dignity. All other residents will be assisted individually from their place at their table, to the restroom off of the dining room, or to the whirlpool room to maintain privacy/dignity.</p> <p>Criteria 3: The nursing staff have received in-service education on the: need to assist Residents requiring a lift to their room or the whirlpool room</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Debra Francis Teresa Scully</i>	TITLE Adm.	(X6) DATE 02-13-14
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

In order to be in compliance with the regulation, we are submitting this plan of correction, without admitting or conceding either the existence or the cope of severity of any of the deficiencies.

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F 241	<p>Continued From page 1</p> <p>Vascular Accident, and Dementia with abnormal behaviors. Review of the annual MDS assessment, dated 12/07/13, revealed the facility assessed the resident as severely cognitively impaired.</p> <p>Observation of Resident #2, on 01/21/14 at 9:00 AM, revealed the resident was sitting in a wheelchair in the dining room for breakfast. After completing the meal, he/shè was placed in a line in the dining room with other residents waiting for the staff to toilet them. Resident #2 was placed in a mechanical lift outside of the bathroom in the dining room and transported while suspended from the lift into the bathroom, while other residents and visitors were continuing to eat breakfast. An additional observation, on 01/21/14 at 1:20 PM, revealed Resident #2 was transported using the mechanical lift to the same bathroom during lunch, where eight (8) residents remained in the dinning room.</p> <p>Interview with Certified Nurse Aide (CNA) #1, on 01/21/14 at 9:15 AM, revealed residents were placed in line for the bathroom after they finished eating, and were taken in order to the bathroom. The residents that required the assistance of two (2) were taken to the bathroom on the right; the ones that required assistance of one (1) were taken to the bathroom on the left side of the room.</p> <p>Interview with the Director of Nurses (DON), on 01/22/14 at 2:00 PM, revealed she expected the resident to be taken to his/her room to use the bathroom if other residents were still eating in the dining room.</p>	F 241	<p>when toileting assistance is required during meal time, and to assist all other Residents individually from their table to the restroom off of the dining room, or to the whirlpool room to maintain privacy/dignity as provided by the DON on February 13, 2014.</p> <p>Criteria 4: The CQI indicator for the monitoring of resident dignity will be utilized quarterly as per the established CQI calendar under the supervision of the DON.</p> <p>Criteria 5:</p>	Feb 14, 2014

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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1984, 1986</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type II (222)</p> <p>SMOKE COMPARTMENTS Five (5) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with 85 heat and 140 smoke detectors</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system.</p> <p>GENERATOR: Two (2) Type II generators. Fuel source is diesel.</p> <p>A standard Life Safety Code survey was conducted on 01/22/14. Carmel Home was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for eighteen (18) beds with a census of seventeen (17) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)</p>	K 000		

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

TITLE

(X6) DATE

M. Francis Teresa Scully Adm. 02-13-14

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.

In order to be in compliance with the regulation, we are submitting this plan of correction, without admitting or conceding either the existence or the cope of severity of any of the deficiencies.

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K 011 SS=F	<p>Deficiencies were cited with the highest deficiency identified at "F" level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the fire wall was in accordance with NFPA standards. The deficiency had the potential to affect two (2) of five (5) smoke compartments, Eighteen (18) residents, staff, and visitors. The facility is certified for eighteen (18) beds with a census of seventeen (17) on the day of the survey. The facility failed to ensure the fire doors in the two hour fire wall, in the new section, was rated for the wall.</p> <p>The findings include:</p> <p>Observation, on 01/22/14 at 2:15 PM with the Maintenance Supervisor, revealed the two hour wall separating the skilled nursing facility from the personal care home had doors and frame</p>	K 011	<p>Criteria 1: The fire doors and frame in the two hour wall separating the skilled nursing facility from the personal care home have been replaced with doors meeting the two hour rating requirement.</p> <p>Criteria 2: All other doors in the new addition have been inspected to determine that they meet the required fire rating standard.</p> <p>Criteria 3: The Maintenance Supervisor has received in-service education on the need to verify that any newly added or replaced doors must meet the required fire rating standard as</p>	

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K 011	<p>Continued From page 2</p> <p>Installed that were rated for only 20 minutes in the two hour fire wall.</p> <p>Interview, on 01/22/14 at 2:15 PM with the Maintenance Supervisor, revealed he was unaware the doors were not rated properly for a two hour wall.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>19.1.1.4 Additions, Conversions, Modernization, Renovation, and Construction Operations. 19.1.1.4.1 Additions. Additions shall be separated from any existing structure not conforming to the provisions within Chapter 19 by a fire barrier having not less than a 2-hour fire resistance rating and constructed of materials as required for the addition. (See 4.6.11 and 4.6.6.) 19.1.1.4.2 Communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire doors. (See also Section 8.2.) 19.1.1.4.3 Doors in barriers required by 19.1.1.4.1 shall normally be kept closed. Exception: Doors shall be permitted to be held open if they meet the requirements of 19.2.2.2.6.</p> <p>8.2.3.2 Fire Protection-Rated Opening Protectives. 8.2.3.2.1 Door assemblies in fire barriers shall be of an approved type with the appropriate fire protection rating for the location in which they are installed and shall comply with the following.</p>	K 011	<p>provided by the Administrator on February 12, 2014.</p> <p>Criteria 4: The CQI indicator for the monitoring of resident corridor doors will be utilized monthly X 2 months and then quarterly as per the established CQI calendar under the supervision of the Director of Maintenance.</p> <p>Criteria 5:</p>	Feb 28 2014

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K 011	Continued From page 3 (a) * Fire doors shall be installed in accordance with NFPA 80, Standard for Fire Doors and Fire Windows. Fire doors shall be of a design that has been tested to meet the conditions of acceptance of NFPA 252, Standard Methods of Fire Tests of Door Assemblies. Exception: The requirement of 8.2.3.2.1(a) shall not apply where otherwise specified by 8.2.3.2.3.1. (b) Fire doors shall be self-closing or automatic-closing in accordance with 7.2.1.8 and, where used within the means of egress, shall comply with the provisions of 7.2.1.	K 011		
K 017 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5 This STANDARD is not met as evidenced by:	K 017		

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K 017	<p>Continued From page 4</p> <p>Based on observation and interview, the facility failed to ensure that rooms open to the corridor would not interfere with egress requirements in accordance with NFPA standards. The deficiency had the potential to affect two (2) of five (5) smoke compartments, Eighteen (18) residents, staff and visitors. The facility is certified for eighteen (18) beds with a census of seventeen (17) on the day of the survey. The facility failed to ensure the rehab department was not open to the exit corridors.</p> <p>The findings include:</p> <p>Observation, on 01/22/14 at 12:55 PM with the Maintenance Supervisor, revealed the therapy department was part of the exit corridor at the east end of zone 13. The contents of these rooms are not permitted to be in an area open to the corridor.</p> <p>Interview, on 01/22/14 at 12:55 PM with the Maintenance Supervisor, revealed he was unaware the therapy/rehab department could not located in the exit corridor of zone 13.</p> <p>Reference: NFPA 101 (2000 edition) 19.3.6.1 Corridors shall be separated from all other areas by partitions complying with 19.3.6.2 through 19.3.6.5. (See also 19.2.5.9.) Exception No. 1: Smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.3 shall be permitted to have spaces that are unlimited in size open to the corridor, provided that the following criteria are met: (a) The spaces are not used for patient sleeping rooms, treatment rooms, or hazardous areas.</p>	K 017	<p>Criteria 1: The therapy department will be relocated to an area that is not in the exit corridor of zone 13.</p> <p>Criteria 2: The exit corridor areas have been inspected by the Administrator and Director of Maintenance to determine that there are no other rooms open to the corridor that interfere with egress requirements in accordance with NFPA standards.</p> <p>Criteria 3: The Director of Maintenance has received in-service education on the need to inspect and determine that no rooms open to the corridor would interfere with egress requirements in accordance with the NFPA standard as provided by the Administrator on February 12, 2014..</p> <p>Criteria 4: The CQI indicator for the monitoring of exit egress clearance will be utilized monthly X 2 months and then</p>	

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K 017	Continued From page 5 (b) The corridors onto which the spaces open in the same smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, or the smoke compartment in which the space is located is protected throughout by quick-response sprinklers. (c) The open space is protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, or the entire space is arranged and located to allow direct supervision by the facility staff from a nurses' station or similar space. (d) The space does not obstruct access to required exits.	K 017	quarterly as per the established CQI calendar under the supervision of the Administrator. Criteria 5:	Feb 15, 2014
K 143 SS=E	7.5.1.1 Exits shall be located and exit access shall be arranged so that exits are readily accessible at all times. NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2	K 143		

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K 143	Continued From page 6 This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to assure the room being used to transfer liquid oxygen was rated per NFPA requirements. The deficiency had the potential to affect three (3) of five (5) smoke compartments, Eighteen (18) residents, staff and visitors. The facility is certified for eighteen (18) beds with a census of seventeen (17) on the day of the survey. The facility failed to ensure the oxygen transferring room had a fire rated door and frame that had a 1 hour fire resistive rating. The findings include: Observation, on 01/22/14 at 1:51 PM with the Maintenance Supervisor, revealed the oxygen trans-filling room did not have a fire rated door and frame installed. The door frame is steel but there was no visible fire rating attached to the door or the frame. Interview, on 01/22/14 at 1:51 PM with the Maintenance Supervisor, revealed he was unaware the door and the frame were required to have a one hour fire resistive rating. Reference: NFPA 99 (1999 Edition). 8-6.2.5.2 Transferring Liquid Oxygen.	K 143	Criteria 1: The door and frame to the oxygen transferring room has been replaced with a door/frame that meets and has visible the fire rating in accordance with the NFPA standard. Criteria 2: There are no other areas where oxygen transfer takes place in the facility. Criteria 3: The Director of Maintenance has received in-service education, by the Administrator on February 12, 2014, on the inspecting of the door and frame to the oxygen transfer area to determine that the fire rating is attached and visible at all times. Criteria 4: The CQI indicator for the monitoring of identification of fire rating on doors/frames, will be utilized		

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K 143	Continued From page 7 Transferring of liquid oxygen from one container to another shall be accomplished at a location specifically designated for the transferring that is as follows: a. Separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; and b. The area is mechanically ventilated, is sprinklered, and has ceramic or concrete flooring; and c. The area is posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted. Transferring shall be accomplished utilizing equipment designed to comply with the performance requirements and producers of CGA Pamphlet P-2.6, Transfilling of Low-Pressure Liquid Oxygen to be Used for Respiration, and adhering to those procedures. The use and operation of small portable liquid oxygen systems shall comply with the requirements of CGA Pamphlet P-2.7, Guide for the Safe Storage, Handling and Use of Portable Liquid Oxygen Systems in Health Care Facilities.	K 143	monthly X 2 months and then quarterly as per the established CQI calendar under the supervision of the Administrator. Criteria 5:	Feb 12, 2014	