

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

PRINTED: 11/29/2010
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 11/09/2010
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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 An annual survey was conducted on 11/08/10 through 11/09/10 to determine the facility's compliance with Federal requirements. The facility failed to meet requirements for recertification with the highest S/S of "F". This was a FOSS survey.	F 000		
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.	F 164	Criteria 1: Residents #4 and #7 are provided privacy during care including but not limited to closing of the window blinds, and completely pulling the privacy curtain around the bed. Criteria 2: Residents are provided privacy during care including but not limited to closing of the window blinds, and completely pulling the privacy curtain around the bed.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Dr. M. Francis Teresa Scully* TITLE Administrator (X6) DATE 12-17-10

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

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F 164	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interviews and record reviews, it was determined the facility failed to provide privacy for two residents (#4 and #7), in the selected sample of eight. Staff members failed to close the window blinds and/or completely close curtains around the residents' beds during the provision of incontinent care. Findings include:</p> <p>A review of the Policy on Resident Dignity, dated January 2007, revealed residents were to be treated in a manner that maintained the privacy of their bodies. A closed door or drawn curtain shields the resident from others passing by the room. People not involved in the care of the resident shall not be present without the resident's consent while they were being treated or examined.</p> <p>1. An observation, on 11/08/10 at 11:32 AM, revealed CNA #1 and CNA #2 provided incontinent care for Resident #7, who had a roommate and visitors present in the room. The CNAs did not pull the curtain around the end of the resident's bed or close the window blinds that overlooked the parking lot.</p> <p>An interview, on 11/08/10 at 11:40 AM, with the CNAs revealed they were aware the blinds and curtains should have been pulled.</p> <p>2. An observation, on 11/09/10 at 9:32 AM, revealed CNA #3 and CNA #4 provided incontinent care for Resident #4. The CNAs did not pull the privacy curtain around the end of the bed. The resident was exposed to a staff member who entered the room to ask the CNAs</p>	F 164	<p>Criteria 3: On December 7, 2010 the facility nursing staff received in-service education on the need to provide privacy during care including but not limited to closing of the window blinds, and completely closing the privacy curtain around the bed, as provided by the ADON.</p> <p>Criteria 4: -The CQI indicator for the monitoring of resident privacy during care, including but not limited to closing of the window blinds, and completely closing the privacy curtain around the bed, will be utilized monthly X 2 months by the ADON and then as per the established CQI calendar under the supervision of the Director of Social Services. The CQI indicator will be utilized by the ADON/Director of Social Services interviewing 5 residents to ensure that their rights, privacy during care, and care needs are being met.</p> <p>Criteria 5:</p>	Dec. 10 2010	

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F 164	Continued From page 2 for assistance. An interview, on 11/09/10 at 9:45 AM, with CNA #3 revealed she did not close the curtain because there was no roommate or visitors in the room when the care was provided. An interview with Licensed Practical Nurse (LPN) #1, on 11/09/10 at 9:40 AM, revealed she expected the CNAs to pull the privacy curtain around the end of the residents' beds and the staff members received training regarding use of the privacy curtains. An interview with the Director of Nursing (DON), on 11/09/10 at 6:20 PM, revealed the CNAs were trained to provide privacy and knew to pull the curtains and blinds when providing resident care and the DON stated she expected staff to follow the practice.	F 164		
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 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. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and	F 225		

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F 225	<p>Continued From page 3</p> <p>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>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 personnel record reviews and staff interviews, it was determined the facility failed to ensure Nurse Aide Abuse Registry (NAAR) checks were conducted prior to employment for two of four new employees hired. Findings include:</p> <p>A review of the "Resident Abuse, Neglect and Misappropriation of Property" policy, dated July 2000 revealed, "All potential employees will be screened for a history of abuse, neglect or mistreating residents, to include: b) The department supervisor will check with the appropriate state licensing board/registry."</p> <p>1. A review of the personnel file for one</p>	F 225	<p>Criteria 1: -Employee files have been audited by particular department heads to determine that abuse registry and criminal record checks have been obtained.</p> <p>-Abuse registry and criminal record checks will be requested/obtained prior to hire of new employees by their particular department heads.</p> <p>Criteria 2: -Department heads received in-service by the Administrator on December 15. All were instructed that abuse registry and criminal record checks must be obtained prior to hire of new employees.</p> <p>Criteria 3: The Business Office Manager will determine proof of abuse registry and criminal record check information prior to hire for verification, and prior to the scheduling of their orientation training.</p> <p>Criteria 4: The CQI indicator for the monitoring of timeliness of abuse registry and</p>		

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F 225	Continued From page 4 housekeeping aide revealed a hire date of 09/10/10. The NAAR was not checked, until 09/13/10. An interview with the Housekeeping Supervisor, on 11/09/10 at 9:30 AM, revealed he submitted the names of new hires for the Housekeeping Department to the Business Office and they obtained the required background checks. An interview with the Business Office Assistant, on 11/09/10 at 9:40 AM, revealed the Business Office Manager was on vacation and unable to be reached. She stated she was not sure of the procedure for the background checks for new hires, but knew they were supposed to be checked. 2. A review of the personnel file for a Certified Nurse Aide (CNA) revealed a hire date of 10/12/10. The NAAR was not checked, until 10/14/10. An interview with the Assistant Director of Nursing (ADON), on 11/09/10 at 9:00 AM, revealed she was responsible for the newly hired employees for the Nursing Department. She stated her secretary was responsible for obtaining the NAAR checks. An interview with Secretary #1, on 11/09/10 at 9:25 AM, revealed the ADON made her aware of new hires and she completed a background check, which included the NAAR. She stated she checked the NAAR prior to the hire date, but did not have evidence the check had been completed for the CNA prior to 10/12/10.	F 225	criminal record checks will be utilized monthly X 2 months and then quarterly as per the established CQI calendar under the supervision of the Administrator. Criteria 5:	Dec. 17 2010	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP	F 280			

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F 280	<p>Continued From page 5</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to review and or revise the comprehensive care plan for one resident (#1), in the selected sample of eight. The facility failed to review and revise care plans related to weight, cataract surgery and a fracture of the right ankle. Findings include:</p> <p>Resident #1 was admitted, on 03/30/09, with diagnoses to include Dementia, Diabetes Mellitus, Type II and a History of UTIs. A review of the annual Minimum Data Set (MDS) assessment, dated 05/18/10, revealed the facility identified</p>	F 280	<p>Criteria 1: -The comprehensive care plan for resident # 1 was reviewed/ revised by the ADON to address the resident's current weight, with revisions to the care plan problems addressing the previous cataract surgery, and right ankle fracture.</p> <p>Criteria 2: An audit was completed of the care plans of in-house residents by the ADON to determine that the comprehensive care plans reflect their current weight status, and resolved issues have been revised..</p> <p>Criteria 3: On December 6, 2010, the ADON received in-service education from the Nursing Consultant on the need to address resident current weight status and to revise all resolved issues as indicated on the comprehensive care plan.</p> <p>Criteria 4: The CQI indicator for the monitoring of</p>		

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F 280	Continued From page 6 Resident #1 as having a modified independence in cognition, with occasional confusion. Resident #1 required extensive assistance of two staff members with all activities of daily living and was frequently incontinent of bowel and bladder. A review of the Comprehensive Care Plan, dated 04/06/09, revealed the last review of the resident's care for potential for weight loss occurred on 12/14/09. The resident weighed 210 pounds, at that time. According to the last quarterly assessment, dated 08/19/10, the resident's weight was 183 pounds. The resident's diet had been changed in accordance with nutritional assessments. However, the care plan interventions had not been revised. The care plans for cataract surgery and a fractured ankle were dated 03/30/09 and remained unrevised. An interview with LPN #1, on 11/09/10 at 1:20 PM, revealed the Assistant Director of Nursing (ADON) was responsible for all reviews and revisions of the resident's care plan. No revisions were made by staff nurses. An interview with the ADON, on 11/09/10 at 1:37 PM, revealed the care plans for nutrition should have been revised in accordance with recommendations of the Nutritional Assessment completed by the Dietician. The resident's weight loss was due to a trial of the NCS Diet and the resident's loss of appetite. The revisions were part of the ADON's responsibility. The facility did not have a policy or procedure developed for the implementation or revision of the care plan.	F 280	care plans will be utilized monthly X 2 months and then quarterly as per the established CQI calendar under the supervision of the ADON. Criteria 5:	Dec. 17 2010
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility	F 281		

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F 281	<p>Continued From page 7 must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure professional standards of quality for one resident (#3), in the selected sample of eight. The administration of an intravenous antibiotic was altered without consultation with the resident's physician. Findings include:</p> <p>Record review revealed Resident #3 was admitted to the facility, on 04/16/10, with diagnoses to include Multiple Myeloma, Failure To Thrive and Uncontrolled Pelvic and Back Pain.</p> <p>A review of a Physician Medication Orders Discharge Summary, dated 10/22/10, revealed the resident was discharged from an acute care hospital with an order to continue the antibiotic intravenously (IV) daily. The antibiotic was administered daily at 2:00 PM, during the hospitalization.</p> <p>A review of Resident #3's physician orders, dated November 2010, revealed an order for an antibiotic per IV to be administered daily, at 7:00 AM.</p> <p>A review of the Medication Administration Record, dated 11/01/10, revealed Resident #3 received the antibiotic IV daily, at 2:00 PM.</p> <p>An interview with Licensed Practical Nurse (LPN) #1, on 11/09/10 at 2:15 PM, revealed the facility changed the antibiotic administration time from</p>	F 281	<p>Criteria 1: -Resident #3 has completed the IV antibiotic therapy.</p> <p>Criteria 2: -All residents currently receiving IV antibiotic therapy have had review of their MARs and orders to determine that the medications are being administered in accordance with the physician specifications.</p> <p>Criteria 3: -Licensed nursing staff have received in-service education on December 7, 2010, by the ADON on the need to consult with the physician before changing the administration times on medications.</p> <p>Criteria 4: -Medication administration times will be audited monthly by the DON/ADON/designee to determine that they are in accordance with MD orders.</p> <p>Criteria 5:</p>	Dec. 10 2010

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F 281	Continued From page 8 7:00 AM to 2:00 PM without consultation with the physician.	F 281		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is Incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record review, it was determined the facility failed to ensure one resident (#4,) in the selected sample of eight, received appropriate incontinent care, to prevent Urinary Tract Infection. Findings include: A review of Mosby's Clinical Nursing Skills and Techniques, (used by the facility as a reference for procedures), revealed during female incontinence care, the staff member should wipe in the direction from the perineum to rectum, and repeat on the opposite side of the perineum using a separate section of the wash cloth. The rationale was that this cleansing method reduced the transmission of microorganisms. An observation, on 11/09/10 at 9:32 AM, during incontinent care provided for Resident #4, revealed CNA #3 used the same area of the wash	F 315	Criteria 1: Administrative nursing observations indicate that resident #4 is provided peri-care in accordance with infection control standards of practice. Criteria 2: Administrative nursing observations indicate that residents are provided peri-care in accordance with infection control standards of practice. Criteria 3: Nursing assistants have received in-service education on the provision of peri-care and catheter care, and handwashing/changing of gloves in accordance with infection control standards of practice as provided by the ADON/designee on December 7, 2010. Criteria 4: The CQI indicator for the monitoring of peri-care/catheter care and handwashing will be utilized	

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F 315	Continued From page 9 cloth several times before folding the wash cloth. The CNA used the contaminated cloth repeatedly on the same area, which had been cleaned. An interview, with CNA #3, on 11/09/10 at 9:40 AM, revealed she normally used this method as long and as she did not use a back and forth motion and thought the method was acceptable. An interview, with LPN #1, on 11/09/10 at 9:45 AM, revealed staff members were taught to use one wipe and then fold the wash cloth and use another area of the wash cloth for the next wipe.	F 315	monthly X 2 months and then quarterly in accordance with the established CQI calendar under the supervision of the ADON. Criteria 5:	Dec. 10 2010	
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record reviews, it was determined the facility failed to ensure the resident's environment remained as free from accident hazards as possible for two residents (#1 and #5), in the selected sample of eight, and two residents (#9 and #10), not in the selected sample. The facility failed to assess residents prior to the use of lift chairs to ensure the use was safe and/or that the residents were able to use the controls independently.	F 323	Criteria 1: Residents #1, 5, 9 and 10 have been assessed for the use of the electric lift chairs, and are utilizing these devices or alternative chairs in accordance with their assessment findings. Criteria 2: An audit was completed by the ADON and MDS Coordinator to determine that electric lift chair assessments have been completed for all residents who		

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F 323	<p>Continued From page 10</p> <p>Findings include:</p> <p>1. Observations of Resident #1, on 11/09/10 at 9:10 AM and 10:35 AM, revealed the resident was sitting alone in his/her room. The resident was in a lift chair with his/her feet elevated and the control to the lift chair was located in the seat of the chair next to the resident's left hand. A clip alarm was connected to the resident's right shoulder.</p> <p>An interview, with Resident #1's family member, on 11/08/10 at 4:18 PM, revealed Resident #1 had been increasingly confused.</p> <p>2. An observation, on 11/09/10 at 9:12 AM, revealed Resident #5 was alone in his/her room and seated in the lift chair, holding the lift control in his/her hand. A sensor pad alarm was observed in the pad underneath the resident.</p> <p>A review of the "Electric Lift Chair Assessments" completed for Residents #1 and #10 revealed the residents were assessed with a score of two, which meant the residents could not safely transfer in and out of the chairs without assistance. According to the assessments, other chair alternatives should be considered or the chairs should be disconnected from the electrical source at the breaker box.</p> <p>An interview, with the Director of Nursing (DON), on 11/09/10 at 6:20 PM, revealed another chair source had not been utilized and the lift chairs were still available to be used by all four of the residents. There were no lift chair assessments completed for Residents #5 and #9. The DON stated the assessments should have been completed on admission.</p>	F 323	<p>have these devices available, and the residents are utilizing these as indicated by the assessment findings. Chair alternatives have been implemented for those residents determined not to be candidates for the use of electric lift chairs.</p> <p>Criteria 3: The ADON and MDS Coordinator have received in-service education on the need to complete electric lift chair assessments for residents prior to the implementation of use, and to utilize electric lift chairs in accordance with the assessment findings, conducted by the Nurse Consultant on December 6, 2010.</p> <p>Criteria 4: The CQI indicator for the monitoring of electric lift chair and device use will be utilized monthly X 2 months and then quarterly as per the established CQI calendar, under the supervision of the ADON.</p> <p>Criteria 5:</p>	Dec. 14 2010

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105226	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/09/2010
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NAME OF PROVIDER OR SUPPLIER CARMEL HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 2601 OLD HARTFORD RD. OWENSBORO, KY 42303
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F 371 SS=F	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, it was determined the facility failed to store, distribute and serve food under sanitary conditions during the lunch meal on 11/08/10. There were personal food items stored in the reach-in milk refrigerator located in the kitchen. Food temperatures were not monitored daily for the reach-in milk refrigerator. Additionally, bread items were stored on a bottom shelf in the walk-in freezer and the shelf was located on the floor. Findings include:</p> <p>A review of the policy for "Refrigerator Temperatures" (undated), revealed "Each Dietary Manager must maintain a temperature sheet, posted with the temperature of all storage refrigerators being recorded daily".</p> <p>Observations of the kitchen during a tour, on 11/08/10 from 11:10 AM until 11:40 AM, revealed:</p> <p>1. The reach-in milk refrigerator temperatures had not been monitored and recorded on 11/03/10, 11/04/10 and 11/06/10.</p>	F 371	<p>Criteria 1: -Facility personal food items are stored in the separate refrigerator designated for this purpose. -Food temperatures are monitored daily for the reach-in milk refrigerator. -The bottom shelf in the walk-in freezer has been repaired so that it is no longer in contact with the floor, and bread items are stored on the upper level shelving.</p> <p>Criteria 2: -An audit was completed of the kitchen to identify any dietary sanitation issues. All identified issues have been addressed as indicated.</p> <p>Criteria 3: The dietary staff have received in-service education, on November 17, 2010, on dietary sanitation issues including but not limited to: storage of employee personal food items in the designated refrigerator;</p>	
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NAME OF PROVIDER OR SUPPLIER CARMEL HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2601 OLD HARTFORD RD. OWENSBORO, KY 42303	
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F 371	<p>Continued From page 12</p> <p>2. There were personal food items stored next to opened gallon containers of milk in the reach-in refrigerator.</p> <p>3. Observation of the walk-in freezer revealed there were loaves of bread stored on a bottom shelf of a plastic shelving unit and the bottom shelf was directly on the surface of the floor.</p> <p>An interview with the Dietary Manager, on 11/08/10 at 11:35 AM, revealed she was unaware the staff's food stored in the refrigerator and stated the food should have been in the employee's refrigerator. She also stated the refrigerator temperatures were to be monitored and recorded every morning and had not realized they were not monitored on those days. The shelf in the walk-in freezer contained the extra bread and food the facility collected to distribute to the poor. She was aware there was to be no food on the floor of the freezer.</p> <p>A review of the policy for "Handwashing and Glove Use" (undated) related to the Dietary Department revealed, "When gloves are used, handwashing must occur prior to putting on gloves and whenever gloves are changed. Gloves must be changed as often as hands need to be washed. Gloves may be used for one task only".</p> <p>Observations of the tray line service, during the lunch meal on 11/08/10 from 12:15 PM until 12:25 PM in the main dining room of the infirmary revealed one staff member was serving food. The staff member, who was wearing gloves, transported a food cart to the serving area wearing gloves, positioned all the food containers</p>	F 371	<p>monitoring of reach-in milk refrigerator temperatures daily;</p> <p>and storage of bread items on the upper level shelving in the walk-in freezer, as provided by the Dietary Manager.</p> <p>Criteria 4: The CQI indicator for the monitoring of dietary sanitation will be utilized monthly as per the established CQI calendar under the supervision of the Dietary Manager.</p> <p>Criteria 5:</p>	Dec. 3, 2010

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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 371	Continued From page 13 onto the steam table and uncovered the food. The employee took temperatures of the food, placed the serving spoons into the food and began serving food from the tray line, without washing her hands nor donning a clean pair of gloves. The employee placed bread on the plates without changing gloves and returned to serving food from the tray line without changing gloves. The employee took a bowl from a staff member to fill with gravy, handed the bowl back to the employee and returned to serving food with the same gloved hands. The employee was observed to pick up a slice of ham and bread without changing gloves and placed the ham and bread in the top of a domed tray lid and gave it to a staff member for resident service. An interview with the Dietary Aide, on 11/08/10 at 12:30 PM, revealed she should have changed her gloves after taking the food temperatures and should not have touched the bread with her gloved hands. She stated she was nervous. An interview with the Dietary Manager, on 11/08/10 at 12:35 PM, revealed the Dietary Aide should have washed her hands and applied new gloves to obtain the food temperatures and again prior to touching food items. She expected staff to follow the policy.	F 371			
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS 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. (a) Infection Control Program	F 441			

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NAME OF PROVIDER OR SUPPLIER CARMEL HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2601 OLD HARTFORD RD. OWENSBORO, KY 42303		
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F 441	<p>Continued From page 14</p> <p>The facility must establish an Infection Control Program under which it -</p> <p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(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.</p> <p>(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</p> <p>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, interviews and record review, it was determined the facility failed to ensure handwashing was performed after administering direct resident care related to staff members not sanitizing or washing their hands between residents served in the dining room, on</p>	F 441	<p>Criteria 1: -Residents #4 and 6 are provided peri-care and catheter care in accordance with infection control standards of practice.</p> <p>-Nursing assistants perform handwashing in accordance with infection control standards of practice when providing care for residents #4 and 6.</p> <p>Criteria 2: -Residents are provided peri-care and catheter care, including but not limited to Residents who are incontinent, have indwelling catheters, or require assistance with personal care needs, in accordance with infection control standards of practice.</p> <p>-Nursing assistants perform handwashing in accordance with infection control standards of practice</p> <p>Criteria 3: Nursing assistants have received inservice education on the provision of peri-care and catheter care, and handwashing in accordance with infection control standards of</p>		

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F 441	<p>Continued From page 15</p> <p>11/08/10, and following incontinent care for two residents (#4 and #6,) in the selected sample of eight.</p> <p>Findings include:</p> <p>A review of the September 2006 Hand Hygiene Policy revealed the staff members were to wash their hands before and after donning and removing gloves and before and after direct contact with the resident.</p> <p>1. An observation of the noon meal, on 11/08/10 at 12:15 PM, revealed five Certified Nurse Aides (CNAs) who were serving the meal to residents in the Main Dining Room, failed to wash or sanitize their hands in between repositioning residents, cutting meat and buttering bread for the residents.</p> <p>An interview with CNA #5, on 11/08/10 at 12:30 PM, revealed the CNA stated the CNAs were to wash their hands one time, prior to the meal. The CNA stated the staff members were to keep sanitizer in their pockets, in case they needed this; however, the CNA stated she had left hers at the nursing desk, on the 100 Wing and it was not available.</p> <p>2. An observation of incontinent care for Resident #4, on 11/09/10 at 9:32 AM, revealed CNAs #3 and #4 were completing incontinent care and bagging the dirty linens when CNA #4 walked out of the room without washing her hands, went down the hall to the soiled utility room and deposited the dirty linen into the barrel. She then left that room and went down the hall to talk with staff and then to the ice machine before washing her hands.</p>	F 441	<p>practice as provided by the ADON/designee on December 7, 2010.</p> <p>Criteria 4: The CQI indicator for the monitoring of peri-care/catheter care and handwashing will be utilized monthly X 2 months and then quarterly in accordance with the established CQI calendar under the supervision of the DON.</p> <p>Criteria 5:</p>	Dec 10 2010	

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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 441	Continued From page 16 An interview, on 11/09/10 at 9:55 AM, with CNA #4 revealed she should have washed her hands before and after incontinent care and should have completed the handwashing prior to leaving the resident's room. An interview, on 11/09/10 at 6:20 PM, with the Director of Nursing (DON) revealed she expected the CNAs to wash their hands whenever they took off their gloves and before they left the room.	F 441			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185226	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 11/09/2010
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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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K 000	<p>INITIAL COMMENTS</p> <p>A Life Safety Code survey was initiated and conducted on 11/09/10 to determine the facility's compliance with Title 42, Code of Federal Regulations, 483.70 (Life Safety from Fire) and found the facility to be in compliance with NFPA 101 Life Safety Code 2000 Edition. No deficiencies were identified during this survey.</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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