

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

PRINTED: 06/09/2015
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 05/22/2015
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 314	Continued From page 73 and the Physician should be notified. He stated it was his expectation that the skin assessments be completed weekly. He further stated the care plan should be revised with each new skin issue and also as the wound worsened and changed, the care plan should be revised to indicate the stage for Pressure Ulcers. Continued interview revealed this revision of the care plan would be the responsibility of the MDS nurses as they received copies of Physician's Orders for the areas of skin breakdown. The DON further stated the care plan should be followed related to skin issues and if new skin breakdown was noted the Physician should be notified as per the Care Plan. Continued interview with the DON, revealed they were in the middle of a Performance Improvement Plan (PIP) which was started about three (3) weeks ago and headed up by RN #2 because they had recognized there was problems with Pressure Ulcers, notification and documentation. However, he further stated, there was no recent inservices or education done with the nursing staff.	F 314			
F 323 88-G	463.25(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, Interview, record review	F 323	1) For Resident #2 LPN #1 was counseled on 11/13/14 related to accident, by Director of Nursing and Unit Manager. CNA #2 was counseled and terminated on 11/13/14 by DON and Unit Manager. A different bed was obtained on 11/13/14 that did not include the side rail pin, and a new Geri-chair was ordered after Therapy recommendation for proper size on 11/19/14. 2) Any resident that utilizes the hooyer lift for transfer will have seating device evaluated by therapy personal by 6/19/15	7/6/15	

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F 323 Continued From page 74
and review of the facility's policy and Incident/Accident Report, it was determined the facility failed to ensure each resident received adequate supervision and assistive devices to prevent accidents for one (1) of fifteen (15) sampled residents (Resident #2).

Resident #2 was assessed by the facility to require total assistance of two (2) persons for transfers per the Minimum Data Set (MDS) Assessment dated 10/15/14. According to the Comprehensive Care Plan dated 04/17/14, Resident #2 was to be transferred with a Hoyer lift for all transfers. However, on 11/12/14, Resident #2 was not transferred, as per the care plan, and was transferred with a stand and pivot transfer with two (2) staff and a gait belt. Resident #2's leg got caught during the transfer on the side rail button which raised the side rails up and down and the resident sustained a large deep laceration to the left leg and also sustained a skin tear to the left shin. Resident #2 had to be sent to the hospital emergency room (ER) as a result and received eighteen (18) staples to the lacerated area.

The findings include:

Review of the facility's policy titled, "Incident/Accident", undated, revealed incidents and accidents were to be reported immediately to the Charge Nurse, and the Physician was to be notified in a timely manner. Per the Policy, the nursing notes should include interventions to prevent re-occurrence.

Review of Resident #2's medical record revealed the facility admitted the resident on 04/10/12, with diagnoses which included Alzheimer's Disease,

F 323 for proper fit and ability to manipulate Hoyer lift pad as needed easily.

3) LPN #1 rein-serviced on following resident care plan as written, and procedure to follow if unable to follow care plan as written by Director of Nursing by 6/19/15. All nursing staff educated to following resident care plan as written and procedure to follow if unable to follow care plan, by DON, Unit Manager and MDS Nurse by 7/1/15

4) Policy and procedure related to proper procedure in following resident care plan was reviewed and revised, as needed, per DON by 6/19/15.

5) QI monitor relative to following resident Care Plan relative to transfers will be developed by DON and will be initiated by 7/2/15. To be completed by DON, Unit Manager, MDS nurse(s), computer nurse, nursing QA staff, or designated charge nurse. To be completed weekly x 4 weeks, every other week x 8 weeks and monthly x 6 months, then quarterly. The Director of Nursing will review all QI monitors relative to following resident Care Plan relative to transfers to assure compliance and forward to the Quality Assurance Director for tracking and trending. All results will be reviewed at the monthly Quality Assurance Committee Meeting.

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F 323 Continued From page 75

Muscle Disuse Atrophy and Arthritis. Review of the Fall Assessment Tool and Guidelines for Use, dated 07/16/14, revealed Resident #2's risk factors for falls included: over the age of eight (80); having confusion at all times; and requiring assistance with elimination. Continued review of the Assessment Tool revealed Resident #2 was not assessed to be at risk for falls as a score of ten (10) or above placed residents at risk for falls, and the resident scored nine (9).

Review of the Quarterly MDS Assessment dated 10/15/14, revealed the facility assessed Resident #2 as having both short term and long term memory loss. Further review revealed the facility assessed the resident as requiring total assistance of two (2) for bed mobility and transfers, and as ambulation not occurring.

Review of Resident #2's Comprehensive Care Plan of Care, dated 04/17/14, revealed the resident was at risk for falls related to: requiring total care; having contractures; receiving Coloxa (an antidepressant medication); unable to make needs known; and was unable to sit or stand unsupported. Continued review of the risk for falls care plan revealed interventions which included: repositioning the resident as needed; get-in-chair when up and out of bed for proper positioning; and Hoyer lift for all transfers.

Review of the facility's Incident/Accident Report, dated 11/12/14, revealed on 11/12/14 at 7:30 PM two (2) staff were transferring Resident #2 to bed without the use of the Hoyer lift. The Incident/Accident Report revealed during the transfer Resident #2 sustained a large deep skin tear to the lower left leg calf muscle and a small skin tear to the left shin. Per the Report, the

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F 323 Continued From page 76

section labeled "additional comments" revealed the Certified Nursing Assistants (CNAs) needed to use the Hoyer lift as per the Plan of Care.

Review of the Clinical Notes Report dated 11/13/14 at 1:59 AM, completed by Registered Nurse (RN) #1, revealed an event occurred on 11/12/14 at 7:30 PM, when two (2) "nurse aides" went to transfer Resident #2 from the geri-chair to bed. Per the Note, Resident #2 was to have the Hoyer lift used for all transfers per the Plan of Care, but the Hoyer lift was not used for this transfer. Continued review revealed during the transfer Resident #2's lower leg got caught on the button which lowered the bed's side rail and the resident sustained a large laceration/deep tissue injury. The Note revealed the large laceration/deep tissue injury was on Resident #2's lower calf muscle, left leg lateral side ventral surface and measured approximately five (5) inches long and one and a half (1.5) inches deep. Further review revealed the wound was packed with Normal Saline (N/S) soaked 4 x 4 sterile gauze, two (2) dry 4 x 4 gauze to cover the wound and then wrapped in roll gauze. In addition, review revealed Resident #2 also received a small skin tear approximately two (2) inches below the other wound on the medial surface of the left shin which was approximately two (2) inches long and steri-strips were applied after cleansing with N/S. Review of the Clinical Note Report dated 11/13/14 at 2:09 AM, revealed the Administrator on duty, the Physician and Resident #2's Power of Attorney (POA) were notified and the resident was transferred to the hospital ER at 8:50 PM.

Review of the Hospital ER Notes and Discharge Instructions, dated 11/13/14, revealed Resident

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F 323 Continued From page 77

#2 arrived in the ER at 9:03 PM, and was diagnosed with a large full skin thickness laceration involving the lateral aspect of his/her proximal calf, left leg which measured eleven (11) centimeters (cms) in length. Per the ER Notes, the laceration was closed with staples and the wound area "dressed" with a sterile dressing. Continued review of the Notes revealed Resident #2 was given a tetanus immunization prior to discharge. Review of the Discharge Instructions revealed the instructions included: clean wound twice a day and apply Polysporin (an antibiotic ointment); dressing change as needed; keep wound clean and dry; watch for signs and symptoms of infection including redness, swelling or drainage; Tylenol (pain medication) for pain; and return as needed.

Further review of Resident #2's medical record Clinical Note Report dated 11/13/14 at 2:15 PM, for the "event" which occurred on 11/12/14, revealed a nurse from the ER called at 9:55 PM on 11/12/14, and reported Resident #2 had received eighteen (18) staples to the left lower leg and was given a tetanus shot. Further review of the Clinical Note Report revealed Resident #2 arrived back at facility without incident on 11/12/14, at 10:40 PM.

Interview was attempted on 05/20/15 at 11:30 AM with Resident #2 without success.

Interview, on 05/22/15 at 10:30 AM and 2:30 PM, with Licensed Practical Nurse (LPN) #1, revealed she was still a CNA back on 11/12/14, and was assigned to Resident #2. Continued interview revealed on 11/12/14, she and another CNA, who no longer worked at the facility, were going to transfer Resident #2 from the geri-chair to the

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F 323 Continued From page 78
bed and were aware the resident's CNA Care Plan stated he/she was to be transferred per the Hoyer Lift. LPN #1 stated however, the Hoyer lift pad under Resident #2 was not positioned correctly in order for them to use the Hoyer Mt. She stated they attempted to adjust the lift pad; however, the resident fit too snug in the geri-chair and they were unable to reposition the pad by repositioning the resident and his/her legs. Per interview, they tried to hook up the Hoyer lift to the pad under the resident; however, were unable to do so as it would not reach the way the pad was positioned. LPN #1 stated they then pushed the Hoyer lift out of the way, and attempted to do a two (2) person transfer using a gait belt with their arms under Resident #2's arms. She stated Resident #2 could bear some weight because the resident used to use the Sara Lift (standing and raising aid); however, they had never transferred the resident with a stand and pivot of two (2) staff before. Further interview revealed the two (2) CNAs positioned the geri-chair at the end of the bed facing the head of the bed and stood Resident #2 first to see how he/she would do. LPN #1 revealed Resident #2 stood with no problems so they started pivoting him/her, and the resident's leg got caught on the push button which dropped the side rail. Per LPN #1, Resident #2 sustained a laceration to the leg during the pivot because the push button was sticking out, but there was nothing wrong with the bed or how it functioned. Observation, during the interview, with LPN #1 revealed the type of bed Resident #2 used on 11/14/15, had side rails that when lowered, needed to be pushed in towards the bed in order for the push button (a rectangle shaped device) to recess. LPN #1 revealed she and CNA #1 might not have had the side rail pushed in all the way prior to the transfer causing

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F 323 : Continued From page 79
the push button to stay out.

F 323

Phone interview with RN #1 on 05/22/15 at 11:30 AM, revealed Resident #2's leg was caught during an improper transfer and the resident sustained a large laceration to the leg. Continued interview revealed the CNAs had tried to do a two (2) person transfer instead of using the Hoyer lift, as per the care plan, and Resident #2 sustained a laceration to the leg as a result. RN #1 revealed Resident #2 was lying on the bed when he entered the room and assessed the resident and situation, noting the laceration was too deep to treat at the facility. Per interview, he remembered packing the wound and sending Resident #2 to the ER. Further interview revealed if the CNAs were unable to get the lift pad under Resident #2 properly, they should have informed him in order for him to provide additional instructions.

Phone interview was attempted with CNA #1 on 05/22/15 at 2:30 PM; however, was unsuccessful and the CNA was never reached.

Interview, on 05/22/15 at 2:50 PM, with the Unit Manager (UM) and the DON, revealed on hire all staff was inserviced related to transfer techniques for residents, as well as, following the care plan. He stated the Staff Development Nurse (SDN) was off on leave and unable to be reached for interview at the time. The DON revealed when the CNAs could not reposition the Hoyer lift pad under Resident #2 in order to use the lift, they should have asked for assistance from the nurse, so the nurse could assess the situation and find the best way to transfer the resident. He stated no other resident had ever gotten injured on the beds and Resident #2 would not have been, had the CNAs transferred the resident with the Hoyer

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F 323	Continued From page 80 lift as per the care plan. Per the UM, LPN #1 was counseled and educated related to the incident, and CNA #1 was terminated after the incident. Interview with the Administrator on 05/22/15 at 12:00 PM, revealed Resident #2 sustained a laceration due to an improper transfer technique because the resident's care plan was not followed by the CNAs.	F 323		
F 371 SS-F	483.35(j) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY 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 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility's policy, it was determined the facility failed to ensure food was stored, prepared, and distributed under sanitary conditions. Observation on 05/19/15 and 05/20/15 revealed the pantry and the kitchen had foods on shelves, and in the refrigerators/freezers which had been opened with no open dates and some foods had no labels. In addition, there was food which were not sealed tightly in the pantry refrigerator, on the	F 371	1) All food products which were not labeled, not dated, and improperly wrapped were discarded immediately 5/19/15. 2) All Dietary staff were in-serviced on: a) Labeling and dating all food products. b) Proper hand hygiene and glove usage. c) Cleaning schedule and verification of completion by the Director of Food Service and the Dietary Supervisor on 5/20/15, 5/21/15, 6/2/15 and 6/3/15. 3) Policies related to: a) Labeling and dating food products. b) Proper glove usage. c) Bread service were reviewed, updated or established, as well as, a Food Storage Timeline Chart by 6/11/15. 4) All Dietary staff were in-serviced regarding: a) Food Storage Timeline Chart b) Policy on Labeling and Dating c) Policy on Proper Glove Usage	7/6/15

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F 371	Continued From page 81 pantry shelf, and in the dried storage. There was soiled potholders and dishtowels stored in a drawer in the pantry. The pantry microwave was soiled with food particles. The pantry freezer had dried spills. Spices on the shelf in the kitchen and ready for use, had an open date of over a year ago, and interview revealed the spices lost their flavor after a year. Further observation on 05/20/15 of the supper tray line, revealed two (2) cooks were using gloved hands to obtain bread out of a bag and plating food with the same gloved hands. The findings include: Review of facility "Storage" Dietary/Nursing, undated, revealed air space around foods in refrigerator and freezer storage needed to be considered for air circulation. Keep foods in leak proof, non absorbant, sanitary wrappings, thermometer to be permanently displayed in each refrigerator and freezer, and after opening juices, they were to be labeled as to contents and dated. Review of the facility policy "Cleaning/Sanitation Care of Dietary Equipment", undated, revealed a properly scheduled and carefully monitored program of equipment care and cleaning ensured adequate sanitation and maintenance of the dietary department. The Dietary Director must review all end of shift cleaning lists and daily cleaning lists for completion. All equipment was to be cleaned after each use. Review of the Daily Cleaning List, undated, revealed the inside and outside of cabinets/refrigerators was to be cleaned out on Wednesdays and Thursdays.	F 371	d) Policy on Bread Service on 6/11/15, 6/12/15, and 6/15/15 through 6/19/15 by the Director of Food Service, Dietary Supervisor and/or the Cook/Supervisor. 5) Quality Assurance Audits for: a) Proper hand hygiene b) Proper glove usage c) Labeling and dating food products. d) Bread service were established and implemented and are being completed beginning on 6/15/15 daily by the Director of Food Service, Dietary Supervisor, Dietician, and/or the Cook/Supervisor for a period of two months, then 3 times per week for two months, and then completed at least twice weekly from then on. All monitors will be forwarded to the Quality Assurance Director for tracking and trending. All results will be reviewed at the monthly Quality Assurance Committee Meeting.		

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F 371 Continued From page 82
A Policy related to labeling, dating, and storage of food products was requested; however, not received.

Review of an inservice related to labeling, dating and storage of food products and cleaning and proper hand hygiene dated 05/20/15 and 05/21/15 during the survey was provided for review. According to the inservice, all foods were to be dated upon receiving, date opened, date pulled from freezer, use by date/expiration date, and all food products would be labeled as to what the item was. Further review, revealed all opened foods would be completely wrapped and resealed for re-storage with proper labeling and dating. Further review revealed all cleaning would be done according to policy and cleaning list. Continued review revealed staff were to use proper hand hygiene with handwashing and usage of gloves, and other areas covered included preventing cross contamination and proper handling of read to eat food.

Observation on 05/19/15 at 6:05 AM, of initial tour with the Dietary Manager (DM) revealed the pantry area had a drawer containing soiled potholders and soiled dishtowels, and a container with a brown substance with no label or date on a shelf. Further observation revealed there were seven (7) containers of pudding which were wrapped with no label or date, and five (5) pieces of pie which were wrapped with no label or date on a shelf. The DM stated the pot holders and dish towels should not have been stored soiled and the food was to be labeled and dated. The microwave was noted to have food particles inside. The DM stated the microwave was to be cleaned after each meal.

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F 371 Continued From page 83

Continued observation with the Dietary Director (DD) of the pantry refrigerator revealed a bag of shredded cheese which was not sealed, a bottle of prune juice which was open with no open date, seven (7) jello cups not labeled or dated, and pitchers of apple juice, cranberry juice and tomato juice with no label or date. There was also a package of Swiss cheese which was opened with an open date of 04/15/15, and a package of Honey Ham which was open with no open date. The DD, stated he was unsure how long the Swiss cheese was good for after it was opened and the Honey Ham should have had an open date and would need to be discarded. The freezer was noted to have dried spills and the DD stated the freezer needed to be wiped out.

Observation of the kitchen which was across the hall from the pantry, revealed an opened box of Gelatin Dessert with an open date of 03/02/15 in the cabinet. The DD stated the Gelatin Dessert was good for a month after opened, and needed to be discarded. There was a pan of cookies which were half wrapped with no date or label and the DD stated the cookies should have been wrapped, dated and labeled. There was a bag of cereal which was not labeled or dated on the counter which the DD said was used for the residents snacks and should have been labeled and dated. Observation of the spices revealed there was a container of Thyme with an open date of 04/02/12, a container of Ground White Pepper with an open date of 09/07/12, and a container of Chicken Spice with an open date of 02/21/14. Continue interview revealed the spices did not expire but may lose their flavor after a year, and he discarded the spices.

Observation of the walk in kitchen refrigerator

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135208	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/22/2015
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 (EXCEPT 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) COMPLETE/IN CARE	
F 371	Continued From page 84 revealed there were five (5) bologna and cheese sandwiches dated 05/15/15 and he thought the sandwiches were good for seven (7) days, and would need to check. Also, it was noted the thermometer was not working and the DD took a temperature with an infrared thermometer revealing a temperature of 33.1 degrees Fahrenheit (within normal limits). Observation of the kitchen freezer revealed there were four (4) angel food cakes with no date of expiration or date of receipt of the food. In addition, observation revealed there were boxes stacked almost to the ceiling and the DD stated it looked as though the boxes were two (2) to three (3) inches from the ceiling and should be at least six (6) inches from the ceiling for air circulation. Observation on 05/20/15 at 9:15 AM of the dry storage with the DD, revealed there was a bag of noodles on a shelf not sealed, a bag of split peas sealed with a tie with no open date, and a bag of powdered milk which was loosely covered with plastic wrap and the powdered milk was spilling out on to the shelf. Further interview on 05/20/15 at 9:40 AM with the DD, revealed all food should be dated as received, and left over food should have the production date or date the food was prepared and the food was good for three (3) days, if mayonnaise based and seven (7) days if not mayonnaise based. He further stated any food which had been opened should have an open date and all food should have a label. The DD revealed it was the responsibility of the staff working with the food to label and date the food. He stated each refrigerator and freezer should have a working thermometer. Continued	F 371			

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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 371	Continued From page 85 interview revealed the person receiving the new food should clean the refrigerator and freezer checking for expiration dates and ensure food was labeled at least two (2) times a week which was usually the prep person. He further stated the refrigerators and freezers should have been cleaned yesterday and his people did not do what they were supposed to do. The DD stated the pantry was to be cleaned daily by the dietary aide, and the microwaves were to be cleaned after each meal by the dietary aides. Observation on 05/20/15 starting at 5:05 PM of the supper tray line, revealed two (2) cooks were using gloved hands to get bread out of a bag and plating food with the same gloved hands. Interview with the DD on 05/20/15 at 8:20 PM, revealed he saw the cooks use the gloved hands to obtain the bread and they should have used longa.	F 371			
F 431 SS-D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 431	1) Identified undated vials were dated/discarded, as needed, by charge nurse on 5/19/15. 2) All other multiuse vials were reviewed for proper dating. Any vials found undated were dated/disposed of by charge nurses on 5/19/15. 3) All nurses educated to proper storage and dating of multi-dose vials by DON, Unit Manager, MDS nurse by 7/1/15. 4) Policy and procedure on proper storage and dating of multi-dose vials was reviewed and revised, as needed, per DON by 6/19/15. 5) QI monitor relative to proper storage	7/6/15	

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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)	(X5) PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
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F 431 Continued From page 86

In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1970 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

This REQUIREMENT is not met as evidenced by:
Based on observation and interviews regarding the storage of medication in the medication refrigerator, it was determined the facility failed to ensure proper storage of drugs and biologicals.

Observation revealed three (3) multi-use vials stored in the medication refrigerator which had not been labeled with the date and time the vials were opened. Additionally, one (1) of the vials had expired 03/16/15; however, was still available for use.

The findings include:

Review of the facility's policy titled, "Pharmacy Policy for Storage of Medications", effective date

F 431

and dating of multi-dose vials developed by DON and initiated by 7/2/15. To be completed by DON, Unit Manager, MDS nurse(s), computer nurse, nursing QA staff, or designated charge nurse. To be completed weekly x 4 weeks, every other week x 8 weeks, monthly x 6 months, then quarterly. The Director of Nursing will review all QI monitors relative to proper storage and dating of multi-dose vials to assure compliance and forward to the Quality Assurance Director for tracking and trending. All results will be reviewed at the monthly Quality Assurance Committee Meeting.

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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)	LSC COMPLETION DATE
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F 431 Continued from page 87

00/14/07, revealed the purpose of the policy was to provide guidelines for the storage of medications per federal, state, and local regulations. The Policy revealed periodically the medicine should be reviewed and all "soon to expire" medications should be removed and reordered if deemed necessary.

Observations conducted on 05/19/15 at 8:00 AM of the locked medication refrigerator in the medication room revealed three (3) Purified Protein Derivative (PPD) vials which had been opened; however, the multi-use vials had not been labeled with the date and time of when the vials had been opened. Continued observation revealed one (1) of the vials had expired on 03/16/15.

Interview with Registered Nurse (RN) #6 on 05/19/15 at 9:10 AM, revealed it was the standard practice of the facility to label and date any medication vial when it was opened. RN #6 revealed she did not know why the vials were not labeled with the date and time of when the vials were opened, or why an expired medication vial was still in the refrigerator.

Interview with the Unit Coordinator of the Long Term Care Unit on 05/22/15 at 6:50 PM, revealed it was her expectation all nurses at the facility properly label a multi-use medication vial with the date and time the medication vial was opened.

Interview with the Director of Nursing (DON) on 05/22/15 at 7:00 PM, revealed she did monthly random checks of the medical equipment and medication supplies. Per interview, the DON was not aware of the expired medication or undated and untimed medications being in the medication

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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)	DATE COMPLETION DATE
F 431	Continued From page 88 refrigerator. The DON revealed not remembering when the last time was the medication refrigerator had last been checked, but audits were performed at least once a month.	F 431		
F 441 SS-D	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 The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility, (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens	F 441	1) Whirlpool tub disinfected by housekeeping staff using disinfectant manufacturers specifications on 5/21/15 and continued daily. (Resident #3 sacral wound was monitored for signs/symptoms of infection beginning 5/21/15). 2) All tubs in common bathing areas cleaned by housekeeping staff using disinfectants manufactures specification on 5/21/15 and continued daily afterwards. LPN #2 and RN #2 were re-educated regarding proper handwashing technique during and after contact with wound per DON by 5/22/15. 3) LPN #2 and RN #2 re-educated regarding handwashing technique during and after contact with a wound by DON by 5/22/15. All nurses educated on proper handwashing technique during and after contact with a wound by DON, Unit Manager, MDS nurse by 7/1/15. All nursing staff and housekeeping staff in-serviced on proper disinfecting technique for public tubs per Housekeeping Director, Maintenance Director, DON, Unit Manager or MDS nurse by 7/1/15. 4) Policy and procedure for tub disinfecting reviewed, revised by Administration by 6/19/15. Policy and	7/6/15

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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 441 Continued from page 09
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

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 have an effective Infection Control Program that ensured the facility's whirlpool (w/p) tubs were disinfected between resident uses, for two (2) unsampled residents (Unsampled Residents A and B). In addition, the facility failed to ensure all nursing staff performed skin assessments and dressing changes while adhering to proper infection control procedures, for one (1) of fifteen (15) sampled residents (Resident #3).

Observation on 05/20/15 revealed a w/p tub was being used for resident baths in the facility. However, staff interviews revealed they were not knowledgeable regarding the proper procedure for disinfecting the w/p system according to the manufacturer's recommendations.

Observation on 05/20/15 revealed the nurse completed a skin assessment and dressing changes for Resident #3 without proper handwashing and changing of gloves between tasks.

The findings include:

Review of the facility's "Infection Control" Policy.

F 441 procedure for infection control technique related to handwashing during wound care reviewed and revised by DON by 6/19/15. QI monitor for disinfecting tub developed by Administration and initiated by 7/2/15. To be completed by Environmental Services Director, Maintenance Director, DON, Unit Manager, MDS nurse(s), computer nurse, nursing QA nurse, or designated charge nurse. Handwashing with wound care QI monitor developed by DON and initiated by 7/2/15. To be completed by DON, Unit Manager, MDS nurse(s), computer nurse, nursing QI staff, or designated charge nurse. Both QI monitors to be completed weekly x 4 weeks, every other week x 8 weeks, monthly x 6 months, then quarterly.

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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 441	<p>Continued From page 90</p> <p>undated, revealed the infection prevention/control program was created through education, prevention, surveillance, investigation, identification, control and reporting of organisms, and was based on standard and transmission-based precautions as well as the assurance of proper hand hygiene.</p> <p>1. Review of the Disinfection System Procedure for the facility's w/p system, undated, revealed staff were to complete the following steps to disinfect the w/p tub after each use: recline the tub with the door closed; put the plug in the drain; place the turn key valve on disinfection and turn on the disinfectant; spray down the inside of the tub thoroughly with the red disinfectant hose and wand; spray down any cushions or accessories that were used in the bath; and place the disinfection wand over each of the air jets and spray thoroughly to inhibit residue buildup. Continued review revealed staff should allow the disinfectant solution to remain on the surface for the time indicated on the manufacturer's instructions found on the container's label prior to rinsing.</p> <p>Review of the Meriz Plus Germicidal Solution label revealed it should be allowed to remain wet on the surface to be cleaned for thirty (30) seconds to remove any gross filth or heavy soil. Continued review revealed to ensure disinfection, the solution should be allowed to remain wet on the surface for six (6) minutes prior to removing or letting the solution air dry.</p> <p>Interview with CNA #4, on 05/20/15 at 4:45 PM, revealed she was aware of only one (1) resident who took w/p baths (Unsampled Resident A). She stated she could not recall being trained on</p>	F 441		
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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 441	<p>Continued From page 91</p> <p>cleaning and disinfecting the w/p. Continued interview revealed she was not sure of the disinfectant used, but knew she sprayed a disinfectant in the tub. She reported she was not certain how the jets were cleaned. She further stated it was important to correctly disinfect the whirlpool between residents to prevent cross-contamination.</p> <p>Interview with CNA #5, on 05/20/15 at 5:00 PM, revealed she was not certain of the disinfectant that was used to clean the whirlpool. She stated in order to clean the jets within the whirlpool, she would observe the whirlpool to see if there was any mold or mildew built up in the jets, and if so, she would leave a note for housekeeping to clean it as they had better cleaning solutions than the CNAs did. Continued interview revealed CNA #5 stated it was important to clean the w/p tub effectively to prevent infection.</p> <p>Interview with CNA #6, on 05/20/15 at 4:40 PM, reported she used the w/p with Unsampled Resident A. She reported the resident used the w/p twice weekly. CNA #6 stated she thought housekeeping kept the disinfectant used to clean out the w/p. CNA #6 demonstrated cleaning out the whirlpool by spraying the tub down with the disinfect, then spraying it down with water, without allowing the disinfectant to remain on the surface for six (6) minutes. She further stated she was not certain how the jets in the w/p were cleaned, but believed housekeeping did it.</p> <p>Interview with CNA #7, on 05/20/15 at 9:30 AM, revealed she used the w/p for Unsampled Residents A and B. She reported she was not aware of any other residents who used the w/p. She stated she cleaned the w/p by spraying the</p>	F 441		
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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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disinfectant in the tub. She further stated she used a clean cloth to wipe the tub down. CNA #7 was not aware of how long the disinfectant was to remain on the surface before wiping. Continued interview revealed she was not certain how the jets in the tub should be cleaned.

Interview with Housekeeper #1, on 05/20/15 at 9:36 AM, revealed the disinfectant used for the w/p was "Meritz Plus". She stated staff sprayed it in the tub, rinsed it, and washed it really good. Continued interview revealed she stuck her finger in the jets to clean them out. She further stated housekeeping staff was responsible for changing out the disinfectant and should alert the housekeeping supervisor if it got low.

Interview with Registered Nurse (RN) #1, on 05/20/15 at approximately 6:30 PM, revealed he was familiar with Unsampled Resident A who took w/p baths. He reported he was not certain how to clean the w/p and stated the CNAs did that. RN #1 further stated it was important the w/p was cleaned effectively to prevent any cross-contamination or infection control concerns.

Interview with the Maintenance Director, on 05/20/15 at 10:00 AM, revealed the maintenance department was not responsible for the cleaning of the w/p tubs, or the distribution of the disinfectant. He stated housekeeping staff cleaned the whirlpool, and it was the responsibility of nursing to ensure the w/p was cleaned after each resident use.

Interview with the Housekeeping Supervisor, on 05/22/15 at approximately 11:30 AM, revealed she was aware of the proper procedure for cleaning the w/p system. However, based on

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NAME OF PROVIDER OR SUPPLIER CARMEL MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 199 CARMEL MANOR ROAD FORT THOMAS, KY 41075
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F 441 | Continued From page 93

staff demonstrations of the process, she stated the w/p was not being disinfected correctly. Continued interview revealed the staff needed further education on the procedure.

Interview with the Unit Manager and the Director of Nursing (DON), on 05/22/15 at 5:15 PM, revealed the Education Director trained staff on how to clean the w/p when they were first hired. The Unit Manager reported the housekeeping staff was responsible for cleaning the tubs. Continued interview with the Unit Manager and the DON revealed they acknowledged staff needed re-education to ensure the w/p tubs were cleaned and disinfected properly, to prevent concerns related to infection control.

2. Review of Resident #3's medical record revealed diagnoses which included Dementia with Behavioral Disturbance, Peripheral Vascular Disease, and a History of Pressure Ulcers. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 03/02/15, revealed the facility assessed Resident #3 to have a Brief Interview for Mental Status (BIMS) score of fourteen (14), which indicated the resident was cognitively intact.

Observation of a skin assessment and dressing changes for Resident #3, on 05/20/15 from 2:45 PM until 4:00 PM, revealed Licensed Practical Nurse (LPN) #2/Wound Nurse removed the resident's sacral dressing, washed her hands and applied clean gloves. She measured the wound, applied Santyl to the wound bed, and placed a 2 x 2 gauze dressing to the wound bed. Without changing her gloves or washing her hands, LPN #2 picked up the spray bottle of Wound Barrier, sprayed the wound, and stated the Wound Barrier

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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 441	<p>Continued From page 94</p> <p>would be placed back into the treatment cart.</p> <p>Interview with LPN #2, on 05/20/15 at 4:10 PM, revealed she was unsure if she had washed her hands after measuring the wound to the sacral area. Continued interview revealed LPN #2 stated she should have removed the soiled gloves and washed her hands after measuring the wound and before handling the Wound Barrier spray.</p> <p>Subsequent observation, on 05/20/15 at 4:50 PM, revealed RN #2/Wound Nurse entered the room to assess Resident #3's right heel. RN #2 measured the wound, removed her gloves, and exited the room without washing her hands and proceeded to the nurses' station before washing her hands.</p> <p>Interview with RN #2, on 05/20/15 immediately after the observation, revealed she did not touch anything with her hands after assessing and measuring Resident #3's heel wound, but used her elbow to open doors to the resident's room and the nurses station bathroom. Continued interview revealed she did handle the faucet in the nurse's station bathroom with her soiled hands. She stated she did not wash her hands in the resident's bathroom because there was other staff in the same bathroom washing their hands.</p> <p>Interview with the DON, on 05/22/15 at 6:00 PM, revealed staff should wash their hands after treating a wound, and before handling containers which would go back into the treatment cart, such as the Wound Barrier spray. Further interview revealed staff should wash their hands after providing any care, including a skin assessment, and prior to exiting the room.</p>	F 441			

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

PRINTED: 06/08/2015
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 05/22/2015
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NAME OF PROVIDER (X) 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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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/08/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185208	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 05/19/2015
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
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K 000	INITIAL COMMENTS	K 000		
	<p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1989</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: Two (2) story with a basement Type III (211)</p> <p>SMOKE COMPARTMENTS: Three (3) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with one hundred and forty-two (142) heat and sixty (60) smoke detectors</p> <p>SPRINKLER SYSTEM: Complete automatic wet and dry sprinkler system.</p> <p>GENERATOR: Type II generator. Fuel source is diesel.</p> <p>A Standard Life Safety Code Survey, using a 2786S Short Form, was conducted on 05/19/15. The facility was found to be in compliance with Title 42, Code of Federal Regulations, 483.70(a) et seq., Life Safety from Fire, the requirements for participation in Medicare and Medicaid. The facility is certified for sixty-five (65) beds with a census of sixty (60) on the day of the survey.</p>			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Sister Marie Mack* TITLE: *Administrator* (X6) DATE: *06-16-2015*

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.