

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155181	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/12/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CARMEL HEALTH & LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 118 MEDICAL DR CARMEL, IN 46032
--	---

(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
F000000	<p>This visit was for the Recertification and State Licensure Survey.</p> <p>Survey dates: August 4, 5, 6, 7, 8, 11, and 12, 2014.</p> <p>Facility number : 000095 Provider number : 155181 AIM number : 100290490</p> <p>Survey team: Michelle Hosteter, RN-TC Sandie Nolder, RN Gloria Bond, RN</p> <p>Census bed type : SNF: 23 SNF/NF : 120 Total : 143</p> <p>Census payor type : Medicare : 25 Medicaid : 102 Other : 16 Total : 143</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review was completed by Tammy Alley RN on August 19, 2014.</p>	F000000	<p>Please accept the Plan of Correction, official 2567, as credible allegatin of compliance for Carmel Health and Living, effective September 2, 2014. The submission of this plan of correction, does not constitute admission by Carmel Health and Living or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does the submission constitute an agreement of admission of the survey allegations. The facility is respectfully requesting a face to face informal dispute resolution for Federal Tags 250, 309, and 406.</p>	

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155181		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/12/2014	
NAME OF PROVIDER OR SUPPLIER  CARMEL HEALTH & LIVING COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 118 MEDICAL DR CARMEL, IN 46032			
(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			
F000250 SS=D	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on record review and interview, the facility failed to ensure a Neuropsychological evaluation was completed when recommended by an outside agency for 1 of 1 residents reviewed for specialized evaluation needs. (Resident #181)</p> <p>Findings include:</p> <p>Resident #181's record was reviewed on 8/8/2014 at 9:04 A.M. Diagnoses included, but were not limited to, Wernicke's encephalopathy (a condition causing a decline in mental ability due to the lack of B-vitamin reserves, in particular thiamine / vitamin B 1), depression, anxiety, delusions, and Crohn's disease (chronic inflammatory disease of the intestines).</p> <p>The record indicated the resident was admitted to the facility on 6/25/2013 after a hospitalization for AMS (Altered Mental Status) / confusion due to possible Wernicke's encephalopathy. Prior to her hospitalization the resident was living independently but since her</p>	F000250	<p><b>F250 Provision of Medically Related Social Services</b> It is the practice of this provider to provide medically related social services to attain or maintain the highest practical physical, mental, and psychosocial well being of each resident. The facility does not agree with the Federal citation and respectfully requests a face to face informal dispute resolution based on the fact that the neuro psych evaluation was scheduled at the time of the survey for September 4, 2014. <b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b> · Resident #181 has a neuropsych eval scheduled for September 4, 2014. · Resident #181 4B was approved foregoing the Level 2 neuropsych request the week prior to the annual survey approving the resident for nursing facility level of care. <b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b> · All residents who have who are identified by the PASARR level 2 process have the potential to be</p>	09/02/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155181		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/12/2014	
NAME OF PROVIDER OR SUPPLIER  CARMEL HEALTH & LIVING COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 118 MEDICAL DR CARMEL, IN 46032			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>confusion was not cleared up, the hospital felt a home discharge was not a safe option.</p> <p>A nursing progress note dated 11/18/13, indicated, " Resident very tearful and emotional at this time...asking how long she had been here at facility and why she was here.... "</p> <p>A progress nursing note dated 11/19/2013 indicated the following: "resident upset tonight states room mate mocks her and is rude...." A progress note dated 11/20/2013 indicated, "Arguing with room mate...."</p> <p>The record indicated the resident had a, PASARR/MI (Pre Admission Screening Annual Resident Review/Mental Illness) dated 11/22/2013, completed.</p> <p>According to, " medicaid.gov" a PASRR, "...is a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care...."</p> <p>The resident's PASRR document indicated the resident was mentally ill and to continue current MH (mental health) services and yearly resident review. In addition it indicated: "(X) Needs Further Review - Specify: Needs</p>		<p>affected. <b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</b> · An in-service will be provided to social services to review the PASARR Level 2 process to ensure all recommended procedures are obtained timely regardless of payor source. · All Level 2's will be reviewed at the clinical meeting to ensure all recommended services are added to the resident's care plan.</p> <p><b>How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</b> · An audit tool will be used monthly x 3 months, quarterly thereafter, to ensure all interventions from the Level 2 were followed and implemented into the residents plan of care. · Any identified areas lacking from audits will be addressed immediately. · Employees not adhering to policy will be re-educated up to and including termination. · The results of these audits will be discussed at the monthly facility Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155181	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/12/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CARMEL HEALTH & LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 118 MEDICAL DR CARMEL, IN 46032
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>neuropsychological evaluation. (X) Other - Specify: Appropriate placement is difficult to identify pending results of neuropsychological evaluation...."</p> <p>The 11/22/2013 PASARR/MI narrative description indicated the following, "... [name of resident] needs a neuropsychological evaluation to further assess her cognitive impairment secondary to Wernicke's Encephalopathy and whether it is progressing to Wernicke-Korsakoff [a psychosis resulting from permanent damage to areas of the brain involved with memory due to vitamin B 1 deficiency]. She could also benefit from more frequent psychiatric sessions largely due to increasing agitation and outbursts towards facility staff, especially since her dose of Olanzapine [an anti-psychotic medication] was decreased at her last session in 10/2013. It appears that the current facility is not an appropriate setting for her, but a more appropriate placement is difficult to determine pending results of neuropsychological testing...."</p> <p>At the bottom of the PASARR/MI: "This person's current or past behavior presents a danger to self or others?[ X ] Yes...Increasingly aggressive/angry towards staff due to her delusions and</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155181		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/12/2014	
NAME OF PROVIDER OR SUPPLIER  CARMEL HEALTH & LIVING COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 118 MEDICAL DR CARMEL, IN 46032			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>confusion. She denies any suicidal or homicidal idealation."</p> <p>A psychiatric progress note dated 12/3/13 indicated the following : "very very confused. Extremely tearful and anxious. SS[social service] feels like this is not an appropriate placement for her. Neuro [neurological] eval [evaluation] is in the works. Pt.[patient] crying - wants to go home. Believes she can care for her self. Nsg [nursing] reports frequent episodes daily of crying. Sometimes becomes agitated with staff. c/o[complaining of] inability to stay asleep @ [at] noc [night]. Pt has no recollection of memory..." Mood indicated as, " dysphoric [feeling unwell or unhappy]."</p> <p>An activity progress note dated 12/30/13, indicated, " ...refuses to come to any of the group activities.... "</p> <p>A nursing progress note dated 1/9/14, indicated, " Resident refused shower x[times] 2.... "</p> <p>A nursing progress note dated 1/12/14, indicated, " ...very upset crying walking up and down hall... ' How did I get here, How long have I been here,...?' .... "</p> <p>A nursing progress note dated 1/13/2014, indicated the following: "Resident very</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155181	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/12/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CARMEL HEALTH & LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 118 MEDICAL DR CARMEL, IN 46032
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>upset and shaking at this time. Stating she wants to leave facility...Resident MD ordered one dose Ativan [anti-anxiety] 1 mg [milligram]...."</p> <p>A psychiatric progress note dated 1/21/14 indicated, "...recommend neuropsych testing...will discuss above with social worker...."</p> <p>A psychiatric progress note dated 2/03/14, "continues to cry consistently. Very paranoid that people are out to get her and make her stay here. Has taken a few showers which is an improvement from last month...."</p> <p>A Social Services progress note dated 2/18/14, " Writer called and spoke with resident's son regarding the current status of scheduling her Neuro appt.... "</p> <p>A mental and behavioral health visit note dated 2/27/2014, and under description and purpose of clinician intervention, "...Met w [with] /pt [patient] to assess mood and discuss recent interaction with other resident. Worked to understand trigger and cause of pt aggression. Tried to help pt relax and engage and reassure her that she is being well taken care of...Patient's response to Intervention/Progress toward Goal: Pt was disengaged and agitated throughout</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155181		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/12/2014	
NAME OF PROVIDER OR SUPPLIER  CARMEL HEALTH & LIVING COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 118 MEDICAL DR CARMEL, IN 46032			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>session. Pt continues to have increased agitation about being in facility and not knowing why - memory impairment causes her to forget repeated conversations about why she's in facility and future plan. Pt reported she doesn't remember getting into it with any other residents yesterday...Resistance to Change/Barriers to Goal Attainment: Pt memory impairment makes her increased agitation difficult to assess regarding the root of the agitation and triggers for future aggressive acts...."</p> <p>An event report dated 4/01/2014, "...Resident has been upset since staff asked resident to take shower on previous shift...."</p> <p>A psychiatric progress note dated 4/01/2014, "...No real [symbol for changes]. Still has episodes of tearfulness which is difficult to redirect. Confused @ x's[times] &amp; unable to comprehend her circumstances. Resting in bed. Startled when her name called. Pt pleasant a little more talkative then previous visits. Lots of supetative [sic] questions during her confusion. She states 'trying to accept things' Records dates of her son's visits so she remembers when he has visited."</p> <p>A nursing progress note dated 4/2/14, "</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155181	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/12/2014
NAME OF PROVIDER OR SUPPLIER  CARMEL HEALTH & LIVING COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 118 MEDICAL DR CARMEL, IN 46032		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>Message left for son [name] regarding neuro appt to be made.... "</p> <p>A mental &amp; behavioral health visit note dated 5/14/2014, "Description &amp; Purpose of Clinician Intervention: Met w/pt in room to discuss adjustment to having a roommate. Encouraged her to look at the activities calendar and try to get out of her room once each day for a change in scenery. Staff mentioned that pt has neuro consult coming up soon...Patient's response to intervention/progress toward goal: Pt has significant memory impairment and stated that her roommate has only been there for one night (roommate moved in 3-4 days ago). Pt is struggling to adjust to having all of the extra 'stuff' in her room. She stated that she will look at the events calendar but was hesitant to commit to leaving the room. Resistance to change/barriers to goal attainment: memory impairment."</p> <p>Resident #181's record indicated the resident did not have an appointment with a neurologist until May 20,2014. Tests were ordered at that time. An EEG (Electroencephalogram - a test that detects electrical activity in the brain) was performed on 6/12/14 and an MRI (Magnetic Resonance Imaging) of the brain was done on 7/24/14. The resident's record indicated, Neuro Psych</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155181	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/12/2014
NAME OF PROVIDER OR SUPPLIER  CARMEL HEALTH & LIVING COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 118 MEDICAL DR CARMEL, IN 46032		
(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	
F000282 SS=E	<p>testing was still needing to be completed.</p> <p>During an interview on 8/8/2014 at 9:57 A.M., the Assistant Social Service Director indicated she thought neuropsychological testing had been done with the resident's son involved, but she would have to look at the documentation.</p> <p>During an interview on 8/12/2014 at 10:44 A.M., the Assistant SSD indicated, the responsibility of who makes sure something like a neuropsych testing is scheduled and completed is really a team effort involving social service, nursing and the family.</p> <p>Upon exit on 8/12/2014 at 1:15 P.M., the Administrator indicated that the neuropsych testing for Resident #181 was never done because of a billing issue.</p> <p>3.1-34(a)</p> <p>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.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155181		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/12/2014	
NAME OF PROVIDER OR SUPPLIER  CARMEL HEALTH & LIVING COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 118 MEDICAL DR CARMEL, IN 46032			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>Based on observation, interview and record review, the facility failed to follow the residents plan of care regarding fluid restriction, insulin coverage, weights and Neuropsychological evaluation for 4 of 26 residents reviewed for care plans in a sample of 26. (Residents #226, #227, #181 and #84)</p> <p>Findings include:</p> <p>1. Resident #226's record was reviewed on 8/11/14 at 8:06 A.M. Diagnoses included, but were not limited to, altered mental status, hyponatremia (Low sodium levels), hypertension with chronic kidney disease, Alzheimer's disease, anxiety state, senile dementia and and chronic airway obstruction.</p> <p>An Admission History and Physical dated 7/18/14, indicated the resident was brought to the Emergency Room for a decreased level of consciousness. He was found to have a Sodium level of 118 mmol / L (millimol / Liter) and was later hospitalized. The normal Sodium level should have been 135-145 mmol / L. He was treated with Intravenous fluids and his Citalopram (An Anti-depressant medication) and Mirtazepine (An Anti-depressant medication) was discontinued and the Sodium level was corrected to 130 mmol / L. He was</p>	F000282	<p><b>F282</b></p> <p><b>Services by Qualified Person/Per Care Plan</b></p> <p>It is the practice of this provider to ensure services are provided or arranged by the facility by qualified persons in accordance with each resident's written plan of care.</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <ul style="list-style-type: none"> <li>· Resident #181 has a neuropsych eval scheduled for September 4, 2014.</li> <li>· Resident #84 weight has been stable and increasing since May, 2014.</li> <li>· Resident #226 plan of care has been reviewed and updated to reflect non compliance with fluids.</li> <li>· Resident #227 physician's orders for sliding scale insulin have been reviewed and updated and physician notified.</li> </ul>	09/02/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155181	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/12/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CARMEL HEALTH & LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 118 MEDICAL DR CARMEL, IN 46032
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

	<p>released to a facility for rehabilitation. The Physician indicated he had prior issues with Hyponatremia approximately one year ago and was hospitalized and underwent rehabilitation at the same facility and was released to an apartment. The physician indicated he was confused, which had worsened with his present illness and the past medical history included, but was not limited to, hyponatremia and dementia.</p> <p>During an observation on 8/4/14 at 2:42 P.M., the resident had a clear 8 ounce plastic glass sitting on his bedside table with a clear fluid in it. At this time, during an interview the resident indicated he was on a fluid restriction.</p> <p>During an observation on 8/11/14 at 5:10 P.M., the resident had a white styrofoam cup with a lid and a straw in the lid that had a clear fluid in it that was three-fourths full. At this time, during an interview the resident indicated the cup was his glass with water.</p> <p>During an interview on 8/11/14 at 5:15 P.M., LPN #6 indicated the resident was on a fluid restriction and he was not suppose to have water sitting at his bedside.</p> <p>The Medication Administration Record</p>		<p><b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p> <ul style="list-style-type: none"> <li>· All residents who have physician orders/care plans for fluid restriction , insulin coverage, weights and neuropsychological evaluations could be effected by the deficient practice.</li> <li>· An audit of residents with fluid restriction orders was completed and updates to orders and care plans completed.</li> <li>· An audit of residents with physician orders with sliding scale insulin coverage was completed and updates to orders and care plans was completed.</li> <li>· An audit of residents with Level 2's was completed to ensure all services were added to residents care plans.</li> <li>· An audit of residents with g-tubes was completed to ensure weights were accurate and care plans were updated.</li> </ul> <p><b>What measures will be put into place or what systemic changes you will make to</b></p>	
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155181		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/12/2014	
NAME OF PROVIDER OR SUPPLIER  CARMEL HEALTH & LIVING COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 118 MEDICAL DR CARMEL, IN 46032			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>(MAR) dated August 2014, indicated the resident's Physician's orders included, but were not limited to the following:</p> <p>07/18/14--Fluid restriction 1000 cc (cubic centimeters) daily. Discontinued on 8/6/14. Diagnosis: Hypertension with chronic kidney disease Days: 400 cc every shift Evenings: 400 cc every shift Nights: 200 cc every shift</p> <p>The vital sign area of the computer indicated the resident had consumed the following amount of fluids on the following dates and times. The fluids were not totaled on the computerized form.</p> <p>The abbreviation ml (milliliters) was the equivalent to cc (cubic centimeters) while referring to amount of fluid intakes. 7/18/14 at 3:04 P.M.--1000 ml and 8:45 P.M.--720 ml ( Oral fluids totaled 1720 ml for the 24 hours). 7/20/14 at 12:31 P.M.--480 ml, 3:10 P.M.--360 ml and 10:36 P.M.--500 ml (Oral fluids totaled 1340 ml for the 24 hours). 7/29/14 at 2:49 P.M.--960 ml and 9:05 P.M.--725 ml (Oral fluids totaled 1685 ml for the 24 hours). 8/2/14 at 7:11 P.M.--1400 ml (Oral fluids totaled 1400 ml for the 24 hours). 8/3/14 at 9:57 A.M.--720 ml and 7:43</p>		<p><b>ensure that the deficient practice does not recur?</b></p> <ul style="list-style-type: none"> <li>· An inservice will be provided to social services to review the PASARR Level 2 process to ensure all recommended procedures are obtained timely regardless of payor source.</li> <li>· All Level 2's will be reviewed at the clinical meeting to ensure all recommended services are added to the resident's care plan.</li> <li>· An inservice will be provided to nursing staff related to fluid restriction documentation, insulin coverage and weights. Return demonstration of each task will be acknowledged at 100%.</li> <li>· All new orders are reviewed by the medical records nurse Monday through Friday and the weekend supervisor on Saturday and Sunday to ensure new orders for fluid restriction, weights or insulin coverage, or neuro psych eval are followed through and added to resident plans of care.</li> <li>· All new orders are discussed with the nurse management meeting Monday through Friday and reviewed Saturday and Sunday by the weekend supervisor.</li> </ul>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155181		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/12/2014	
NAME OF PROVIDER OR SUPPLIER  CARMEL HEALTH & LIVING COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 118 MEDICAL DR CARMEL, IN 46032			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>P.M.--720 ml (Oral fluids totaled 1440 ml for the 24 hours). 8/4/14 at 11:36 A.M.--1420 ml and 9:58 P.M.--180 ml (Oral fluids totaled 1600 ml for the 24 hours).</p> <p>The Medication Administration Record (MAR) dated August 2014, indicated the resident's Physician's orders included, but were not limited to the following:</p> <p>08/06/14--Fluid restriction 1800 cc daily. Discontinued on 8/8/14. Diagnosis: Hypertension with chronic kidney disease. Days: 700 cc every shift Evenings: 700 cc every shift Nights: 400 cc every shift</p> <p>The vital sign area of the computer indicated the resident had consumed the following amount of fluids on the following dates and times. The fluids were not totaled on the computerized form.</p> <p>8/7/14 at 12:35 A.M.--400 ml, 11:52 A.M.--700 ml, 2:40 P.M.--780 ml, 4:20 P.M.--700 ml and 7:37 P.M.--1060 ml (Oral fluids totaled 3640 ml for the 24 hours). 8/8/14 at 3:34 A.M.--400 ml, 9:26 A.M.--700 ml, 4:50 P.M.--500 ml, 6:28 P.M.--120 ml and 11:55 P.M.--200 ml (Oral</p>		<ul style="list-style-type: none"> <li>· The administration compliance report is reviewed daily by the ADON or weekend supervisor, for non compliance with physician orders or discrepancies.</li> <li>· Any discrepancies identified on the administration compliance report are called to physicians and observations opened for resident assessment for 24 hours.</li> </ul> <p><b>How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</b></p> <ul style="list-style-type: none"> <li>· An audit tool will be used weekly x 3 months, monthly x 3 months, quarterly thereafter, to ensure all residents plans of care are being followed for those residents requiring fluid restriction , insulin coverage, weight monitoring, and neuro psych evaluations.</li> <li>· Any identified areas lacking from audits will be addressed immediately.</li> <li>· Employees not adhering to policy will be re-educated up to</li> </ul>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155181	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/12/2014
NAME OF PROVIDER OR SUPPLIER  CARMEL HEALTH & LIVING COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 118 MEDICAL DR CARMEL, IN 46032		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>fluids totaled 1920 ml for the 24 hours).</p> <p>The Medication Administration Record (MAR) dated August 2014, indicated the resident's Physician's orders included, but were not limited to the following:</p> <p>08/08/14--Fluid restriction 1000 cc daily. Diagnosis: Hypertension with chronic kidney disease. Days: 500 cc every shift Evenings: 300 cc every shift Nights: 200 cc every shift</p> <p>The vital sign area of the computer indicated the resident had consumed the following amount of fluids on the following dates and times. The fluids were not totaled on the computerized form.</p> <p>8/9/14--10:08 A.M.--1840 ml, 1:36 P.M.-500 ml, 4:44 P.M.--300 ml and 8:48 P.M.--360 ml (Oral fluids totaled 3000 cc for the 24 hours)</p> <p>8/10/14 at 5:53 A.M.--120 ml, 10:08 A.M.--360 ml, 11:10 A.M.--500 ml, 2:25 P.M.--360 ml, 4:33 P.M.--300 ml and 6:52 P.M.--1060 ml (Oral fluids totaled 2700 ml for the 24 hours)</p> <p>The July and August 2014, MAR indicated by nurse's signature, the resident received the ordered amount of</p>		<p>and including termination.</p> <p>The results of these audits will be discussed at the monthly facility Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155181	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/12/2014
NAME OF PROVIDER OR SUPPLIER  CARMEL HEALTH & LIVING COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 118 MEDICAL DR CARMEL, IN 46032		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>fluids.</p> <p>Progress Notes lacked documentation that the resident was noncompliant with his fluid restriction order.</p> <p>The record indicated Basic Metabolic Panel (BMP) (Laboratory test that measures the amount of electrolytes) was completed on the listed dates with these results: 7/21/14: Sodium level=128 low Normal-135-145 mmol / L 7/28/14: Sodium level=130 low 8/04/14: Sodium level=125 low</p> <p>A BMP laboratory test was ordered for Friday. 8/06/14: Sodium level=126 low</p> <p>A Repeat BMP laboratory test was ordered for Friday and the resident was placed on an 1800 cc fluid restriction. 8/08/14: Sodium level=123 low</p> <p>A 1000 cc fluid restriction was ordered and a Stat (Immediately) BMP laboratory test was ordered on 8/8/14. 8/09/14: Sodium level=120 critically low</p> <p>A PICC (peripherally inserted central catheter) line was inserted and IV (intravenous) therapy of NS (normal</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155181		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/12/2014	
NAME OF PROVIDER OR SUPPLIER  CARMEL HEALTH & LIVING COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 118 MEDICAL DR CARMEL, IN 46032			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>saline) at 75 cc / hour was started to correct the sodium level.</p> <p>8/10/14: Sodium level=117 critically low, IV therapy at 75 cc / hour continues. 8/11/14: Sodium level=122 low, IV therapy at 75 cc / hour continues.</p> <p>During an interview on 8/12/14 at 10:02 A.M., LPN #8 indicated she documented the amount of fluids the resident received in the computer. She indicated she determined the amount of fluid he received by the amount of fluid the computer order indicated he was allowed to receive. She indicated his daughter brought him in drinks and he was able to walk around and was able to obtain water himself, but not lately since he had been sick. She indicated the CNA's were not supposed to give the resident extra fluids.</p> <p>During an interview on 8/12/14 at 10:10 A.M., CNA #9 indicated she documented the amount of fluids she gave the resident in the computer. She indicated she knew the amount of fluids he could receive by the assignment sheet. She indicated he should receive 500 cc for dayshift. She indicated she did not give him extra fluids.</p> <p>During an interview on 8/12/14 at 10:00 A.M., the DoN indicated the nursing staff</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155181	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/12/2014
NAME OF PROVIDER OR SUPPLIER  CARMEL HEALTH & LIVING COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 118 MEDICAL DR CARMEL, IN 46032		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>gave the resident his fluids on his meal trays. She indicated the Dietary services would not have known how many fluids to give him since they did not place the fluids on the resident's tray during meal service.</p> <p>During an interview on 8/12/14 at 11:08 A.M., the Director of Nursing (DoN) nodded that she agreed if the nurses initials were in the box on the MAR for the shift worked for the fluid restriction order indicated the resident received the full amount of fluids ordered for that shift. She indicated the night shift nurse was responsible for totaling the 24 hour fluid intake and ensuring the resident was not exceeding his allotted amount of fluids for the 24 hour period. The DoN indicated if the resident had gone over his allotted fluid restriction amount, the resident's Physician was to be notified. The DoN indicated she could not determine if the fluid amounts from the MAR and the vital sign area of the computer had been totaled together at the end of the 24 hours to determine if the resident had stayed within his allotted fluid restriction amount.</p> <p>During an interview on 8/12/14 at 11:12 A.M., the Administrator indicated that RN #4 would have to educate the resident's daughter not to bring drinks</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155181		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/12/2014	
NAME OF PROVIDER OR SUPPLIER  CARMEL HEALTH & LIVING COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 118 MEDICAL DR CARMEL, IN 46032			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>into him to drink and she felt she would understand the education the first time she was educated. She indicated the facility had realized they had a problem with the fluid restriction and resident's intakes and they had started addressing that issue yesterday after it was brought to their attention. She indicated the last time the resident's Sodium was low while he was hospitalized, he was treated with IV fluids.</p> <p>A current policy titled "Hydration Monitoring" dated 11/12, provided by the DoN on 8/12/14 at 10:00 A.M., indicated, "...Policy: It is the policy of this facility to monitor the resident's fluid balance in accordance assessed needs or problems. Examples of resident problems or needs which may require hydration monitoring: ...4. medical need for exact measuring of fluid intake and output; i.e. fluid restrictions, force fluids or enteral feedings...Procedure: ...A plan of care shall be developed to address any hydration concerns. This plan of care will be developed utilizing the clinical conditions and risk factors identified, taking into account the estimated fluid needs of the resident. When indicated, shift and 24-hour fluid intake totals shall be calculated and analyzed by a licensed nurse...."</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155181		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/12/2014	
NAME OF PROVIDER OR SUPPLIER  CARMEL HEALTH & LIVING COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 118 MEDICAL DR CARMEL, IN 46032			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>A current policy titled "Fluid Restriction" undated, provided by the DoN on 8/12/14 at 11:45 A.M., indicated "Policy: Residents are placed on restricted fluid intake when ordered by the physician. Procedure: ...3. It is the responsibility of the charge nurse and the Dining Services Director to determine the best method to meet the fluid restrictions based upon the resident's fluid intake history, number of medications and medication passes, etc... ...8. Fluid restrictions are noted on the care plan."</p> <p>2. Resident #227's record was reviewed on 8/11/14 at 1:43 P.M. Diagnoses included, but were not limited to gastroparesis, diabetes mellitus type II, above knee amputation and nausea and vomiting.</p> <p>The Medication Administration Record (MAR) dated August 2014, indicated the resident's Physician's orders included, but were not limited to the following: 7/20/14--Novolog Flexpen Insulin 100 unit / ml sliding scale subcutaneous at bedtime Give 2 units if Blood Glucose (BG) was 180-250 Give 3 units if BG was 251-300 Call Physician if Blood Glucose was greater than 300 7/20/14--Novolog Flexpen 100 unit / ml</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155181	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/12/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CARMEL HEALTH & LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 118 MEDICAL DR CARMEL, IN 46032
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>sliding scale subcutaneous before meals If BG 131-150=Give 2 units If BG 151-200=Give 3 units If BG 201-250=Give 6 units If BG 251-300=Give 9 units Call Physician if BG greater than 300</p> <p>The Medication Administration Record (MAR) dated July 2014, indicated dates and times the following Blood Glucose results with the documented amount of Novolog insulin was given: 7/21/14 at 7 A.M.--133 No insulin was given--2 units should have been given. 7/21/14 at 4 P.M.--137 3 units were given-- 2 units should have been given. 7/21/14 at 8 P.M.--270 2 units were given--3 units should have been given. 7/22/14 at 4 P.M.--157 6 units were given--3 units should have been given. 7/23/14 at 4 P.M.--175 6 units were given--3 units should have been given. 7/28/14 at 7 A.M.--207 No insulin was given--6 units should have been given. 7/29/14 at 4 P.M.--167 6 units were given--3 units should have been given. 7/30/14 at 4 P.M.--157 6 units were given--3 units should have been given.</p> <p>The Medication Administration Record (MAR) dated August 2014, indicated dates and times the following Blood Glucose results with the documented amount of Novolog insulin was given:</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155181	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/12/2014
NAME OF PROVIDER OR SUPPLIER  CARMEL HEALTH & LIVING COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 118 MEDICAL DR CARMEL, IN 46032		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>8/4/14 at 4 P.M.--131 3 units were given- -2 units should have been given.</p> <p>During an interview on 8/12/14 at 10:00 A.M., the Director of Nursing indicated the above insulin doses were given inaccurately for the documented blood sugars.</p> <p>3. Resident #181's record was reviewed on 8/8/2014 at 9:04 A.M. Diagnoses included, but were not limited to, Wernicke's encephalopathy (a condition causing a decline in mental ability due to the lack of B-vitamin reserves, in particular thiamine / vitamin B 1), depression, anxiety, delusions, and Crohn's disease (chronic inflammatory disease of the intestines).</p> <p>The record indicated the resident was admitted to the facility on 6/25/2013 after a hospitalization for AMS (Altered Mental Status) / confusion due to possible Wernicke's encephalopathy. Prior to her hospitalization the resident was living independently but since her confusion was not cleared up, the hospital felt a home discharge was not a safe option.</p> <p>The record indicated the resident had a, PASARR/MI (Pre Admission Screening Annual Resident Review/Mental Illness) dated 11/22/2013, done.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155181	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/12/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CARMEL HEALTH & LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 118 MEDICAL DR CARMEL, IN 46032
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>According to, " medicaid.gov" a PASRR, "...is a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care...."</p> <p>The PASARR/MI dated 11/22/2013, indicated the resident was mentally ill. It indicated to continue current MH (mental health) services and yearly resident review. In addition it indicated, needs neuropsychological evaluation, "... Appropriate placement is difficult to identify pending results of neuropsychological evaluation...."</p> <p>The PASARR/MI narrative description indicates the following: "[name of resident]needs a neuropsychological evaluation to further assess her cognitive impairment secondary to Wernicke's Encephalopathy and whether it is progressing to Wernicke-Korsakoff [a psychosis resulting from permanent damage to areas of the brain involved with memory due to vitamin B 1 deficiency]. She could also benefit from more frequent psychiatric sessions largely due to increasing agitation and outbursts towards facility staff, especially since her dose of Olanzapine [an anti-psychotic medication] was decreased at her last session in 10/2013. It appears that the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155181	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/12/2014
NAME OF PROVIDER OR SUPPLIER  CARMEL HEALTH & LIVING COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 118 MEDICAL DR CARMEL, IN 46032		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>current facility is not an appropriate setting for her, but a more appropriate placement is difficult to determine pending results of neuropsychological testing...."</p> <p>A psychiatric progress note dated 1/21/14 indicates, "...recommend neuropsych testing...will discuss above with social worker."</p> <p>Resident #181's record indicated the resident did not have an appointment with a neurologist until May 20, 2014. Tests were ordered at that time. An EEG (Electroencephalogram - a test that detects electrical activity in the brain) was performed on 6/12/14 and an MRI (Magnetic Resonance Imaging) of the brain was done on 7/24/14. The resident's record indicated Neuro Psych testing was still needing to be completed.</p> <p>During an interview with the Assistant SSD (Social Service Director) on 8/11/2014 at 11:03 A.M., she indicated she did not know where the neuropsych testing was.</p> <p>During an interview with the Assistant SSD on 8/12/2014 at 10:44 A.M., she indicated the responsibility of who makes sure something like a neuropsych testing is schedule and done is really a team</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155181		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/12/2014	
NAME OF PROVIDER OR SUPPLIER  CARMEL HEALTH & LIVING COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 118 MEDICAL DR CARMEL, IN 46032			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>effort involving social service, nursing and the family.</p> <p>On exit on 8/12/2014 at 1:15 P.M., the Administrator indicated that the neuropsych testing for Resident #181 was never done because of a billing issue.</p> <p>4. On 8/11/14 at 10:00 A.M., the record review for Resident #94 was completed. Diagnoses included, but were not limited to, stroke, hemiplegia (paralysis on one side of body), aphasia, and dysphagia.</p> <p>The physician's orders dated 5/17/14, indicated to weigh monthly. A 7/2/14 order indicated to weigh the resident weekly for 8 weeks.</p> <p>The care plan for tube feeding indicated date of 4/7/13, "... monitor/weight record weight. Notify MD and family of significant weight change. 7/2/14- Daily weights for seven days then weekly x 8 weeks...."</p> <p>The resident's weight are as follows: 10/7/13: 188 11/15/13: 187 12/11/13: 184 1/7/14: 187.4 2/7/14 : 184.4 3/5/14: 185.2 No documented weight for April 2014 5/1/14: 187 pounds, there was a</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155181		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/12/2014	
NAME OF PROVIDER OR SUPPLIER  CARMEL HEALTH & LIVING COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 118 MEDICAL DR CARMEL, IN 46032			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>correction weight that indicated the resident weighed 137 pounds.</p> <p>6/2/14 140.2 6/7/14: 139.1 6/8/14: 147.2 6/15/14: 148.2 (reweight same) 7/7/14: 150.4 8/4/14 : 150.8 8/5/14 : 150.4</p> <p>The Nurse Practitioner (NP) indicated on 8/6/14, "...8/5/14 : weight 150.4...7/7/14: resident weight 150.4 ?...no edema...Renal functions stale, BUN usually 55-60, continue weekly BMP's [Basic Metabolic panel], TF [tube feeding] per MD [medical doctor] orders...continue to monitor weight. on 1/15/14, the NP indicated, "...weight 187.4, no edema, weight is up, renal functions are stable...."</p> <p>The Nursing Consultant indicated during an interview on 8/11/14 at 4:00 P.M., that she had discovered the weight discrepancies back in May and she had realized the CNA's were not re-weighing the residents and addressed the issue. She indicated if a weight was off the CNA's were to do a reweight.</p> <p>The Administrator indicated during an interview on 8/11/14 at 4:30 P.M. that they were aware there were concerns with</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155181		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/12/2014	
NAME OF PROVIDER OR SUPPLIER  CARMEL HEALTH & LIVING COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 118 MEDICAL DR CARMEL, IN 46032			
(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			
F000309 SS=G	<p>the weights and that they were having the Registered Dietician (RD) following residents monthly as of May 2014, and that they were monitoring the RD's performance more closely at that time. There was no other explanation given as to the change in weights from March 2014 to May 2014.</p> <p>3.1-35(g)(2)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, interview and record review, the facility failed to accurately monitor fluid intake for 1 of 1 resident on a fluid restriction being reviewed for monitoring of fluid intake amounts. (Resident #226) Resident #226's Sodium level was 130 mmol / L (millimol / Liter) upon discharge from the hospital, 128 mmol / L on 7/21/14 after admission to the facility and 117 mmol / L on 8/10/14 which was critically low.</p> <p>Findings include:</p>	F000309	<p><b>F309 Provide Care/Services for highest well being</b> It is the practice of this provider to ensure that residents receive the necessary care and treatment to maintain the highest practicable physician well-being. The facility does not agree with the federal citation and therefore is requesting a face to face informal dispute resolution due to the resident's complex medical history.</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b> · Resident #226 remains in the facility with labs</p>	09/02/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155181		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/12/2014	
NAME OF PROVIDER OR SUPPLIER  CARMEL HEALTH & LIVING COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 118 MEDICAL DR CARMEL, IN 46032			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>Resident #226's record was reviewed on 8/11/14 at 8:06 A.M. Diagnoses included, but were not limited to, altered mental status, hyponatremia (Low sodium levels), hypertension with chronic kidney disease, Alzheimer's disease, anxiety state, senile dementia and and chronic airway obstruction.</p> <p>An Admission History and Physical dated 7/18/14, indicated the resident was brought to the Emergency Room for a decreased level of consciousness. He was found to have a Sodium level of 118 mmol / L (millimol / Liter) and was later hospitalized. The normal Sodium level should have been 135-145 mmol / L. He was treated with Intravenous fluids and Sodium level was corrected to 130 mmol / L. He was released to a facility for rehabilitation. The Physician indicated he had prior issues with Hyponatremia approximately one year ago and was hospitalized and underwent rehabilitation at the same facility and was released to an apartment. The physician indicated he was confused, which had worsened with his present illness and the past medical history included, but was not limited to, hyponatremia and dementia.</p> <p>The resident had a Care Plan dated 7/18/14, that addressed the problem</p>		<p>within normal limits for the resident. Residents plan of care was updated to include non compliance issues with fluids.</p> <p><b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p> <ul style="list-style-type: none"> <li>· All residents who have fluid restrictions have the potential to be effected. · All residents with fluid restriction orders plans of care were reviewed and updated.</li> <li>· All residents with fluid restriction orders have signage at their room door and on their care sheet noting type of fluid restriction. <b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</b></li> <li>· Progress notes are reviewed daily by Nursing Management to identify changes Monday through Friday and by the Weekend manager on Saturday and Sunday. · Physician orders are reviewed daily by Nursing Management to identify new orders/changes in condition. · Administration compliance records will be reviewed daily by Nursing Management and by the Weekend supervisor Saturday and Sunday. · Nurse consultant will randomly audit identified residents who have fluid restrictions upon her weekly visit.</li> <li>· Any discrepancies noted on the</li> </ul>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155181		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/12/2014	
NAME OF PROVIDER OR SUPPLIER  CARMEL HEALTH & LIVING COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 118 MEDICAL DR CARMEL, IN 46032			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>"Resident is at risk for fluid imbalance and weight changes related to diuretic use and CKD [chronic kidney disease] and fluid restriction."</p> <p>Intervention indicated, "...8/1/14--Hold Lasix per order, Maintain fluid restriction per current order...7/18/14--Encourage fluid intake...."</p> <p>The resident's record lacked a Care Plan for non compliance with fluid restrictions.</p> <p>During an observation on 8/4/14 at 2:42 P.M., the resident had a clear 8 ounce plastic glass sitting on his bedside table with a clear fluid in it. At this time, during an interview the resident indicated he was on a fluid restriction.</p> <p>The Medication Administration Record (MAR) dated August 2014, indicated the resident's Physician's orders included, but were not limited to the following:</p> <p>07/18/14--Fluid restriction 1000 cc (cubic centimeters) daily. Discontinued on 8/6/14. Diagnosis: Hypertension with chronic kidney disease Days: 400 cc every shift Evenings: 400 cc every shift Nights: 200 cc every shift</p>		<p>compliance report will be called to the physician and an observation opened for resident assessment for 24 hours. · All staff were educated on fluid restrictions on 8-26-14. <b>How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</b></p> <p>· An audit tool will be used to ensure fluid restriction orders are being followed/monitored weekly x 12, monthly x 3, quarterly thereafter. · Any identified areas from audits will be addressed immediately. · Employees not adhering to policy will be re-educated up to and including termination. · The results of these audits will be discussed at the monthly facility Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155181		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/12/2014	
NAME OF PROVIDER OR SUPPLIER  CARMEL HEALTH & LIVING COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 118 MEDICAL DR CARMEL, IN 46032			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>The vital sign area of the computer indicated the resident had consumed the following amount of fluids on the following dates and times. The fluids were not totaled on the computerized form.</p> <p>The abbreviation ml (milliliters) was the equivalent to cc (cubic centimeters) while referring to amount of fluid intakes.</p> <p>7/18/14 at 3:04 P.M.--1000 ml and 8:45 P.M.--720 ml ( Oral fluids totaled 1720 ml for the 24 hours).</p> <p>7/20/14 at 12:31 P.M.--480 ml, 3:10 P.M.--360 ml and 10:36 P.M.--500 ml (Oral fluids totaled 1340 ml for the 24 hours).</p> <p>7/29/14 at 2:49 P.M.--960 ml and 9:05 P.M.--725 ml (Oral fluids totaled 1685 ml for the 24 hours).</p> <p>8/2/14 at 7:11 P.M.--1400 ml (Oral fluids totaled 1400 ml for the 24 hours).</p> <p>8/3/14 at 9:57 A.M.--720 ml and 7:43 P.M.--720 ml (Oral fluids totaled 1440 ml for the 24 hours).</p> <p>8/4/14 at 11:36 A.M.--1420 ml and 9:58 P.M.--180 ml (Oral fluids totaled 1600 ml for the 24 hours).</p> <p>The Progress notes on these dates and times indicated the following:</p> <p>7/26/14 at 11:10 A.M., the resident had fluids within his reach.</p> <p>7/26/14 at 11:16 A.M., the resident had fluid within his reach.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155181	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/12/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CARMEL HEALTH & LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 118 MEDICAL DR CARMEL, IN 46032
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

	<p>The Medication Administration Record (MAR) dated August 2014, indicated the resident's Physician's orders included, but were not limited to the following:</p> <p>08/06/14--Fluid restriction 1800 cc daily. Discontinued on 8/8/14. Diagnosis: Hypertension with chronic kidney disease. Days: 700 cc every shift Evenings: 700 cc every shift Nights: 400 cc every shift</p> <p>The vital sign area of the computer indicated the resident had consumed the following amount of fluids on the following dates and times. The fluids were not totaled on the computerized form.</p> <p>8/7/14 at 12:35 A.M.--400 ml, 11:52 A.M.--700 ml, 2:40 P.M.--780 ml, 4:20 P.M.--700 ml and 7:37 P.M.--1060 ml (Oral fluids totaled 3640 ml for the 24 hours).</p> <p>8/8/14 at 3:34 A.M.--400 ml, 9:26 A.M.-700 ml, 4:50 P.M.--500 ml, 6:28 P.M.-120 ml and 11:55 P.M.--200 ml (Oral fluids totaled 1920 ml for the 24 hours).</p> <p>The Medication Administration Record (MAR) dated August 2014, indicated the resident's Physician's orders included, but</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155181	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/12/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CARMEL HEALTH & LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 118 MEDICAL DR CARMEL, IN 46032
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

	<p>were not limited to the following:</p> <p>08/08/14--Fluid restriction 1000 cc daily. Diagnosis: Hypertension with chronic kidney disease. Days: 500 cc every shift Evenings: 300 cc every shift Nights: 200 cc every shift</p> <p>The vital sign area of the computer indicated the resident had consumed the following amount of fluids on the following dates and times. The fluids were not totaled on the computerized form.</p> <p>8/9/14--10:08 A.M.--1840 ml, 1:36 P.M.-500 ml, 4:44 P.M.--300 ml and 8:48 P.M.--360 ml (Oral fluids totaled 3000 cc for the 24 hours)</p> <p>8/10/14 at 5:53 A.M.--120 ml, 10:08 A.M.--360 ml, 11:10 A.M.--500 ml, 2:25 P.M.--360 ml, 4:33 P.M.--300 ml and 6:52 P.M.--1060 ml (Oral fluids totaled 2700 ml for the 24 hours)</p> <p>The July and August 2014, MAR indicated by nurse's signature, the resident received the ordered amount of fluids.</p> <p>Progress Notes lacked documentation that the resident was noncompliant with his fluid restriction order.</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155181	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/12/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CARMEL HEALTH & LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 118 MEDICAL DR CARMEL, IN 46032
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

	<p>The record indicated Basic Metabolic Panel (BMP) (Laboratory test that measures the amount of electrolytes) was completed on the listed dates with these results:</p> <p>7/21/14: Sodium level=128 low Normal-135-145 mmol / L</p> <p>7/28/14: Sodium level=130 low 8/04/14: Sodium level=125 low</p> <p>A BMP laboratory test was ordered for Friday. 8/06/14: Sodium level=126 low</p> <p>A Repeat BMP laboratory test was ordered for Friday and the resident was placed on an 1800 cc fluid restriction. 8/08/14: Sodium level=123 low</p> <p>8/9/14 at at 9:50 P.M., "During med round noticed resident slumped in chair. Assessed him and found his speech to be slurred and resident acting restless. Resident was alert not oriented. Vitals were wnl [within normal limits]. Called MD [Medical Doctor] and stat labs were ordered and IV [Intravenous] fluids. Labs were returned and MD notified. IV infiltrated, MD notified. PICC [Peripherally Inserted Central Catheter] line now being placed, per MD, this evening, when IV team arrives. Resident being monitored, family aware."</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155181	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/12/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CARMEL HEALTH & LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 118 MEDICAL DR CARMEL, IN 46032
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>A 1000 cc fluid restriction was ordered and a Stat (Immediately) BMP laboratory test was ordered on 8/9/14.</p> <p>8/09/14: Sodium level=120 critically low</p> <p>8/10/14: Sodium level=117 critically low, IV therapy at 75 cc / hour continues.</p> <p>8/11/14: Sodium level=122 low, IV therapy at 75 cc / hour continues.</p> <p>During an observation on 8/11/14 at 5:10 P.M., the resident had a white styrofoam cup with a lid and a straw in the lid that had a clear fluid in it that was three-fourths full. At this time, during an interview the resident indicated the cup was his glass with water.</p> <p>During an interview on 8/11/14 at 5:15 P.M., LPN #6 indicated the resident was on a fluid restriction and he was not suppose to have water sitting at his bedside.</p> <p>8/11/14 at 6:18 P.M., "Resident sitting up in chair next to bed/table, some audible congestion noted, no wheezing, O2 on per n/c [nasal canula], nurse asked to provide nebulizer treatment prn [as needed]. Resident able to answer questions asked appropriately, +2 pitting edema in bilateral lower extremities.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155181	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/12/2014
NAME OF PROVIDER OR SUPPLIER  CARMEL HEALTH & LIVING COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 118 MEDICAL DR CARMEL, IN 46032		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>0.9% IV fluids running...."</p> <p>During an interview on 8/12/14 at 10:02 A.M., LPN #8 indicated she documented the amount of fluids the resident received in the computer. She indicated she determined the amount of fluid he received by the amount of fluid the computer order indicated he was allowed to receive. She indicated his daughter brought him in drinks and he was able to walk around and was able to obtain water himself, but not lately since he has been sick. She indicated the CNA's were not suppose to give the resident extra fluids.</p> <p>During an interview on 8/12/14 at 10:10 A.M., CNA #9 indicated she documented the amount of fluids she gave the resident in the computer. She indicated she knew the amount of fluids he could received by the assignment sheet. She indicated he should receive 500 cc for dayshift. She indicated she did not give him extra fluids.</p> <p>During an interview on 8/12/14 at 10:00 A.M., the DoN indicated the nursing staff gave the resident his fluids on his meal trays. She indicated the Dietary services would not have known how many fluids to give him since they did not place the fluids on the residents tray during meal service.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155181	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/12/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CARMEL HEALTH & LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 118 MEDICAL DR CARMEL, IN 46032
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

	<p>During an interview on 8/12/14 at 11:08 A.M., the Director of Nursing (DoN) nodded that she agreed if the nurses initials were in the box on the MAR for the shift worked for the fluid restriction order indicated the resident received the full amount of fluids ordered for that shift. She indicated the night shift nurse was responsible for totaling the 24 hour fluid intake and ensuring the resident was not exceeding his allotted amount of fluids for the 24 hour period. The DoN indicated if the resident had gone over his allotted fluid restriction amount, the resident's Physician was to be notified. The DoN indicated she could not determine if the fluid amounts from the MAR and the vital sign area of the computer had been totaled together at the end of the 24 hours to determine if the resident had stayed within his allotted fluid restriction amount.</p> <p>During an interview on 8/12/14 at 11:12 A.M., the Administrator indicated that RN #4 would have to educate the resident's daughter not to bring drinks into him to drink and she felt she would understand the education the first time she was educated. She indicated the facility had realized they had a problem with the fluid restriction and resident's intakes and they had started addressing</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155181	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/12/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CARMEL HEALTH & LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 118 MEDICAL DR CARMEL, IN 46032
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>that issue yesterday after it was brought to their attention. She indicated the last time the resident's Sodium was low while he was hospitalized, he was treated with IV fluids.</p> <p>During an observation on 8/12/14 at 12:45 P.M., the resident had 2+ bilateral lower extremity edema.</p> <p>During an interview on 8/12/14 at 11:20 A.M., the Assistant Director of Nursing indicated the resident had a new order for nebulizer treatments for every four hours as of today to treat the congestion.</p> <p>A current policy titled "Hydration Monitoring" dated 11/12, provided by the DoN on 8/12/14 at 10:00 A.M., indicated, "...Policy: It is the policy of this facility to monitor the resident's fluid balance in accordance assessed needs or problems. Examples of resident problems or needs which may require hydration monitoring: ...4. medical need for exact measuring of fluid intake and output; i.e. fluid restrictions, force fluids or enteral feedings...Procedure: ...A plan of care shall be developed to address any hydration concerns. This plan of care will be developed utilizing the clinical conditions and risk factors identified, taking into account the estimated fluid needs of the resident. When indicated,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155181	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/12/2014
NAME OF PROVIDER OR SUPPLIER  CARMEL HEALTH & LIVING COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 118 MEDICAL DR CARMEL, IN 46032		
(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	
F000325 SS=D	<p>shift and 24-hour fluid intake totals shall be calculated and analyzed by a licensed nurse...."</p> <p>A current policy titled "Fluid Restriction" undated, provided by the DoN on 8/12/14 at 11:45 A.M., indicated "Policy: Residents are place on restricted fluid intake when ordered by the physician. Procedure: ...3. It is the responsibility of the charge nurse and the Dining Services Director to determine the best method to meet the fluid restrictions based upon the resident's fluid intake history, number of medications and medication passes, etc....8. Fluid restrictions are noted on the care plan."</p> <p>3.1-37(a)</p> <p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155181		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/12/2014	
NAME OF PROVIDER OR SUPPLIER  CARMEL HEALTH & LIVING COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 118 MEDICAL DR CARMEL, IN 46032			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>Based on interview and record review, the facility failed to follow up on weight concerns for 1 of 1 residents reviewed for nutrition. (Resident #94)</p> <p>Findings include:</p> <p>On 8/11/14 at 10:00 A.M., the record review for Resident #94 was completed. Diagnoses included, but were not limited to, stroke, hemiplegia (paralysis on one side of body), aphasia, and dysphagia.</p> <p>The physician's orders dated 5/17/14, indicated to weigh monthly. A 7/2/14 order indicated to weigh the resident weekly for 8 weeks.</p> <p>The care plan for tube feeding indicated date of 4/7/13, "... monitor/weight record weight. Notify MD and family of significant weight change. 7/2/14- Daily weights for seven days then weekly x 8 weeks...."</p> <p>The resident's weight are as follows: 10/7/13: 188 11/15/13: 187</p>	F000325	<p><b>F325</b></p> <p><b>Maintain Nutrition Status Unless Unavoidable</b></p> <p>It is the practice of this provider to ensure that residents maintain acceptable parameters of nutritional status unless the resident's clinical condition demonstrates that this is not possible.</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <p>Resident #94 remains at the facility with a stable weight which has increased since May, 2014.</p> <p><b>How will you identify other residents having the potential to be affected by the same deficient practice and what</b></p>	09/02/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155181		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/12/2014	
NAME OF PROVIDER OR SUPPLIER  CARMEL HEALTH & LIVING COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 118 MEDICAL DR CARMEL, IN 46032			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>12/11/13: 184 1/7/14: 187.4 2/7/14 : 184.4 3/5/14: 185.2 No documented weight for April 2014 5/1/14: 187 pounds, there was a correction weight that indicated the resident weighed 137 pounds. 6/2/14 140.2 6/7/14: 139.1 6/8/14: 147.2 6/15/14: 148.2 (reweight same) 7/7/14: 150.4 8/4/14 : 150.8 8/5/14 : 150.4</p> <p>The Nurse Practitioner (NP) indicated on 8/6/14, "...8/5/14 : weight 150.4...7/7/14: resident weight 150.4 ?...no edema...Renal functions stale, BUN usually 55-60, continue weekly BMP's [Basic Metabolic panel], TF [tube feeding] per MD [medical doctor] orders...continue to monitor weight. on 1/15/14, the NP indicated, "...weight 187.4, no edema, weight is up, renal functions are stable...."</p> <p>The Nursing Consultant indicated during an interview on 8/11/14 at 4:00 P.M., that she had discovered the weight discrepancies back in May and she had realized the CNA's were not re-weighing the residents and addressed the issue.</p>		<p><b>corrective action will be taken?</b></p> <ul style="list-style-type: none"> <li>All residents who have a fluctuation in weight have the potential to be effected.</li> <li>All residents with g-tubes weights' have been audited.</li> </ul> <p><b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</b></p> <ul style="list-style-type: none"> <li>An inservice for nursing staff on how to obtain weights, when to re-weigh, and appropriate monitoring of weight fluctuations will be held on August 26, 2014.</li> <li>The ADON will monitor the weight program until the facility hires a new Clinical Dietary Manager.</li> <li>The consulting RD will monitor weights upon weekly visits and make recommendations that will be followed up on within 3 business days by nursing staff.</li> </ul> <p><b>How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality</b></p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155181	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/12/2014
NAME OF PROVIDER OR SUPPLIER  CARMEL HEALTH & LIVING COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 118 MEDICAL DR CARMEL, IN 46032		
(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	
F000406 SS=D	<p>She indicated if a weight was off the CNA's were to do a reweight.</p> <p>The Administrator indicated during an interview on 8/11/14 at 4:30 P.M. that they were aware there were concerns with the weights and that they were having the Registered Dietician (RD) following residents monthly as of May 2014, and that they were monitoring the RD's performance more closely at that time. There was no other explanation given as to the change in weights from March 2014 to May 2014.</p> <p>3.1-46(a)(2)</p> <p>483.45(a) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services.</p> <p>Based on record review and interview, the facility failed to ensure a</p>	F000406	<p><b>assurance program will be put into place?</b></p> <ul style="list-style-type: none"> <li>· An audit tool will be used to ensure weights are accurate and monitored appropriately weekly x 4, and monthly thereafter.</li> <li>· Any identified areas from audits will be addressed immediately.</li> <li>· Employees not adhering to policy will be re-educated up to and including termination. The results of these audits will be discussed at the monthly facility Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed.</li> </ul> <p><b>F406 Provide/obtain Specialized Rehab Services</b> It is the practice of this provider to</p>	09/02/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155181	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/12/2014
NAME OF PROVIDER OR SUPPLIER  CARMEL HEALTH & LIVING COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 118 MEDICAL DR CARMEL, IN 46032		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>Neuropsychological evaluation was completed as recommended by the resident's PASRR (Pre Assessment Resident Review) for 1 of 1 resident's reviewed for PASRR services. (Resident #181)</p> <p>Findings include:</p> <p>Resident #181's record was reviewed on 8/8/2014 at 9:04 A.M. Diagnoses included, but were not limited to, Wernicke's encephalopathy (a condition causing a decline in mental ability due to the lack of B-vitamin reserves, in particular thiamine / vitamin B 1), depression, anxiety, delusions, and Crohn's disease (chronic inflammatory disease of the intestines).</p> <p>The record indicated the resident was admitted to the facility on 6/25/2013 after a hospitalization for AMS (Altered Mental Status) / confusion due to possible Wernicke's encephalopathy. Prior to her hospitalization the resident was living independently but since her confusion was not cleared up, the hospital felt a home discharge was not a safe option.</p> <p>A nursing progress note dated 11/18/13, indicated, " Resident very tearful and emotional at this time... asking how long</p>		<p>ensure that residents who require specialized rehab services by an outside services such as PT, OT, ST, or rehab services for mental illness and mental retardation are required in the residents plan of care, the facility must provide the required services from an outside provider. The facility does not agree with the federal citation and therefore is reequesting a face to face informal dispute resolution process due to the fact that the resident did have a neuro psych eval scheduled for September 4, 2014, at the time of the recertification survey. <b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b> · Resident #181 has a neuropsych eval scheduled September 4, 2014. · Resident #181 4B was approved the week prior to annual recertification foregoing the neuro psych evaluation. <b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b> · All residents who have who are identified by the PASARR level 2 process have the potential to be affected. <b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</b> · An</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155181		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/12/2014	
NAME OF PROVIDER OR SUPPLIER  CARMEL HEALTH & LIVING COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 118 MEDICAL DR CARMEL, IN 46032			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>she had been here at facility and why she was here.... "</p> <p>A progress nursing note dated 11/19/2013 indicated the following: "resident upset tonight states room mate mocks her and is rude...." A progress note dated 11/20/2013 indicated, "Arguing with room mate...."</p> <p>The record indicated the resident had a, PASARR/MI (Pre Admission Screening Annual Resident Review/Mental Illness) dated 11/22/2013, done.</p> <p>According to, " medicaid.gov" a PASRR, "...is a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care...."</p> <p>The resident's PASRR document indicated the resident was mentally ill and to continue current MH (mental health) services and yearly resident review. In addition it indicated: "(X) Needs Further Review - Specify: Needs neuropsychological evaluation. (X) Other - Specify: Appropriate placement is difficult to identify pending results of neuropsychological evaluation...."</p> <p>The 11/22/2013 PASARR/MI narrative description indicated the following, "...</p>		<p>inservice will be provided to social services to review the PASARR Level 2 process to ensure all recommended procedures are obtained timely regardless of payor source. · All Level 2's will be reviewed at the clinical meeting to ensure all recommended services are added to the resident's care plan.</p> <p><b>How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</b> · An audit tool will be used monthly x 3 months, quarterly thereafter, to ensure all interventions from the Level 2 were followed and implemented into the residents plan of care. · Any identified areas lacking from audits will be addressed immediately. · Employees not adhering to policy will be re-educated up to and including termination. The results of these audits will be discussed at the monthly facility Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155181	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/12/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CARMEL HEALTH & LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 118 MEDICAL DR CARMEL, IN 46032
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>[name of resident] needs a neuropsychological evaluation to further assess her cognitive impairment secondary to Wernicke's Encephalopathy and whether it is progressing to Wernicke-Korsakoff [a psychosis resulting from permanent damage to areas of the brain involved with memory due to vitamin B 1 deficiency]. She could also benefit from more frequent psychiatric sessions largely due to increasing agitation and outbursts towards facility staff, especially since her dose of Olanzapine [an anti-psychotic medication] was decreased at her last session in 10/2013. It appears that the current facility is not an appropriate setting for her, but a more appropriate placement is difficult to determine pending results of neuropsychological testing."</p> <p>At the bottom of the PASARR/MI: "This person's current or past behavior presents a danger to self or others?[ X ] Yes...Increasingly aggressive/angry towards staff due to her delusions and confusion. She denies any suicidal or homicidal idealation."</p> <p>A psychiatric progress note dated 12/3/13 indicated the following : "very very confused. Extremely tearful and anxious. SS[social service] feels like this is not an</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155181		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/12/2014	
NAME OF PROVIDER OR SUPPLIER  CARMEL HEALTH & LIVING COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 118 MEDICAL DR CARMEL, IN 46032			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>appropriate placement for her. Neuro [neurological] eval [evaluation] is in the works. Pt.[patient] crying - wants to go home. Believes she can care for her self. Nsg [nursing] reports frequent episodes daily of crying. Sometimes becomes agitated with staff. c/o[complaining of] inability to stay asleep @ [at] noc [night]. Pt has no recollection of memory..." Mood indicated as," dysphoric [feeling unwell or unhappy]. "</p> <p>An activity progress note dated 12/30/13, indicated, " ...refuses to come to any of the group activities.... "</p> <p>A nursing progress note dated 1/9/14, indicated, " Resident refused shower x[times] 2.... "</p> <p>A nursing progress note dated 1/12/14, indicated, " ...very upset crying walking up and down hall... ' How did I get here, How long have I been here,...?' .... "</p> <p>A nursing progress note dated 1/13/2014, indicated the following: "Resident very upset and shaking at this time. Stating she wants to leave facility...Resident MD ordered one dose Ativan [anti-anxiety] 1 mg [milligram]...."</p> <p>A psychiatric progress note dated 1/21/14 indicated, "...recommend neuropsych</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155181	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/12/2014
NAME OF PROVIDER OR SUPPLIER  CARMEL HEALTH & LIVING COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 118 MEDICAL DR CARMEL, IN 46032		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>testing...will discuss above with social worker...."</p> <p>A psychiatric progress note dated 2/03/14, "continues to cry consistently. Very paranoid that people are out to get her and make her stay here. Has taken a few showers which is an improvement from last month...."</p> <p>A Social Services progress note dated 2/18/14, " Writer called and spoke with resident's son regarding the current status of scheduling her Neuro appt... "</p> <p>A mental and behavioral health visit note dated 2/27/2014, and under description and purpose of clinician intervention, "...Met w [with] /pt [patient] to assess mood and discuss recent interaction with other resident. Worked to understand trigger and cause of pt aggression. Tried to help pt relax and engage and reassure her that she is being well taken care of...Patient's response to Intervention/Progress toward Goal: Pt was disengaged and agitated throughout session. Pt continues to have increased agitation about being in facility and not knowing why - memory impairment causes her to forget repeated conversations about why she's in facility and future plan. Pt reported she doesn't remember getting into it with any other</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155181		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/12/2014	
NAME OF PROVIDER OR SUPPLIER  CARMEL HEALTH & LIVING COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 118 MEDICAL DR CARMEL, IN 46032			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>residents yesterday...Resistance to Change/Barriers to Goal Attainment: Pt memory impairment makes her increased agitation difficult to assess regarding the root of the agitation and triggers for future aggressive acts...."</p> <p>An event report dated 4/01/2014, "...Resident has been upset since staff asked resident to take shower on previous shift...."</p> <p>A psychiatric progress notes dated 4/01/2014, "...No real [symbol for changes]. Still has episodes of tearfulness which is difficult to redirect. Confused @ x's[times] &amp; unable to comprehend her circumstances. Resting in bed. Startled when her name called. Pt pleasant a little more talkative then previous visits. Lots of supetative[sic] questions during her confusion. She states 'trying to accept things' Records dates of her son's visits so she remembers when he has visited."</p> <p>A nursing progress note dated 4/2/14, " Message left for son [name] regarding neuro appt to be made.... "</p> <p>A mental &amp; behavioral health visit note dated 5/14/2014, "Description &amp; Purpose of Clinician Intervention: Met w/pt in room to discuss adjustment to having a</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155181	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/12/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CARMEL HEALTH & LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 118 MEDICAL DR CARMEL, IN 46032
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>roommate. Encouraged her to look at the activities calendar and try to get out of her room once each day for a change in scenery. Staff mentioned that pt has neuro consult coming up soon...Patient's response to intervention/progress toward goal: Pt has significant memory impairment and stated that her roommate has only been there for one night (roommate moved in 3-4 days ago). Pt is struggling to adjust to having all of the extra 'stuff' in her room. She stated that she will look at the events calendar but was hesitant to commit to leaving the room. Resistance to change/barriers to goal attainment: memory impairment."</p> <p>Resident #181's record indicated the resident did not have an appointment with a neurologist until May 20,2014. Tests were ordered at that time. An EEG (Electroencephalogram - a test that detects electrical activity in the brain) was performed on 6/12/14 and an MRI (Magnetic Resonance Imaging) of the brain was done on 7/24/14. The resident's record indicated Neuro Psych testing was still needing to be completed.</p> <p>During an interview on 8/8/2014 at 9:57 A.M., the Assistant Social Service Director indicated, she thought neuropsychological testing had been done with the resident's son involved but she</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155181	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/12/2014
NAME OF PROVIDER OR SUPPLIER  CARMEL HEALTH & LIVING COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 118 MEDICAL DR CARMEL, IN 46032		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>would have to look at the documentation.</p> <p>During an interview with the Assistant SSD on 8/12/2014 at 10:44 A.M., she indicated the responsibility of who makes sure something like a neuropsych testing is schedule and done is really a team effort involving social service, nursing and the family.</p> <p>Upon exit on 8/12/2014 at 1:15 P.M., the Administrator indicated some of the PASARR / MI recommendations had been followed, but the neuropsych testing for Resident #181 was never done because of a billing issue.</p> <p>3.1-23(a)(2)</p>				