

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

FORM APPROVED
OMB NO. 0938-0301

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185200	(X2) MULTIPLE CORRECTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/19/2013
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NAME OF PROVIDER OR SUPPLIER CARMEL MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 100 CARMEL MANOR ROAD FORT THOMAS, KY 41075
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(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
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F 000 INITIAL COMMENTS

A Standard Recertification Survey was conducted on 07/16/13 through 07/19/13 with deficiencies cited. The highest Scope and Severity was a 'G' at 42 CFR 483.25 Quality of Care (F-323) and 42 CFR 483.20 Resident Assessment (F-280) with the facility having an opportunity to correct before remedies would be recommended for imposition.

F 280 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP

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.

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.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review

F 000 Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state laws. A request for an IDR has been filed for deficiencies cited at tags F280 and F323.

F 280.

1) For resident #2 Fall Committee reviewed 8/24/13 falls from 5/24/13 and 6/1/13 and reviewed chronic care plan. Fall Committee made recommendations regarding initiation of new interventions for resident. Chronic Care Plan was updated; staff was in-serviced by Director of Nursing by 8/9/13.

2) All residents who had a fall since 5/15/13 will have chronic care plan reviewed for evidence of purposeful interventions put in place related to fall. Any falls not satisfactorily care planned will be brought to Fall Committee for further review and recommendations. Director of Nursing/Unit Manager/MDS RN will review falls and address falls not deemed adequately care planned by 8/16/13.

3) Policies and procedures related to fall prevention, fall investigation committee and fall investigation and tracking will be reviewed and revised, as needed, by Director of Nursing as of 8/12/13.

RECEIVED
AUG 12 2013
BY: _____

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Sister Teresa Kennedy</i>	TITLE <i>Administrator</i>	(X6) DATE <i>08-12-13</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plan 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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NAME OF PROVIDER OR SUPPLIER CARMEL MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 100 CARMEL MANOR ROAD FORT THOMAS, KY 41075
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F 280 Continued From page 1

and review of the facility's policy, it was determined the facility failed to ensure the Comprehensive Care Plan was revised for one (1) of fifteen (15) sampled residents (Resident #2).

Resident #2 had a history of falls prior to and after admission to the facility. Resident #2 experienced falls while attempting to self ambulate after releasing his/her self releasing alarmed seat belt; however, the facility failed to thoroughly investigate the 06/24/13 fall and failed to revise the plan of care to include effective interventions to prevent further falls. On 06/01/13, Resident #2 fell and was diagnosed with a right hip fracture. (Refer to F-323)

The findings include:

Review of the facility's policy, "Fall Investigation Committee", undated, revealed the Committee was to share ideas to prevent, reduce and provide safety for the facility's residents. The Committee was to review the circumstances surrounding falls with recommendations made based on the review, the care plan was to be reviewed and new interventions initiated.

Review of Resident #2's record revealed the facility admitted the resident on 03/12/12, with diagnoses which included a history of Falls, History of hip fracture prior to admission; Abnormally of Gait; Dementia; Muscle Disease Atrophy; and Anxiety. Review of the Significant Change Minimum Data Set (MDS) Assessment, dated 03/05/13, revealed the facility assessed Resident #2 to have a Brief Interview of Mental Status (BIMS) of ninety-nine (99) which indicated the resident was unable to complete the

F 280

4) In-service all nursing staff regarding changes in policies, and procedures, interventions will be completed by Education Nurse by 8/23/14.

5) Create a QI monitor that will monitor for appropriate interventions in place for each fall. This will be created by Director of Nursing. Monitoring will be completed by Director of Nursing/Unit Manager/MDS Nurse/designee. Monitor will be completed for each fall x 4 weeks, then weekly x 8 weeks, then every other week x 16 weeks, then monthly 5 months to begin 8/23/13.

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F 280	<p>Continued From page 2</p> <p>Interview. Continued review of the MDS revealed the facility assessed Resident #2 to have short term and long term memory impairment and to be moderately impaired with cognitive skill for daily decision making. The facility assessed the resident to require extensive assistance of one (1) staff for Activities of Daily Living (ADLs) and ambulation, and to be frequently incontinent with bowel and bladder.</p> <p>Review of Resident #2's Comprehensive Care Plan, dated 03/06/13, revealed the facility had determined Resident #2 was at risk for falls related to falls prior to admission to the facility which resulted in a hip fracture and repair of the fracture. Review revealed the resident was also at risk for falls related to poor decision making, safety awareness, poor balance and was agitated and restless at times. Interventions on this Care Plan included afternoon rest periods in bed or a recliner from either 2:00 PM or 3:00 PM to 5:00 PM were to be initiated by staff and the resident was to be assisted to a recliner by 7:00 PM or right after dinner. Further review revealed interventions included a quick release alarmed seat belt to his/her wheelchair.</p> <p>Review of the Incident Report and Falls Investigation Report documentation, dated 05/24/13, revealed Resident #2 experienced a fall on 05/24/13 at 5:55 PM, while ambulating independently from his/her wheelchair. Review revealed Resident #2 was found in the common area of the unit on his/her "bottom" with no apparent injury and the chair alarm had not sounded related to dead batteries which were replaced. Further review of the Falls Investigation Report revealed no documented evidence of changes in interventions.</p>	F 280			

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F 280	Continued From page 3 Review of the 05/31/13 Physical Restraint Committee Review form revealed Resident #2 had experienced a fall from his/her wheelchair on 05/24/13. Further review of the 05/31/13 Committee form revealed no documented evidence of changes in interventions. Review of Resident #2's Comprehensive Care Plan revealed the care plan had not been revised to address the resident's 05/24/13 fall. Review of the Incident Report, dated 06/01/13 revealed at 11:45 AM, Resident #2 experienced a fall. The Incident Report indicated the resident went into another resident's room, shut the door, and ambulated independently. According to the Incident Report Resident #2 was found on his/her "bottom" and was assessed to have no injuries. Further review of the Incident Report revealed Resident #2 complained of pain "several hours later", an x-ray order was obtained, and results of the x-ray indicated the resident had a right hip fracture and was sent to the hospital. Interview, on 07/18/13 at 11:25 AM, with Nursing Assistant (NA) #1 revealed she was not aware of any new interventions added after Resident #2's fall on 05/24/13. Interview, on 07/18/13 at 11:44 AM, with NA #3 revealed she was not aware of any new interventions added after the resident's fall in May 2013. Interview, on 07/19/13 at 3:23 PM, with Licensed Practical Nurse (LPN) #4 revealed she had cared for Resident #2. She stated Resident #2 had a history of falls and had several interventions in	F 280			

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F 280	<p>Continued From page 4</p> <p>place. LPN #4 stated she was not aware of any new interventions being added to the Care Plan after the resident's fall on 05/24/13.</p> <p>Interview, on 07/19/13 at 3:37 PM, with Registered Nurse (RN) #1 revealed he was not aware of any new interventions added to Resident #2's Care Plan to prevent further falls after his/her fall on 05/24/13. He stated when the fall occurred on 05/24/13 the resident's chair alarm didn't sound related to batteries that needed to be replaced. The RN stated the batteries were replaced and the alarm worked after that. RN #1 stated increased supervision of Resident #2 might have helped to prevent further falls from occurring.</p> <p>Interview, on 07/19/13 at 4:20 PM, with RN #5 revealed the resident had a history of falls and he/she was admitted related to a hip fracture he/she had suffered prior to admission. She stated she was aware Resident #2 had experienced a fall in May 2013. The RN indicated no new interventions were added to the Care Plan to prevent further falls. She stated "we were just following through with our present interventions, nothing changed". According to the RN she thought it would have been good if they could have had increased supervision of the resident and that might have prevented the fall on 06/01/13.</p> <p>Interview, on 06/19/13 at 5:37 PM, with the Minimum Data Set (MDS) Nurse revealed the Care Plan was not revised with new interventions after the 05/24/13 fall. She indicated Resident #2 already had interventions which included a bed alarm, chair alarm, perimeter mattress, and self releasing seat belt with alarm. According to the</p>	F 280			

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F 280	Continued From page 5 MDS Nurse, Resident #2 had "pretty much" all interventions available and there was "only so much you can do". Interview, on 06/19/13 at 3:50 PM, with the Unit Manager who was the acting Director of Nursing (DON) revealed all falls were discussed in morning meetings and in the Falls Committee meetings to attempt to determine the root cause of the fall and if new interventions were indicated. She stated the root cause of Resident #2's fall on 05/24/13 was determined to be "dead batteries" in the chair alarm which were replaced. The acting DON stated if the chair alarm batteries had been working, the alarm would have sounded and staff would have been able to get to the resident to prevent the fall on 05/24/13. Per interview, no additional interventions were indicated to Resident #2's Care Plan.	F 280	
F 281 §§=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and review of the facility's policy, it was determined the facility failed to ensure the services being provided met professional standards of quality according to accepted standards of clinical practice for one (1) of fifteen (15) residents (Resident #5) as evidenced by staff not following Physician's orders. Resident #5 had an order for	F 281	1) Resident #1's lab orders were reviewed with resident's physician on 7/19/13. New orders were obtained by staff nurse and put in place. Lab was notified of new orders on 7/19/13. 2) All residents will have their current "standing" lab orders reviewed by staff nurses and unit manager, and orders will be compared to current physician's orders. Any discrepancies will be reviewed with resident's physician by a staff nurse and new orders obtained/verified by 8/19/13. Current standing order sheets will be kept in designated area on nurse's station after 8/24/13

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F 281 Continued From page 6

BUN/Creatinine/Electrolytes to be drawn every Sept and March. Review of lab results for Sept 2012 and March 2013 revealed only the BUN and Creatinine were obtained.

The findings include:

Review of Facility's policy, "Tests (Laboratory)", with effective date of 05/13/08, revealed staff was to check Physician's order for specific individual tests to be performed. Staff was then to place yellow copies of labs requisitions, after specimens obtained, in designated area for further follow-up. Once laboratory reports were returned to the facility nursing staff was to review all laboratory reports.

Record review revealed the facility admitted Resident #5, on 06/16/08, with diagnoses which included Hemiplegia, Hypertension, Muscle Atrophy, Dysphagia, Peripheral Artery Disease, Chronic Airway Obstruction, Dementia, Abnormal Posture, Anemia, Depression, Osteoarthritis, and history of Cerebral Vascular Accident.

Review of the Physician's Order Sheet, for July 2013, revealed order for Blood Urea Nitrogen (BUN, used to measure renal function), Electrolytes (A substance that dissociates into ions in solution and acquires the capacity to conduct electricity. Sodium, potassium, chloride, calcium, and phosphate are examples of electrolytes, informally known as LYLES), and Creatinine (CREAT: Used to monitor renal impairment) to be drawn every six (6) months in September and March.

Review of the Medication Regimen Review sheet for Resident #5 revealed notations by the

F 281 verification, for daily review by desk nurse/unit manager/Director of Nursing/or designee for appropriate daily results, based on daily orders by 8/19/13.

3) Policy and procedure for Lab Tests will be reviewed and revised by Director of Nursing and updated as needed by 8/12/13.

4) In-service will be completed for all staff nurses by Education Director by 8/23/13

5) A QA monitor will be created by Director of Nursing and initiated by 8/23/13. Monitor will be completed by Director of Nursing/Unit Manager/designee. Monitor will be done weekly x 12 weeks, every other week x 12 weeks, then monthly x 6 months.

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F 281	<p>Continued From page 7</p> <p>Pharmacist, on 06/12/13, stating requested BMP did not contain electrolytes. Further review revealed a notation, on 07/13/13, still waiting for electrolytes.</p> <p>Review of Laboratory Results for Resident #5, dated September 2012 and March 2013) revealed the only results provided were for BUN and Creatinine. No results for LYLES were available for September 2012 and March 2013.</p> <p>Interview with Licensed Practical Nurse (LPN) #3, on 07/18/13 at 11:30 AM, revealed according to Physician's Order, all three laboratory tests (BUN, LYLES, CREAT) should have been drawn together every six (6) months.</p> <p>Interview with LPN #2, on 07/18/13 at 11:35 AM, revealed the three laboratory tests (BUN, LYLES, CREAT) should have been entered into the laboratory computer system which would then print out the tests needed to be performed during the timeframe specified by the Physician's order.</p> <p>Review of the Scheduled Order Entry for laboratory tests for Resident #5 revealed only Hepatic Function and Lipid Profile tests were selected to be drawn every six (6) months.</p> <p>Interview with the Nurse Manager, on 07/18/13 at 11:45 AM, revealed her expectation was the laboratory tests for BUN, LYLES, and CREAT should be drawn every six (6) months as ordered by the Physician.</p> <p>Interview with the Medical Director, 07/18/13 at 3:05 PM, revealed Resident #5 should be having laboratory testing performed for LYLES to monitor Potassium Level since resident was currently</p>	F 281		
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F 281 Continued From page 8
prescribed Potassium. The Medical Director further stated he would have to review the current blood level of Potassium to determine whether or not the resident would be at risk for harm. (Note: The body depends upon the mineral potassium's electrolytic properties to conduct nerve impulses, initiate muscle contractions, regulate the balance of acids and bases in the blood, facilitate biochemical processes and maintain proper fluid levels inside and outside cells.)

F 282 SS=D 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN
The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, it was determined the facility failed to ensure services were provided by the facility in accordance with each resident's written plan of care for one (1) of fifteen (15) sampled residents (Resident #2)

Observations during the survey revealed an alarming seat belt on Resident #2's wheelchair; however, it was either not fastened around the resident's waist or it was fastened during a time in which it shouldn't be fastened according to restraint reduction in place.

The findings include:

F 281

F 282 1) Resident #2's seat belt placement was corrected by staff nurse in accordance to active Restraint Reduction Trial Plan on 7/20/13. Staff nurses, unit manager, and Restraint Coordinator RN continued to monitor resident for correct use of the quick release seat belt, per the Restraint Reduction Trial Plan, throughout the duration of the restraint reduction trial.
8/24/13

2) A Restraint Reduction Trial Plan will be established by Director of Nursing/Unit Manager/Restraint Committee Coordinator or RN by 8/16/13. Currently, there are no residents with current Restraint Reduction Plans.

3) Policy and Procedures for Restraints will be reviewed and revised by Director of Nursing by 8/12/13.

4) Restraint Committee Coordinator, and all nursing staff will be in-serviced

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F 282 Continued From page 9

Review of Resident #2's record revealed the facility admitted the resident on 03/12/12, with diagnoses which included a history of Falls, history of hip fracture prior to admission, Abnormality of Gait, and Dementia. Review of the Significant Change Minimum Data Set (MDS) Assessment, dated 03/05/13, revealed the facility assessed Resident #2 to have short term and long term memory impairment and to be moderately impaired with cognitive skills for daily decision making. Additionally, the facility assessed the resident to require extensive assistance of one (1) staff for Activities of Daily Living (ADLs) and ambulation.

Review of Resident #2's Comprehensive Care Plan, dated 03/06/13, revealed the facility had determined Resident #2 was at risk for falls related to falls prior to admission to the facility which resulted in a hip fracture and repair of the fracture; and poor balance. Interventions on this Care Plan included a quick release alarmed seat belt to wheelchair.

Continued review of the record revealed Resident #2 had experienced a fall resulting in a right hip fracture on 06/01/13, while attempting to self ambulate from his/her wheelchair.

Review of the July 2013 Nurse Aide Care Plan revealed Resident #2 was to have an alarmed seat belt to his/her wheelchair. Further review revealed a "trial to reduce seatbelt starting 07/15/13".

Review of the "Restraint Reduction Plan" for Resident #2 revealed the Velcro alarming seat belt was to be left off after breakfast until lunch.

F 282 regarding new tracking form, and updated Policy and Procedure, by Education RN by 8/23/13.

5) A QI monitor will be created by Director of Nursing/Restraint Coordinator RN and will be initiated by 8/23/13. A QI monitor will be performed daily throughout each Restraint Reduction Trial x 12 months by Director of Nursing/Unit Manager/Restraint Committee RN/other restraint committee members/or designee.

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F 282	<p>Continued From page 10</p> <p>After lunch the Velcro alarming seat belt was to be used for the rest of the day.</p> <p>Observations, on 07/16/13 at 4:10 PM, at 5:21 PM, and 5:55 PM, of Resident #2 revealed the resident had a black Velcro seat belt strapped behind the wheelchair and not around his/her waist. Observations, on 07/17/13 at 12:15 PM, 1:02 PM, 3:50 PM revealed the black Velcro seat belt remained strapped behind Resident #2's wheelchair or dangling at the sides of the wheelchair.</p> <p>Interview, on 07/18/13 at 11:25 AM, with Nursing Assistant (NA) #1 revealed the facility had "sheets" that told NAs what residents care needs were; however, there were not always copies of these "sheets" for NA's to use. She stated she had cared for Resident #2 before. According to NA #1 the resident was to wear an alarming seat belt. Observation, at the time of this interview, revealed Resident #2 did not have the alarming seat belt on; it was observed fastened behind the wheelchair. Further interview with NA #1 revealed Resident #2 should have the alarming seat belt on. Further observation revealed NA #1 proceeded to fasten the seat belt around the Resident #2's waist. Additional interview, at 3:46 PM that day, with NA #1 revealed she had been informed of the reduction after she had fastened the alarming seat belt around Resident #2 earlier. She stated she had not worked with Resident #2 for a while and was not aware of the reduction. The NA stated she should not have placed the alarming seat belt around Resident #2's waist at 11:25 AM that morning as it was before lunch and the reduction indicated it was to be off until after lunch.</p>	F 282			

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F 282 Continued From page 11

Interview, on 07/18/13 at 11:44 AM, with NA #3 revealed she had cared for Resident #2 before. She stated she was aware Resident #2 had an alarming seat belt in place to his/her wheelchair. NA #3 stated the facility had started an alarm restraint reduction of the alarming seat belt. The NA indicated the alarming seat belt was to be put on when the resident was gotten up in the morning; it was to be removed after breakfast, and put back on after lunch for the rest of the day.

Interview, on 07/18/13 at 3:32 PM, with NA #4 revealed she had been employed for approximately one (1) month and had cared for Resident #2 approximately three (3) times. She stated she had never "put a seat belt" on the resident when she cared for the resident.

Observation, on 07/18/13 at 3:15 PM, revealed Resident #2 to have the seat belt dangling at the sides of the wheelchair.

Interview, on 07/18/13 at 3:42 PM, with NA #2 revealed Resident #2 should have had the alarming Velcro seat belt on at 3:15 PM because it was after lunch and that was what was indicated on the alarm reduction.

Observation, on 07/19/13 at 10:10 AM, revealed Resident #2 to be sitting in a wheelchair and to have the black Velcro alarming seat belt strapped around his/her waist.

Interview, on 07/19/13 at 10:25 AM, with NA #5 and NA #6 who were assigned to Resident #2's care, revealed they thought the resident should not have had the black Velcro alarming seat belt on at 10:10 AM. They stated they had not had a "chance" to check the form located on the

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F 282 Continued From page 12
clipboard, which included the information of the alarm seat belt reduction in place as per the care plan. Both NA's indicated they had not had a "chance" to ask the nurses about their resident's care yet that day either. NA #6 stated she was unaware Resident #2 had the alarming seat belt on at 10:10 AM.

Interview, on 07/19/13 at 3:23 PM, with Licensed Practical Nurse (LPN) #4 revealed she had cared for Resident #2. She stated Resident #2 had a history of falls and had an Intervention in place of an alarming self-release seat belt. According to the LPN, the alarming self-release seat belt "seemed to work" because as soon as he/she took it off the alarm would go off and staff would go to him/her. She stated the facility had initiated a restraint reduction of the the alarming seat belt which the NA's were supposed to be aware of. LPN #4 stated the NA's were supposed to review information located on the clipboard which contained new interventions for residents.

Interview, on 06/19/13 at 5:37 PM, with the Minimum Data Set (MDS) Nurse revealed the restraint reduction of Resident #2's alarming seat belt was initiated on 07/15/13. She stated staff was to read the information on the clipboard regarding the restraint reduction prior to beginning work. According to the MDS Nurse Resident #2 should have the alarming seat belt on after lunch.

Interview, on 06/19/13 at 3:50 PM, with the Unit Manager who was the acting Director of Nursing (DON) revealed there was a clipboard located at the nurse's station which contained new information and new Care Plan interventions on residents. She expected staff to follow the new

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F 282: Continued From page 13
Interventions located on the clipboard and Care Plan interventions for resident care.

F 323 483.25(h) FREE OF ACCIDENT
SS=G 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, interview, record review and review of the facility's policy, it was determined the facility failed to ensure each resident received adequate supervision and assistance devices to prevent falls for one (1) of fifteen (15) sampled residents (Resident #2). Resident #2 sustained a fall on 05/24/13 while attempting to self transfer after releasing his/her self-releasing seat belt; however, there was no documented evidence the facility conducted a thorough investigation to determine the root cause of the falls and/or revised fall interventions to prevent further falls. On 06/11/13, Resident #2 sustained another fall while the resident was attempting to ambulate independently and was diagnosed with a right hip fracture. (Refer to F-280)

The findings include:

F 282:

F 323:

- 1) For resident #2 Fall Committee reviewed falls from 5/24/13 and 6/1/13 and reviewed chronic care plan. Fall Committee made recommendations regarding initiation of new interventions for resident. Chronic Care Plan was updated; staff was in-serviced by Director of Nursing by 8/9/13.
- 2) All residents who had a fall since 5/15/13 will have chronic care plan reviewed for evidence of purposeful interventions put in place related to fall. Any falls not satisfactorily care planned will be brought to Fall Committee for further review and recommendations. Director of Nursing/Unit Manager/MDS RN will review falls and address falls not deemed adequately care planned by 8/16/13.
- 3) Policies and procedures related to fall prevention, fall investigation committee and fall investigation and tracking will be reviewed and revised, as needed, by Director of Nursing as of 8/12/13.
- 4) In-service all nursing staff regarding changes in policies, and procedures,

8/24/13

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F 323	Continued From page 14 Review of the facility's policy, "Fall Prevention Program", undated, revealed the purpose was to identify residents at high risk for falls and to prevent injury to residents from falls. Each resident fall was to be investigated in regards to time, location, medication, intrinsic and extrinsic factors. All falls were to be reviewed by the Director of Nursing (DON)/Designee. Review of Resident #2's record revealed the facility admitted the resident on 03/12/12, with diagnoses which included a history of Falls, History of hip fracture prior to admission; Abnormality of Gait; Dementia; Muscle Disease Atrophy; and Anxiety. Review of the Significant Change Minimum Data Set (MDS) Assessment, dated 03/05/13, revealed the facility assessed Resident #2 to have a Brief Interview of Mental Status (BIMS) of ninety-nine (99) which indicated the resident was unable to complete the interview. Continued review of the MDS revealed the facility assessed Resident #2 to have short term and long term memory impairment and to be moderately impaired with cognitive skill for daily decision making. The facility assessed the resident to require extensive assistance of one (1) staff for Activities of Daily Living (ADLs) and ambulation; and to be frequently incontinent with bowel and bladder. Review of Resident #2's Comprehensive Care Plan, dated 03/06/13, revealed the facility had determined Resident #2 was at risk for falls related to falls prior to admission to the facility which resulted in a hip fracture and repair of the fracture; poor decision making; recall ability; and safety awareness; poor balance; and he/she got agitated and restless at times. Interventions on this Care Plan included staff were to initiate			
F 323	interventions will be completed by Education Nurse by 8/23/14. 5) Create a QI monitor that will monitor for appropriate interventions in place for each fall. This will be created by Director of Nursing. Monitoring will be completed by Director of Nursing/Unit Manager/MDS Nurse/designee. Monitor will be completed for each fall x 4 weeks, then weekly x 8 weeks, then every other week x 16 weeks, then monthly 5 months to begin 8/23/13.			

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F 323	<p>Continued From page 15</p> <p>afternoon rest periods in bed or a recliner from 2:00 PM or 3:00 PM to 5:00 PM and assist the resident to recliner by 7:00 PM or right after dinner; and a quick release alarmed seat belt to wheelchair.</p> <p>Review of the Nurse's Note, dated 05/24/13 at 5:55 PM, revealed Resident #2 was "found in common area" on his/her "bottom". The nurse documented the resident had "no injuries" and the alarm on his/her wheelchair did not sound. Further review of the Nurse's Notes revealed no documented evidence the Comprehensive Care Plan was revised to prevent further falls.</p> <p>Review of the Incident Report documentation, 05/24/13, revealed Resident #2 fell on 05/24/13 at 5:55 PM, while ambulating without assistance, "was found in the common area". Review of the Report revealed the resident was "unable to state what happened". Continued review revealed the resident had no apparent injury. Further review revealed no documented evidence of whether Resident #2's alarming seat belt had been on and was functioning.</p> <p>Review of the Fall Investigation Report dated 05/24/13, revealed at 5:55 PM Resident #2 had been ambulating independently and was found sitting in the "common area" on his/her "bottom" and when asked what happened the resident stated "I don't know". Continued review of the Fall Investigation Report revealed Resident #2 had a chair alarm to his/her wheelchair that did not sound related to the batteries which were replaced.</p> <p>Review of the Physical Restraint Committee Review forms revealed Resident #2 had a quick</p>	F 323		
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F 323	Continued From page 16 release "Velcro" alarmed seat belt related to poor safety awareness, unsteady gait, and poor unsupported standing balance since July 2012. Continued review revealed Resident #2 was noted from 07/31/12 to 05/31/13 to "manipulate and release the seatbelt at times". Review of the 05/31/13 Physical Restraint Committee Review form revealed Resident #2 had sustained a fall on 05/24/13 from the wheelchair. Further review of the 05/31/13 form revealed no documented evidence of any changes to the resident's Plan of Care to prevent further falls. Interview, on 07/18/13 at 11:25 AM, with Nursing Assistant (NA) #1 revealed the facility had "sheets" that told NAs what residents care needs were; however, there was not always copies of these "sheets" for NA's to use. She stated she had cared for Resident #2 before she was not aware of any new interventions being put in place after the 05/24/13 fall. Interview, on 07/18/13 at 11:44 AM, with NA #3 revealed she had cared for Resident #2 before. The NA stated she was not aware of any new interventions being put in place after Resident #2's fall in May 2013. Interview, on 07/19/13 at 3:23 PM, with Licensed Practical Nurse (LPN) #4 revealed she had cared for Resident #2. She stated Resident #2 had a history of falls and had several interventions in place such as, the alarming self-release seat belt, a fall mat by the bed, and a low bed. LPN #4 stated Resident #2 tried to stand up on his/her own and would bend over trying to reach for things. According to the LPN, the alarming self-release seat belt "seemed to work" because as soon as he/she took it off the alarm would go	F 323		
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F 323 Continued From page 17
off and staff would go to him/her. She stated no new interventions were added that she was aware of after Resident #2's fall on 05/24/13.

Interview, on 07/19/13 at 3:37 PM, with Registered Nurse (RN) #1 revealed he was aware of the resident's fall on 05/24/13, however he was unaware of any new interventions being put in place to prevent further falls after that fall. He stated at the time of the 05/24/13 the resident's chair alarm didn't sound related to batteries that needed to be replaced and this was done. The RN stated Resident #2 had an alarming seat belt implemented soon after being admitted to the facility related to him/her attempting to ambulate unassisted. RN #1 indicated Resident #2 had a chair alarm and fall mats in place also. He stated this was related to Resident #2 having several "tittle" falls prior to the alarming seat belt, chair alarm, and fall mats. The RN stated increased supervision of Resident #2 might have helped to prevent further falls from occurring.

Interview, on 07/19/13 at 4:20 PM, with RN #5 revealed she had cared for Resident #2. She stated the resident had a history of falls and he/she was admitted related to a hip fracture he/she had suffered prior to admission. RN #5 stated Resident #2 had an alarming self-release seat belt which he/she "fooled with a lot" and would get to the edge of the wheelchair seat where he/she would slide out of the chair. According to the RN, she was knew Resident #2 had experienced a fall in May 2013; however, didn't believe any new interventions were added to prevent further falls. She stated "we were just following through with our present interventions, nothing changed". The RN stated staff attempted

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F 323	<p>Continued From page 18</p> <p>to keep Resident #2 in the common area for observation; however, no one was assigned to only observe this area, staff had other duties and were busy.</p> <p>Interview, on 06/19/13 at 5:37 PM, with the Minimum Data Set (MDS) Nurse revealed no new interventions were added after the 05/24/13 fall as Resident #2 already had a bed alarm, chair alarm, perimeter mattress, self releasing seat belt with alarm. She stated Resident #2 had "pretty much" all interventions available and there was "only so much you can do". According to the MDS Nurse, the main thing was to try and occupy the resident.</p> <p>Review of the Comprehensive At Risk for Falls Care Plan, dated 03/06/13, revealed no documented evidence of any revisions to prevent further falls after the 05/24/13 fall.</p> <p>Review of the Incident Report, dated 06/01/13 revealed at 11:45 AM, Resident #2 experienced a fall when he/she went into another resident's room, shut the door, and ambulated independently. Review revealed the resident was found on his/her "bolton". Continued review revealed Resident #2 was assessed to have no injuries. Review revealed no documented evidence the resident's alarming seat belt had been on and was functioning properly and no indication if a chair alarm was in place and sounding. Further review of the Incident Report revealed a note which stated, "several hours later resident c/o (complained of) pain, order for x-ray, has right hip fx (fracture), sent to hospital".</p> <p>Review of the Nurse's Note, dated 06/01/13 at 12:57 PM, revealed Resident #2 was "found" on</p>	F 323			

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F 323	<p>Continued From page 19</p> <p>the floor of another's resident's room with the door closed. The nurse documented she assessed Resident #2 before staff assisted him/her back into the chair. Continued review revealed Resident #2's range of motion was within normal limits "for all extremities" and the resident had "no pain". Review revealed the nurse documented "no apparent injuries"; the Power of Attorney (POA) was notified; and a "non-urgent" fax was sent to the Primary Care Physician's (PCP) office.</p> <p>Review of a Nurse's Note, dated 06/01/13 at 3:09 PM, recorded by Registered Nurse (RN) #5, revealed Resident #2's daughter/POA came to visit and reported the resident was "expressing pain" in the right hip. The nurse documented Resident #2 was assessed by herself and another nurse and the resident expressed pain by "yelping out" when his/her leg was raised and lowered. RN #5 documented the resident had facial grimacing with the movement and an x-ray order was obtained.</p> <p>Review of a Nurse's Note, dated 06/01/13 at 3:48 PM, recorded by RN #1 revealed the PCP ordered the x-ray STAT (as soon as possible), the portable x-ray company was called and informed of the order. Review of the Physician's Order revealed an order dated 06/01/13 at 3:20 PM for an x-ray of the resident's right hip STAT.</p> <p>Review of a Nurse's Note recorded by RN #1, at 11:03 PM on 06/01/13, revealed the STAT x-ray had been obtained and revealed "an acute complete femoral neck fracture with complete displacement". The RN documented he contacted the PCP for orders regarding the x-ray results. RN #1 documented at 11:07 PM that</p>	F 323	

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F 323	<p>Continued From page 20</p> <p>Resident #2 was grimacing when his/her right leg was touched and he/she was having pain. RN #1 documented he informed the medication nurse of Resident #2's pain and the resident was to receive Percocet (a pain medication). Review of a Nurse's Note dated 06/01/13 at 11:11 PM revealed the PCP had ordered Resident #2 to be sent to the Emergency Room (ER) for evaluation. Review revealed the ambulance service was notified and Resident #2 was transported at 8:20 PM.</p> <p>Review of the Physician's Orders revealed an order dated 06/01/13 timed 7:15 PM, to send Resident #2 to the ER for evaluation. Further record review revealed a hospital Discharge Summary dated 06/05/13, that indicated Resident #2 was admitted to the hospital on 06/01/13 where surgery was performed to repair the resident's fractured hip. Further review revealed Resident #2 was to be discharged from the hospital that day and back to the facility.</p> <p>Interview, on 07/18/13 at 11:25 AM, with Nursing Assistant (NA) #1 revealed on 06/01/13 she came to work at 6:00 PM and Resident #2 was in bed and "looked like" he/she was "sick or something". She indicated the resident was not talking or responding to her questions which was a change for Resident #2. According to NA #1 the resident was to wear an alarming seat belt which was in place on 06/01/13.</p> <p>Interview, on 07/18/13 at 11:44 AM, with NA #3 revealed she had cared for Resident #2 on 06/01/13. She stated she had been on break and came back to the unit between 11:00 AM and 12:00 PM. NA #3 stated she was told Resident #2 had been found in another resident's room on</p>	F 323		

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NAME OF PROVIDER OR SUPPLIER CARMEL MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 100 CARMEL MANOR ROAD FORT THOMAS, KY 41075		
(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 21 the floor. The NA indicated when she went to the room where Resident #2 was on the floor, she could hear the "alarm going off". She stated the resident wasn't having pain when the nurse was moving his/her arms and legs and inquiring of Resident #2 if she had pain. NA #3 reported she and other staff "got" the resident back up and into his/her wheelchair and took Resident #2 to lunch. She stated she didn't think Resident #2 "ate much". According to NA #3, Resident #2 had probably been wandering up and down the hall as he/she always did. She stated Resident #2 had periods of "antsiness" and was always moving around in his/her wheelchair. The NA stated staff "tried" to keep him/her up by the nurse's station. interview, on 07/18/13 at 4:16 PM, with RN #1 revealed he had cared for Resident #2 before. He stated he usually came to work at 3:00 PM. The RN indicated when he came to work on 06/01/13 he came into a "mess". He stated he thought he was told by the nurses on duty that Resident #2 had fallen about 12:30 PM that day and the Charge Nurse had assessed him/her and "it didn't look like anything was broken". According to the RN, two (2) other nurses (RN #5 and the wound nurse) told him they thought Resident #2's hip was broken and the Charge Nurse "refused to get an x-ray". RN #1 stated he immediately notified the PCP and obtained an order for an x-ray which was obtained and showed Resident #2 had a right femoral neck fracture. interview, on 07/19/13 at 4:20 PM, with RN #5 revealed she had worked on 06/01/13 passing medications; however, was not made aware Resident #2 had fallen until approximately 2:15 PM when Resident #2's daughter/POA came to	F 323			

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

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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 07/19/2013
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 22</p> <p>her and asked her to "check" the resident's right leg. She stated the daughter/POA stated she knew Resident #2 had fallen as someone had called her and informed her of this. The RN stated the daughter/POA told her Resident #2 was in pain and so she obtained pain medication for the resident and administered it. RN #5 stated when she assessed Resident #2's right leg the resident stated "oh, oh" as if in pain. The RN indicated she informed RN #1 as soon as he came in at 3:00 PM and he got an order for an x-ray. RN #5 reported she asked the Charge Nurse how the fall had occurred and was told by her that she (Charge Nurse) guessed the resident "just got away" from staff. The RN stated she was sure "everyone had a reason they weren't watching" the resident at the time of the fall. She stated Resident #2 was constantly taking the self release alarming seat belt off and it would sound. RN #5 stated staff just got "used to it going off, like with the little boy who cried wolf" and didn't respond as promptly as they should have she guessed. The RN stated she thought it would have been good if they could have had increased supervision of the resident and that might have prevented the fall on 06/01/13.</p> <p>Interview, on 06/19/13 at 3:50 PM, with the Unit Manager who was the acting Director of Nursing (DON) revealed falls were reviewed daily Monday through Friday in a morning meeting and a meeting was also held every Tuesday to discuss any falls that had occurred. She stated if a resident experienced two (2) falls they were added to the Falls Committee for follow up; however, all falls were discussed at the Falls Committee meetings weekly to attempt to determine the root cause of the fall. She stated Resident #2's fall on 05/24/13 occurred on a</p>	F 323		

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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 07/19/2013
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NAME OF PROVIDER OR SUPPLIER CARMEL MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 100 CARMEL MANOR ROAD FORT THOMAS, KY 41075
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(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
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F 323	Continued From page 23 Friday and it was discussed in the Monday morning meeting and in the Tuesday Falls Committee meeting. She stated the root cause of Resident #2's fall on 05/24/13 was "dead batteries" in the chair alarm which were replaced. According to the acting DON, had the chair alarm batteries been working, the alarm would have sounded and staff would have been able to get to the resident to prevent the fall. Additional interview, on 07/19/13 at 5:08 PM, with the acting DON revealed Resident #2 was taken out of the Falls Committee in February or March 2013 by the DON as he/she had been free of falls for a while.	F 323		
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*Acceptance ROC
8/21/13 date
FDR
+ Lewis
Alper*

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 07/16/2013
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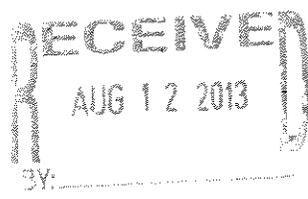
NAME OF PROVIDER OR SUPPLIER CARMEL MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 100 CARMEL MANOR ROAD FORT THOMAS, KY 41075
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 000 INITIAL COMMENTS K 000

CFR: 42 CFR 483.70(a)
BUILDING: 01
PLAN APPROVAL: 08/09/89
SURVEY UNDER: NFPA 101 2000 Existing
FACILITY TYPE: SNF/NF
TYPE OF STRUCTURE: Two stories w/lt basement Type III (211)
SMOKE COMPARTMENTS: 4
FIRE ALARM: Complete fire alarm system
SPRINKLER SYSTEM: Complete (wet and dry) sprinkler system
GENERATOR: One Type II Diesel generator.

A standard Life Safety Code survey was conducted on 07/16/13. Carmel Manor was found to be in compliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire) the facility is licensed for sixty-five (65) beds with a census of sixty (60) on the day of the survey.



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Sister Teresa Kennedy* TITLE *Administrator* (X6) DATE *08-12-13*

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: 10/17/2013
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 R 10/16/2013
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 000}	INITIAL COMMENTS An on-site revisit survey was initiated on 10/15/13/ and concluded on 10/16/13. Based on the acceptable POC, the facility was found to be in compliance as of 08/24/13 as alleged.	{F 000}			
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.