

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 06/08/2015
--	---	--	---

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
F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>This visit was in conjunction with the Investigation of Complaint IN00174553.</p> <p>Survey dates: May 31, and June 1, 2, 3, 4, 5, 6, 7 and 8, 2015.</p> <p>Facility number: 000095 Provider number: 155181 AIM number: 100290490</p> <p>Census bed type: SNF: 18 SNF/NF: 114 Total: 132</p> <p>Census payor type: Medicare: 15 Medicaid: 100 Other: 17 Total: 132</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000	Please find enclosed the Plan of Correction to the annual Recertification and State Licensure Survey conducted on June 8, 2015. This letter is to inform you that the plan of correction attached is to serve as Carmel Health and Living credible allegation of compliance. We allege compliance on June 30, 2015. We are requesting a desk review for this plan of correction.	
F 0225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT			

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 <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 06/08/2015
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	
Bldg. 00	<p>ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on interview and record review, the facility failed to follow their policy</p>	F 0225	F225 I. The corrective actions to be accomplished for those residents found to have been	06/30/2015	

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 06/08/2015
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>and procedure related to reporting and investigating an abuse allegation of a resident. This deficient practice had the potential to affect 1 of 3 sampled residents. (Resident #5)</p> <p>Findings Include:</p> <p>Resident #5's clinical record was reviewed on 06/08/15 5:48 p.m. Resident #5's diagnoses included, but were not limited to, muscle weakness, neuropathy, pain, end stage renal disease, arthritis, dysphagia, borderline personality disorder, and Diabetes Mellitus.</p> <p>Record review of an abuse investigation was completed on 06/06/2015 at 5:58 p.m., and included a document titled "Indiana State Department of Health Division of Long Term Care Incident Report Form." This form indicated that the initial report for this abuse allegation was made on 06/02/2015, and the follow up report was submitted on 06/07/2015.</p> <p>Record review of the investigation on 06/08/2015 at 5:48 p.m., included an e-mail exchange between Resident #5 and the Administrator. On 02/22/2015 at 3:07 p.m., the Administrator e-mailed Resident #5 "...[name of nurse] said you had a concern from yesterday...?"</p>		<p>affected by the deficient practice. The allegation made by resident #5 was reported to ISDH on 6/2/2015. C.n.a #13 was removed from her care on 2/23/2015 upon initial concern and has not cared for resident #5 since. II. The facility will identify other residents that may potentially be affected by the deficient practice. Residents who reside at Carmel Health & Living have the potential to be affected by the alleged deficient practice. Other residents were interviewed throughout the facility about recent care and no other concerns were noted. Staff members were interviewed related to c.n.a #13's character, work ethic, work habits and no concerns noted. III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur. The administrator and director of nursing were re-educated by the CarDon Clinical Nurse Specialist on the Abuse reporting policy and procedure and CQI abuse investigation checklist. A CQI abuse investigation checklist is currently utilized by the administrator and director of nursing for each investigation to ensure future investigations have the necessary documentation to determine the decisions of reinstating employees, terminating employees and reporting</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 06/08/2015
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 #5 responded to the e-mail on 02/22/2015 at 3:28 p.m., indicating that CNA (certified nursing assistant) #13 was trying to hurt her, digging her finger nails in, and moving too fast. Resident #5 also indicated that CNA #13 rolled her eyes when Resident #5 tried to explain what CNA #13 was doing incorrectly.</p> <p>A current facility policy titled, "Abuse Prevention" dated 08/21/2013, provided by the Clinical Specialist on 06/08/2015 at 2:35 p.m., indicated, "...V. Abuse Investigations...All reports of resident abuse, neglect and injuries of an unknown source shall be immediately and thoroughly investigated by facility management...a. The State licensing/certification agency responsible for surveying/licensing the facility immediately...."</p> <p>During an interview on 06/03/2014 at 11:30 a.m., the Administrator with the Clinical Specialist in attendance, the Administrator indicated she did not report the alleged abuse allegation to the state until 06/02/2015.</p> <p>3.1-28(e)</p>		<p>employees to the ISDH andlicensure boards of Indiana. QISinterview tool will be utilized to interview residents within the facility andfamily members to ensure no further risks of harm exists in the current careenvironment for those residents potentially affected Thefacility will re-in-service staff and contracted services on the abusereporting policy and procedure including; identifying multiple and variousforms of abuse, reporting immediately, and overall review of abuse prevention. Apost- test was utilized to ensure the staff and contracted servicescomprehended the abuse guidelines and policy/procedure to protect the residentsand families from harm. Staffmembers who are suspended related to abuse allegations will be reviewed by thecorporate clinical consultant, corporate director of operations and corporateteam human resources director prior to being reinstated into the workplace to ensurethe alleged deficient practice does not reoccur. IV. The facility will monitor thecorrective action by implementing the following measures. A CQIaudit tool will be utilized to audit allegations of abuse to ensure thefacility enacts all the necessary steps of investigation conducted daily, whenallegation occurs, by the Clinical Specialist</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 06/08/2015
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	
F 0226 SS=D Bldg. 00	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident		for 30 days. The Clinical Specialist or Designee will conduct weekly QA audit by randomly interviewing a minimum of 5 staff members weekly for 4 weeks. The Clinical Specialist or designee will audit all allegations of abuse weekly x 4 weeks, to monitor for comprehensive and complete investigation. The QIS abuse questionnaire will be integrated into the facility routine customer service/care program and utilized monthly with residents to create an environment of freedom to report potential abuse without the fear of retaliation. This QIS abuse tool will be performed on at least 10 residents with a BIMS of 10 or higher weekly x 4 weeks. Results of these audits will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed. Staff will be re-educated up to and including termination. Facility Administrator will be responsible for ensuring compliance. V. Plan of Correction completion date. Plan of Correction date is June 30, 2015.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155181	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 06/08/2015
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>property. Based on interview and record review, the facility failed to ensure staff were aware of abuse policy and procedures for 3 of 8 facility staff members interviewed regarding the abuse policy and procedures. (Employees #10, #11 and #12)</p> <p>Findings include:</p> <p>During an interview on 06/08/15 at 3:58 p.m., CNA/RA (Certified Nursing Assistant/Restorative Aide) #10 indicated she would find a supervisor or another staff member if she witnessed an abusive situation involving a resident. CNA/RA #10 indicated it was best to have two people to confront a situation.</p> <p>During an interview on 06/08/2015 at 4:08 p.m., CNA #11 indicated she would immediately find a supervisor if she witnessed an abusive situation involving a resident.</p> <p>During an interview on 06/08/15 at 4:32 p.m., DA (Dietary Aide) #12 indicated he would run and find a nurse if he witnessed an abusive situation involving a resident.</p> <p>During an interview on 06/08/15 at 4:48 p.m., the Administrator indicated the</p>	F 0226	<p>F226</p> <p>I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.</p> <p>Noresidents were affected by the deficient practice.</p> <p>II. The facility will identify other residents that may potentially be affected by the deficient practice.</p> <p>Employee#10, #11, #12 were re-educated on the facility abuse reporting policy.</p> <p>III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.</p> <p>The facility will re-in-service staff and contracted services on the abuse reporting policy and procedure including; identifying multiple and various forms of abuse, reporting immediately, and overall review of abuse prevention.</p> <p>Apost- test was utilized to ensure the staff and contracted services comprehended the abuse guidelines and policy/procedure to protect the residents and</p>	06/30/2015	

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 06/08/2015
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>education provided to the staff in regards to abuse was to protect the resident first, then report.</p> <p>Abuse In-Service dated 6/03/15, indicated what to do if an employee witnesses abuse. The first step is to "Remove the resident from harm; make sure their (sic) okay, report to the Administrator immediately."</p> <p>The current facility policy titled, "Abuse Prevention" dated 08/21/2013, provided by the Clinical Specialist on 06/06/15 at 2:35 p.m., indicated, "...We have established policies and procedures that will provide facility personnel with the knowledge and training to further ensure each resident is treated with individual respect and dignity... Employees, facility consultants and/or attending physicians must report any suspected abuse or incidents of abuse to the Administrator or Designee immediately once the resident is protected from harm and removed from any potential abusive situation...."</p> <p>3.1-28(a)</p>		<p>families from harm.</p> <p>Staffmembers who are suspended related to abuse allegations will be reviewed by the corporate clinical consultant, corporate director of operations and corporate human resources director prior to being reinstated into the workplace to ensure the alleged deficient practice does not reoccur.</p> <p>IV. The facility will monitor the corrective action by implementing the following measures.</p> <p>The Clinical Specialist or Designee will conduct weekly QA audit by randomly interviewing a minimum of 5 staff members weekly for 4 weeks.</p> <p>The Clinical Specialist or designee will audit all allegations of abuse weekly x 4 weeks, to monitor for comprehensive and complete investigation.</p> <p>The QIS abuse questionnaire will be integrated into the facility routine customer service/care program and utilized monthly with residents to create an environment of freedom to report potential abuse without the fear of retaliation. This QIS abuse tool will be performed on at least 10 residents with a BIMS of 10 or higher weekly x 4 weeks.</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 06/08/2015
--	---	--	---

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
F 0248 SS=D Bldg. 00	<p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES</p> <p>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>Based on observation, interview, and record review the facility failed to provide individualized activities for 2 of 2 residents reviewed for activities. (Residents #1 and #140)</p> <p>Findings include:</p>	F 0248	<p>Results of these audits will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed.</p> <p>Staff will be re-educated upto and including termination.</p> <p>Facility Administrator will be responsible for ensuring compliance.</p> <p>V. Plan of Correction completion date.</p> <p>Plan of Correction date is June 30, 2015.</p> <p>F248</p> <p>I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.</p> <p>Resident 1 was re-assessed and care plan reviewed and updated to</p>	06/30/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155181		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 06/08/2015	
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. On 6/6/15 at 11 a.m., the record review for Resident #1 was completed. Diagnoses included, but were not limited to diabetes, heart failure, dementia, and high blood pressure.</p> <p>The Minimum Data Set (MDS) dated 5/14/15, indicated the resident was not interviewable due to her cognition. The Preference for Customary Routine and Activities indicated the resident was interviewed for daily preferences and the resident indicated it was not very important to have newspapers, books and magazines to read, it was very important to have music to listen to, to be around animals, to do things with groups of people, to do her favorite activities, go outside when the weather was good, and to participate in religious services. It was somewhat important to her to keep up with news.</p> <p>On the following dates the resident was observed:</p> <p>On 6/4/2015 at 2:58 p.m., the resident was observed lying in bed with her eyes closed on her left side.</p> <p>On 6/5/15 at 1:27 p.m., the resident was sitting in the television lounge of 300 with her eyes shut. There was an activity of Wii bowling going on in the Activity</p>		<p>meet the individualized activity needs of the resident.</p> <p>Resident 140 was re- assessed and care plan reviewedand updated to meet the individualized activity needs of the resident.</p> <p>II. The facility will identify other residents that may potentially be affected by the deficient practice.</p> <p>All cognitively impaired residents, with BIMS less than 10, have the potential to be affected by the alleged deficient practice.</p> <p>III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.</p> <p>The activities calendar will be reviewed and updated to meet the activity needs of cognitively impaired residents, BIMS less than 10, to include sensory stimulation and one to one visits as appropriate.</p> <p>Activity staff will be re-in serviced on identifying and providing activities for the cognitively impaired, including</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 06/08/2015
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>Room.</p> <p>On 6/5/15 at 2:01 p.m., she was lying on her bed with her eyes closed.</p> <p>On 6/5/15 at 3:06 p.m., the resident was lying in bed while a happy hour with live music was going on in the lounge area.</p> <p>On 6/08/15 at 10:05 a.m., the resident observed sitting in her wheelchair in the 300 unit hallway.</p> <p>The Care Plan for Resident #1 for Activities dated 5/14/15, indicated Resident #1 had potential for little activity involvement related to cognition and hearing loss. Staff would assist the resident to and from activities as needed. Staff would give daily reminders of activities such as; (current events, happy hour, church word games) and provide a monthly activity calendar to allow choice and promote upcoming events. The Staff would observe for changes throughout the next review and address accordingly. The staff would offer ala carte materials of interest for independent leisure such as; activity packets, magazines and pet visits when available. Staff would respect her decisions at all times and autonomy will be maintained.</p> <p>The Activity note dated 10/23/14,</p>		<p>appropriatedocumentation.</p> <p>IV The facility will monitor the corrective action by implementing the following measures.</p> <p>Administrator/Designee will audit random sample of cognitively impaired residents for activity offered and participation weekly x 4 weeks.</p> <p>Results of this audit will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed.</p> <p>Staff will be re-educated up to and including termination.</p> <p>Facility Administrator will be responsible for ensuring compliance.</p> <p>V. Plan of Correction completion date.</p> <p>Plan of Completion date is June 30, 2015</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 06/08/2015
--	---	--	---

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>indicated, the resident enjoyed a variety of activities and enjoyed time spent with others. She had attended functions such as; bingo, coffee junkies, church, hang-man, tall tales, brain teasers, wheel of fortune and baking buddies. She was active during most groups. She attended meals in the dining room where she had extended socialization. She enjoyed watching TV in her room. Staff would continue to encourage participation in groups of interest. Activity care plan was appropriate, would continue thru next review.</p> <p>The Activity note dated 12/17/14, indicated the potential for little activity involvement related to mobility, cognition, and hearing loss. Her current interest were pets, current events, movies, TV, music and church. Staff would give daily reminders of activities such as; church, current events, happy hour and provide a monthly activity calendar to allow choice and promote upcoming events. Would provide ala carte materials for independent leisure such as magazines, pet visits when available, and activity packets. She enjoyed watching TV in the 300 lobby lounge and in her room when not attending activities. Staff would respect her decisions at all times and autonomy will be maintained. Staff would observe for changes 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 06/08/2015
--	---	--	---

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 next review and address accordingly.</p> <p>The Activity note dated 2/11/15, indicated the resident had little potential for group activity involvement related to mobility, cognition, weakness and hearing impairment. Her current interest are pets, current events, movies, TV, music and spiritual activities. Staff would give daily reminders of activities such as; sensory group, movies, happy hour and provide a monthly activity calendar to allow choice and promote upcoming events. The staff would provide ala carte materials for independent leisure such as magazines, pet visits when available, markers and crayons and paper activity packets. She enjoyed watching TV in the 300 lobby lounge and in her room, when not attending activities. Staff would respect her decisions at all times and autonomy would be maintained. Staff would observe for changes throughout the next review and address accordingly. Activity care plan was appropriate.</p> <p>The June 2015, Activity Calendar indicated: 6-1-15 at 10:30 a.m., the resident was passive at the church service activity. The resident was sleeping on the evening shift.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155181	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/08/2015
--	---	---	---

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>6-2-15 the resident was sleeping in the morning and evening</p> <p>6-3-15 was blank</p> <p>6-4-15 was blank</p> <p>6-5-15 was blank</p> <p>6-6-15 was blank</p> <p>6-7-15 was blank</p> <p>There was no documentation regarding offering of activities and the resident's refusal of activities nor was there any one on one activities documented.</p> <p>During an interview on 6/8/15 at 4:32 p.m., the Activity Director (AD) indicated the resident had been more sleepy lately and harder to involve in activities. The AD indicated the staff do one to one visit sheets, but they were not completed for this resident. He indicated if a resident refused activities it should be documented on the one to one sheets or the calendars, but there was no documentation of that for this resident.</p> <p>On 6/8/15 at 5:02 p.m., the AD indicated he had not been documenting to indicate if the resident had been getting her activity needs reviewed and met. He indicated he thought he had her on one on one's, but he had not.</p> <p>2. On 6/4/15 at 10 a.m., the record review for Resident #140 was completed.</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 06/08/2015
--	---	--	---

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>Diagnoses included, but were not limited to, depression, high blood pressure and high cholesterol.</p> <p>The Minimum Data Set (MDS) dated 11/30/14, indicated the resident was moderately cognitively impaired, it was very important to have books, newspapers and magazines to read, and listen to music he liked, to be around animals such as; pets, to go outside to get fresh air when the weather was good and to keep up with the news and to do his favorite activities. The group activities were somewhat important.</p> <p>On the following dates the resident was observed:</p> <p>On 6/4/15 11:24 a.m., the resident was sitting in his recliner in his room and had the television on and it had a zebedee.com on the television screen. He indicated at that time, he did not know what he was watching, but the television was on.</p> <p>On 6/4/15 at 2:53 p.m., the resident was observed to be sitting in his recliner. The television had zebedee.com on the television screen. He indicated he had been napping.</p> <p>On 6/5/15 at 1:20 p.m., the resident was</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 06/08/2015
--	---	--	---

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>lying in bed on his right side. The television was on and the same zebedee.com was on. There was an activity of Wii bowling going on in the Activity Room.</p> <p>On 6/5/15 at 3:06 p.m., the resident was lying in bed while a happy hour with live music was going on in the lounge area.</p> <p>On 6/6/15 at 1:25 p.m., the resident was in his room sitting in his chair. The resident was awake and there was no music or television on and he was awake and alert. The resident indicated he was ok, but that he was lonely sometimes after losing his wife.</p> <p>On 6/6/15 at 1:27 p.m., the resident was lying in bed on his back with his eyes closed and he had the television on.</p> <p>On 6/8/15 10:05 a.m., the resident was observed sitting in his wheelchair in the 400 unit hallway.</p> <p>On 6/8/15 at 10:16 a.m., the resident indicated he was going to nap, then take another nap. He indicated there was nothing else to do as there were no games to play, and he was too old to do some of the other things.</p> <p>The resident's Activity Care Plan dated</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 06/08/2015
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>11/29/14, indicated the resident preferred to structure his own independent activities of interest daily.</p> <p>11/26/14-The staff would encourage him to remain in contact with his support system.</p> <p>11/28/14 -The staff would respect his decision at all times and autonomy would be maintained. Staff would give daily reminders of activities of interest such as; (baking buddies, current events, movie night) and would provide a monthly activity calendar to allow choice and promote upcoming events.</p> <p>11/29/14- The staff would observe for changes throughout the next resident review and address accordingly.</p> <p>12/30/14-The resident preferred to be called Fritz.</p> <p>The June 2015, Activity Calendar indicated :</p> <p>6-1-15-the resident watched television</p> <p>6-2-15- the resident was reading in the morning and evening</p> <p>6-3-15- the resident read and watched television .</p> <p>6-4-15 the resident was reading and watched television</p> <p>6-5-15 the resident slept in morning and afternoon</p> <p>During an interview on 6/8/15 at 4:32</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 06/08/2015
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	
F 0279 SS=D Bldg. 00	<p>p.m., the Activity Director (AD) indicated the resident had been more sleepy lately and harder to involve in activities. The AD indicated the staff do one to one visit sheets, but they were not completed for this resident. He indicated if a resident refused it should be documented on the one to one sheets or the calendars, but there was no documentation of that. He indicated the family of Resident #140 had concerns related to the resident not doing activities.</p> <p>During an interview on 6/8/15 at 5:02 p.m., the AD indicated he had not been documenting to indicate the resident had been getting his activity needs met.</p> <p>3.1-33(a)</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155181	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/08/2015
--	---	---	---

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 care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on interview and record review, the facility failed to develop a Care Plan for a resident at risk for pressure ulcers for 1 of 31 residents reviewed for Care Plans. (Resident C)</p> <p>Finding included:</p> <p>On 6/4/15 at 9:42 a.m., the record review for Resident C was completed.</p> <p>Diagnoses included, but were not limited to, Peripheral Vascular Disease, diabetes, End Stage Renal Disease, gout, chronic pain, and anemia.</p> <p>Resident C lacked a Care Plan for pressure ulcers.</p> <p>During an interview on 6/02/15 at 10:03 a.m., LPN #1 indicated the resident had a lateral (side) right distal foot pressure ulcer measuring 1.8 centimeters (cm) x 1 cm x 0.4 cm.</p> <p>There was a wound on the posterior</p>	F 0279	<p>F248</p> <p>I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.</p> <p>Resident 1 was re-assessed and care plan reviewed and updated to meet the individualized activity needs of the resident.</p> <p>Resident 140 was re- assessed and care plan reviewed and updated to meet the individualized activity needs of the resident.</p> <p>II. The facility will identify other residents that may potentially be affected by the deficient practice.</p> <p>All cognitively impaired residents, with BIMS less than 10, have the potential to be affected by the alleged deficient practice.</p>	06/30/2015

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 06/08/2015
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>(back) area of the left heel. The area measured 3 cm x 2 cm x 0.1 cm. The wounds were acquired in house and were stage 3 wounds.</p> <p>On 6/8/15 at 11 a.m., a request was made for the current Pressure Wound Care Plan. LPN # 4 provided a Care Plan dated 6/8/15, for the resident's skin breakdown.</p> <p>During an interview on 6/8/15 at 5:27 p.m., RN #4 indicated the Care Plan dated 6/8/15, was the resident's current Care Plan for pressure ulcers.</p> <p>3.1-35(a)</p>		<p>III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.</p> <p>The activities calendar will be reviewed and updated to meet the activity needs of cognitively impaired residents, BIMS less than 10, to include sensory stimulation and one to one visits as appropriate.</p> <p>Activity staff will be re-in serviced on identifying and providing activities for the cognitively impaired, including appropriate documentation.</p> <p>IV The facility will monitor the corrective action by implementing the following measures.</p> <p>Administrator/Designee will audit random sample of cognitively impaired residents for activity offered and participation weekly x 4 weeks.</p> <p>Results of this audit will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be</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 06/08/2015
--	---	--	---

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
F 0282 SS=D Bldg. 00	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>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> <p>Based on observation, interview and record review, the facility failed to follow the Care Plan for activities for 2 of 31 residents reviewed for Care Plans. (Residents #1 and #140)</p> <p>Findings include:</p> <p>1. On 6/6/15 at 11 a.m., the record review for Resident #1 was completed. Diagnoses included, but were not limited to diabetes, heart failure, dementia, and high blood pressure.</p>	F 0282	<p>adjusted as needed.</p> <p>Staff will be re-educated upto and including termination.</p> <p>Facility Administrator will be responsible forensuring compliance.</p> <p>V. Plan of Correction completion date.</p> <p>Plan of Completion date is June 30, 2015</p> <p>F282</p> <p>I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.</p> <p>Resident 1 was re-assessed and care plan reviewed and updated to meet the individualized activity needs of the resident.</p> <p>Resident 140 was re- assessed and care plan reviewed and updated to meet the</p>	06/30/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155181	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/08/2015
--	---	---	---

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>On the following dates the resident was observed:</p> <p>On 6/4/2015 at 2:58 p.m., the resident was observed lying in bed with her eyes closed on her left side.</p> <p>On 6/5/15 at 1:27 p.m., the resident was sitting in the television lounge of 300 with her eyes shut. There was an activity of Wii bowling going on in the Activity Room.</p> <p>On 6/5/15 at 2:01 p.m., she was lying on her bed with her eyes closed.</p> <p>On 6/5/15 at 3:06 p.m., the resident was lying in bed while a happy hour with live music was going on in the lounge area.</p> <p>On 6/08/15 at 10:05 a.m., the resident observed sitting in her wheelchair in the 300 unit hallway.</p> <p>The Care Plan for Resident #1 for Activities dated 5/14/15, indicated Resident #1 had potential for little activity involvement related to cognition and hearing loss. Staff would assist the resident to and from activities as needed. Staff would give daily reminders of activities such as; (current events, happy hour, church word games) and provide a monthly activity calendar to allow choice</p>		<p>individualized activity needs of the resident.</p> <p>II. The facility will identify other residents that may potentially be affected by the deficient practice.</p> <p>All cognitively impaired residents, with BIMS less than 10, have the potential to be affected by the alleged deficient practice.</p> <p>III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.</p> <p>Activity staff will be re-in serviced on identifying and providing activities for the cognitively impaired, including review and updating care plans.</p> <p>IV. The facility will monitor the corrective action by implementing the following measures.</p> <p>Administrator/Designee will audit random sample of cognitively impaired residents care plans weekly x4 weeks.</p> <p>Results of this audit will be reviewed at the monthly Quality Assurance Committee meeting and frequency</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155181		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 06/08/2015	
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>and promote upcoming events. The Staff would observe for changes throughout the next review and address accordingly. The staff would offer ala carte materials of interest for independent leisure such as; activity packets, magazines and pet visits when available. Staff would respect her decisions at all times and autonomy would be maintained.</p> <p>The Activity note dated 2/11/15, indicated the resident had little potential for group activity involvement related to mobility, cognition, weakness and hearing impairment. Her current interest are pets, current events, movies, TV, music and spiritual activities. Staff would give daily reminders of activities such as; sensory group, movies, happy hour and provide a monthly activity calendar to allow choice and promote upcoming events. The staff would provide ala carte materials for independent leisure such as magazines, pet visits when available, markers and crayons and paper activity packets. She enjoyed watching TV in the 300 lobby lounge and in her room, when not attending activities. Staff would respect her decisions at all times and autonomy would be maintained. Staff would observe for changes throughout the next review and address accordingly. Activity care plan was appropriate.</p>		<p>and duration of reviews will be adjusted as needed.</p> <p>Staff will be re-educated upto and including termination.</p> <p>Facility Administrator will be responsible for ensuring compliance.</p> <p>V. Plan of Correction completion date.</p> <p>Plan of Completion date is June 30, 2015.</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 06/08/2015
--	---	--	---

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 June 2015, Activity Calendar indicated: 6-1-15 at 10:30 a.m., the resident was passive at the church service activity. The resident was sleeping on the evening shift. 6-2-15 the resident was sleeping in the morning and evening 6-3-15 was blank 6-4-15 was blank 6-5-15 was blank 6-6-15 was blank 6-7-15 was blank</p> <p>There was no documentation regarding offering of activities and the resident's refusal of activities nor was there any one on one activities documented.</p> <p>During an interview on 6/8/15 at 4:32 p.m., the Activity Director (AD) indicated the resident had been more sleepy lately and harder to involve in activities. The AD indicated the staff do one to one visit sheets, but they were not completed for this resident. He indicated if a resident refused activities it should be documented on the one to one sheets or the calendars, but there was no documentation of that for this resident.</p> <p>On 6/8/15 at 5:02 p.m., the AD 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 06/08/2015
--	---	--	---

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>he had not been documenting to indicate if the resident had been getting her activity needs reviewed and met. He indicated he thought he had her on one on one's, but he had not.</p> <p>2. On 6/4/15 at 10 a.m., the record review for Resident #140 was completed. Diagnoses included, but were not limited to, depression, high blood pressure and high cholesterol.</p> <p>On the following dates the resident was observed:</p> <p>On 6/4/15 11:24 a.m., the resident was sitting in his recliner in his room and had the television on and it had a zebedee.com on the television screen. He indicated at that time, he did not know what he was watching, but the television was on.</p> <p>On 6/4/15 at 2:53 p.m., the resident was observed to be sitting in his recliner. The television had zebedee.com on the television screen. He indicated he had been napping.</p> <p>On 6/5/15 at 1:20 p.m., the resident was lying in bed on his right side. The television was on and the same zebedee.com was on. There was an activity of Wii bowling going on in 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 06/08/2015
--	---	--	---

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>Activity Room.</p> <p>On 6/5/15 at 3:06 p.m., the resident was lying in bed while a happy hour with live music was going on in the lounge area.</p> <p>On 6/6/15 at 1:25 p.m., the resident was in his room sitting in his chair. The resident was awake and there was no music or television on and he was awake and alert. The resident indicated he was ok, but that he was lonely sometimes after losing his wife.</p> <p>On 6/6/15 at 1:27 p.m., the resident was lying in bed on his back with his eyes closed and he had the television on.</p> <p>On 6/8/15 10:05 a.m., the resident was observed sitting in his wheelchair in the 400 unit hallway.</p> <p>On 6/8/15 at 10:16 a.m., the resident indicated he was going to nap, then take another nap. He indicated there was nothing else to do as there were no games to play, and he was too old to do some of the other things.</p> <p>The resident's Activity Care Plan dated 11/29/14, indicated the resident preferred to structure his own independent activities of interest daily. 11/26/14-The staff would encourage him</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 06/08/2015
--	---	--	---

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>to remain in contact with his support system.</p> <p>11/28/14 -The staff would respect his decision at all times and autonomy would be maintained. Staff would give daily reminders of activities of interest such as; (baking buddies, current events, movie night) and would provide a monthly activity calendar to allow choice and promote upcoming events.</p> <p>11/29/14- The staff would observe for changes throughout the next resident review and address accordingly.</p> <p>The June 2015, Activity Calendar indicated :</p> <p>6-1-15-the resident watched television 6-2-15- the resident was reading in the morning and evening 6-3-15- the resident read and watched television . 6-4-15 the resident was reading and watched television 6-5-15 the resident slept in morning and afternoon</p> <p>During an interview on 6/8/15 at 4:32 p.m., the Activity Director (AD) indicated the resident had been more sleepy lately and harder to involve in activities. The AD indicated the staff do one to one visit sheets, but they were not completed for this resident. He 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 06/08/2015
--	---	--	---

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
F 0309 SS=D Bldg. 00	<p>if a resident refused it should be documented on the one to one sheets or the calendars, but there was no documentation of that. He indicated the family of Resident #140 had concerns related to the resident not doing activities.</p> <p>During an interview on 6/8/15 at 5:02 p.m., the AD indicated he had not been documenting to indicate the resident had been getting his activity needs met.</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 record review and interview, the facility failed to ensure a clearly documented and communicated code status was provided to the dialysis center for 1 of 3 residents reviewed for death in a sample of 31. (Resident #52) Findings include: Resident #52's clinical record was</p>	F 0309	F309 I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice. The resident #52 no longer resides at the facility. Resident #52 records did reflect a DNR stamp at the top of the face sheet as well as the Out of Hospital DNR form. II. The facility will identify other	06/30/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155181	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/08/2015
--	---	---	---

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>reviewed on 06/05/15 9:56 a.m. Resident #52's diagnoses included, but were not limited to end stage renal disease, pressure ulcer, muscle weakness, atrophy, generalized pain, Diabetes Mellitus.</p> <p>The resident's admission paperwork dated 01/07/15, indicated Resident #52 was a Full Code. The resident's "Admission Record" and "Physician Order Report" dated 01/09/2015, indicated the resident was a Full Code. An out of hospital DNR (Do Not Resuscitate) for Resident #52 was signed by the physician on 01/12/15.</p> <p>The record lacked documentation of Resident #52's code status being changed from a Full Code to a DNR.</p> <p>Resident #52 was ordered to receive dialysis three times a week on Tuesday, Thursday, and Saturday. A document titled "Dialysis Communication Form" with the following documents attached "Resident Admission Record", "Physician Order Report", and "Vitals Report" were included in the clinical record as a packet.</p> <p>On 01/12/15, the "Resident Admission Record" and "Physician Order Report" attached to the "Dialysis Communication</p>		<p>residentsthat may potentially be affected by the deficient practice. Residents with advance directives have the potentialto be affected by the alleged deficient practice. III. Thefacility will put into place the following systematic changes to ensure thatthe deficient practice does not recur. Admissions Department, Social Services and NursingDepartments will be in-serviced on Code status policy and procedures. Admissions will gather information from admitting residents/POA. Licensed staff will be trained to signadvance directives with families/residents. Social Services will provide follow up documentation/support. Medical Records nurse will ensure physicianorder, advance directive and care plan all are consistent. IV Thefacility will monitor the corrective action by implementing the followingmeasures. Medical Records/designee will audit all code statusof residents in house currently to ensure consistency of physician orders,advance directive and care plan. Medical Records will continue to audit newadmissions with the medical records audit tool. Results of this audit will bereviewed at the monthly Quality Assurance Committee meeting and frequency andduration of reviews will be adjusted as needed. 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 06/08/2015
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>Form" indicated Resident #52 was a Full Code. On 01/15/15, the "Resident Admission Record" and "Physician Order Report" attached to the "Dialysis Communication Form" indicated Resident #52 was a Full Code.</p> <p>On 01/24/15, the "Resident Admission Form", attached to the "Dialysis Communication Form", indicated the resident was a DNR. "The Physician Order Report" attached to the "Dialysis Communication Sheet" indicated Resident #52 was a Full Code.</p> <p>On 01/27/15, the "Resident Admission Record" indicated Resident #52 was a DNR and the "Physician Order Report" indicated Resident #52 was a Full Code. The progress note dated 1/27/15 at 11:37 a.m., indicated, "Received phone call from [name of company] Dialysis nurse, [name of nurse] requested code paperwork for resident; resident was unresponsive; presented paperwork to EMT (Emergency Medical Technician) and nurse at [dialysis company], resident passed at 11:55 a.m. Family notified ... and physician notified."</p> <p>During an interview on 06/08/15 at 3:00 p.m., the Administrator indicated the</p>		<p>will be re-educated upto and including termination. Facility Administrator will be responsible forensuring compliance. V. Plan of Correction completion date. Plan of Completion date is June 30, 2015</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 06/08/2015
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	
F 0314 SS=D Bldg. 00	<p>"Dialysis Communication Form," "Resident Admission Record", "Physician Order Report" and the "Vitals Report" were sent with the residents to dialysis.</p> <p>During an interview on 06/08/15 at 4:31 p.m., the DON (Director of Nursing) and Patient Transition Coordinator indicated once a DNR form is completed the code status is changed on everything in the computer, a copy is placed in the hard chart and the order is scanned in.</p> <p>A current facility policy titled, "Code Status Policy" dated 03/31/2014, provided by the Clinical Specialist on 06/08/15 at 03:31 p.m., indicated "...A resident has the right to change their resuscitative choices at any time and the change will be honored by the facility immediately...."</p> <p>3.1-37(a)</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155181	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/08/2015
--	---	---	---

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>unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on interview and record review, the facility failed to have pressure prevention interventions in place for 1 of 3 residents who were high risk for pressure ulcers. (Resident C)</p> <p>Findings include:</p> <p>On 6/4/15 at 9:42 a.m., the record review for Resident C was completed. Diagnoses included, but were not limited to, Peripheral Vascular Disease, diabetes, End Stage Renal Disease, gout, chronic pain, and anemia.</p> <p>The observation documentation indicated on 11/11/14, the left lateral heel had a Stage 2 pressure ulcer area, which measured 4.2 centimeters (cm) x 3.8 cm x 0.1 cm.</p> <p>The observation documentation dated 12/1/14, indicated the wound area was acquired in house and was a Stage 2, which measured 4.2 cm x 3.8 cm x 0.1 cm.</p> <p>The observation documentation dated 12/29/14, indicated the left lateral heel was a Stage 3 and measured 3.0 cm x 4.5</p>	F 0314	<p>F314</p> <p>I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.</p> <p>Resident C was not listed on the resident Identifier.</p> <p>II. The facility will identify other residents that may potentially be affected by the deficient practice.</p> <p>Residents at high risk for pressure ulcers may potentially be affected by the deficient practice.</p> <p>III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.</p> <p>Licensed Nurses will be re-educated on appropriate implementation of pressure reducing interventions and documentation and assessments of wounds upon admission and ongoing.</p> <p>All residents that are high risk for wounds will be reassessed for appropriate interventions</p>	06/30/2015

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 06/08/2015
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>cm x 0.1 cm and depth of 0.1 cm.</p> <p>The observation documentation dated 1/19/15, indicated the left heel pressure area had a date of onset 12/18/14, and had no stage and no length and indicated unable to assess.</p> <p>The observation documentation dated 3/3/15, a Stage 3 pressure wound on the left heel and measured 1.2 cm x 0.2 cm x 0.1 cm.</p> <p>The observation documentation dated 3/25/15, indicated the resident had Stage 3 pressure wound to left heel and graft site remained stable.</p> <p>The observation documentation dated 3/31/15, indicated the left heel graft over wound bed, unable to assess wound site at this time due to physicians orders to not remove dressing.</p> <p>The wound center notes dated 4/29/15, indicated the Stage III pressure ulcer located on the right foot lateral distal has been present for approximately 1 month.</p> <p>The wound center note dated 6/3/15, indicated the resident had a Stage III pressure ulcer on left heel and had been present for approximately 6 months. The pressure ulcer was related to immobility.</p>		<p>including resident caresheets and care plans.</p> <p>IV The facility will monitor the correctiveaction by implementing the following measures.</p> <p>DONor designee will utilize an audit tool for residents at high risk, and thosewith current pressure ulcers and residents with new pressure ulcers forpreventative interventions, documentation, assessment, and treatment weekly for4 weeks.</p> <p>Staff will be re-educated upto and including termination.</p> <p>Results of these audits willbe reviewed at the monthly Quality Assurance Committee meeting and frequencyand duration of reviews will be adjusted as needed.</p> <p>Facility Administrator will be responsible forensuring compliance.</p> <p>V. Plan of Correction completion date.</p> <p>Plan of Completion date is June 30, 2015.</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 06/08/2015
--	---	--	---

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 nurses notes from August 2014 through June 2015, indicated no interventions for his heels.</p> <p>The Treatment Administration Record (TAR) for September 2014, indicated: 9/5/14 through 9/25/14, indicated heel foam to left heel. There were no other documented interventions found on the TAR's for October and November 2014.</p> <p>There was no Pressure Intervention Care Plan found.</p> <p>There were no physician's orders found for prevention of pressure ulcers on the feet prior to the pressure ulcer forming in November 2014. A request was made from the Administrator on 6/7/15 at 11 a.m.</p> <p>There was no documentation found regarding the resident refusing unna boots, to elevate heels, or anything for his lower left or right foot. There was no specific documentation related to intervention for pressure for the resident's left heel.</p> <p>The facility was requested to provide any information regarding pressure prevention interventions for the resident related to the development of pressure</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155181	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/08/2015
--	---	---	---

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
F 0323 SS=E Bldg. 00	<p>areas on his heels. As of exit on 6/8/15 at 8:16 p.m., the facility had not provided any information.</p> <p>This Federal tag relates to complaint IN00174533.</p> <p>3.1-40(a)(1)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation and interview, the facility failed to ensure residents' rooms and unit hallways were free of potential accidental hazards for 3 of 188 rooms and 5 of 6 units reviewed for accidental hazards. (Rooms 812, 216 and 409). (Residents #C, #61, #63, #92, #143, #34, #158, #6, #15, #61, #110, #139, #143 and #209).</p> <p>Findings include:</p> <p>1. On 6/2/15 at 4:05 p.m., in room 812,</p>	F 0323	<p>F323</p> <p>I.The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.</p> <p>Resident rooms 812, 216, and 409, extension cords were removed immediately and were not affected by the deficient practice.</p> <p>Residents #61, 63, 92, 143, 34, 158, 6, 15, 61, 110, 139, 143, and</p>	06/30/2015

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 06/08/2015	
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>two brown extension cords were observed plugged into an outlet behind the night stand at the head of the resident's bed.</p> <p>2. On 6/1/15 at 4:25 p.m., in room 216, a white extension cord was observed plugged into a four prong outlet on the floor and was wrapped around the resident's right sided metal 1/4 side rail. The extension cord was hanging from the bedrail.</p> <p>3. On 6/1/15 at 4:35 p.m., in room 409, an outdoor orange utility cord was observed being used to plug personal items into an outlet.</p> <p>During an interview on 6/2/15 at 8:25 a.m., the Administrator indicated the extension cords and the orange outdoor utility cord had been removed from rooms 216, 409 and 812 last evening and power strips were placed in the residents' rooms instead.</p> <p>4. During the initial tour of the 200 Hall on 05/31/2015 at 7:19 p.m., the Electrical room was observed unlocked. The Electrical room had a sign stating "Warning Electrical Panels." Inside the Electrical room were exposed wires on walls, the ceiling, and boxes of cable. Also found in the Electrical room was a bottle of red juice stain remover, a bottle</p>		<p>209, were not affected by the alleged deficient practice.</p> <p>Resident C is not listed on the resident identifier.</p> <p>II. The facility will identify other residents that may potentially be affected by the deficient practice.</p> <p>All residents that resident at Carmel Health & Living have the potential to be affected by the alleged deficient practice.</p> <p>III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.</p> <p>All staff will be re-educated on maintaining an environment which is as free of accident hazards as possible.</p> <p>All staff will be re-educated on reporting maintenance issues for repair.</p> <p>IV. The facility will monitor the corrective action by implementing the following measures.</p> <p>Maintenance staff conducts daily rounds x 4 weeks to ensure all doors that should be locked remain locked at all times.</p> <p>Housekeeping staff clean rooms</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 06/08/2015	
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>of bleach, disinfectant, hand sanitizer, and stagnant water in a housekeeping bucket. Inside the Electrical room had an unlocked door, which lead to the courtyard. Inside the courtyard there was a ladder, which lead to the roof of the building.</p> <p>Residents C, #61, #63, #92, and #143 were mobile and their rooms were in close proximity to the Electrical room.</p> <p>During an interview with the Administrator, at that time, she indicated, "Both doors should be locked."</p> <p>During an interview with the Maintenance man, at that time, he indicated the free passage knob (bypass key pad lock) above the door handle, on the back of the door, was disabled.</p> <p>5. During the initial tour of the 800 Hall on 05/31/2015 at 6:20 p.m., the Soiled Utility room was observed unlocked. Inside the Soiled Utility room were opened chemicals, disinfectant, bathroom scale remover, and Clorox wipes. Inside the Soiled Utility room was an unlocked Biohazard room.</p> <p>A continuation of the tour of the 800 Hall on 05/31/2015 at 6:35 p.m., the Treatment cart was observed unattended</p>		<p>daily and will monitor resident rooms for extension cords and report to social services/maintenance for removal via the maintenance repair form.</p> <p>Administrator/or designee will utilize and audit tool to ensure facility safety weekly x 4 weeks.</p> <p>Results of these audits will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed.</p> <p>Staff will be re-educated upto and including termination.</p> <p>Facility Administrator will be responsible for ensuring compliance.</p> <p>V. Plan of Correction completion date.</p> <p>Plan of completion date is June 30, 2015.</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 06/08/2015
--	---	--	---

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>and unlocked. Observation of the open cart contained ointments and creams.</p> <p>During an interview on 05/31/2015 at 6:43 p.m., CNA #15 indicated the Soiled Utility door was supposed to be locked and sometimes it did not close all the way when a person exited.</p> <p>During an interview on 05/31/2015 at 6:48 p.m., LPN #16 indicated the Treatment cart should to be locked.</p> <p>During an interview on 6/8/2015 at 6:30 p.m., the Clinical Nurse Consultant indicated the facility did not have a policy regarding Treatment carts.</p> <p>6. During the initial tour of the 700 Hall on 05/31/2015 at 7:00 p.m., the Clean Utility room and Soiled Utility room were observed unlocked. Inside the Soiled Utility room were opened chemicals, disinfectant, bathroom scale remover, and Clorox wipes. Inside the Soiled Utility room was an unlocked Biohazard room.</p> <p>During an interview on 05/31/2015 at 7:05 p.m., RN #17 indicated the lock was broken on the Clean Utility room and the Soiled Utility room door jammed, but both doors should be closed and locked.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155181	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/08/2015
--	---	---	---

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
F 0329 SS=D Bldg. 00	<p>7. During the initial tour of the 500 Hall on 05/31/2015 at 7:10 p.m., the Mechanical and Furnace rooms were unlocked.</p> <p>Residents #34 and #158 were mobile and their rooms were in close proximity to the Mechanical and Furnace rooms.</p> <p>8. During the initial tour of the 400 Hall on 05/31/2015 at 7:14 p.m., the Riser and Furnace rooms were unlocked.</p> <p>Residents #6, #15, #61, #110, #139, #143, and #209 were mobile and their rooms were in close proximity to the Riser and Furnace rooms.</p> <p>3.1-19(z)(3) 3.1-45(a)(1) 3.1-45(a)(2)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</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 06/08/2015	
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 a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to monitor for specific targeted behaviors for the use of an antipsychotic medication for 1 of 5 residents reviewed for unnecessary medications. (Resident # 38)</p> <p>Findings include:</p> <p>On 6/4/15 at 9:19 a.m., the record review for Resident #38 was completed. Diagnoses included, but were not limited to, Alzheimer's Disease and anxiety.</p> <p>The physician's orders for May 2015, indicated: 6/1/15-Seroquel (an antipsychotic medication) 25 milligrams (mg) daily for Dementia with behavior disturbances.</p> <p>There was event documentation dated 4/2/15, which indicated to monitor for signs and symptoms of change in mood</p>	F 0329	<p>F329</p> <p>I.The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.</p> <p>Resident #38 antipsychotic medication was reviewed and a GDR was completed on 6/1/15 from 50 mg to 25 mg and on 6/18/15 discontinued. The resident is currently being monitored.</p> <p>II.The facility will identify other residents that my potentially be affected by the deficient practice.</p> <p>Residents currently receiving antipsychotic medications could be affected.</p> <p>III.The facility will put into place the following systematic changes to ensure that the</p>	06/30/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155181	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 06/08/2015
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>and behavior related to decrease of Seroquel (an antipsychotic medication) 25 milligrams (mg) by mouth at bedtime. On 6/1/15, the documentation indicated the Seroquel was decreased from 50 mg to 25 mg every hour of sleep and will monitor for signs and symptoms of change in mood.</p> <p>There was no documentation from Social Services regarding any behaviors.</p> <p>The Physician Progress Notes since August 2014 through June 2015, had no indication of any behavior concerns.</p> <p>On 6/8/15 at 5:59 p.m., the Administrator provided a Discharge Summary from a psych hospital stay on 4/3/12, which indicated the resident had Dementia, senile type secondary to Parkinson's disease with delusions, aggression and agitation and depression and the resident was on Seroquel by mouth 100 milligrams twice daily.</p> <p>The psych notes indicated: 9/30/14-indicated "...no reports of delusions and will discontinue AM dose of Valproic Acid (an antiseizure medication) monitor and call with concerns...."</p> <p>1/2/15- "...no recent mood swings and no</p>		<p>deficient practice does not recur.</p> <p>The IDT team will be re-educated on the Behavior Management Program by the Clinical Specialist.</p> <p>Facility staff will be re-educated on the behavior program.</p> <p>All residents receiving antipsychotic medications are reviewed by the physician for a potential GDR.</p> <p>All residents receiving antipsychotic medications will have targeted behaviors reviewed and identified and updated to the plan of care and monitoring put in place.</p> <p>The Social Service Director and/or her designee will maintain a log of all antipsychotics, antidepressant, and anti-anxiety medications being used within the facility with order date, diagnosis for use, and gradual dose reduction history. The log will be updated and discussed monthly at facility behavior management meeting.</p> <p>IV. The facility will monitor the corrective action by implement the following measures.</p> <p>The Social Service Director or designee will audit documentation and care plans on residents</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 06/08/2015	
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			
F 0332 SS=D Bldg. 00	<p>recent mood swings no adverse affects for Valproic Acid reduction. Will see the resident in 3 months and will try to reduce Seroquel soon...."</p> <p>4/1/15- indicated "...no more delusions and will trial decreased Seroquel 25 mg 1 tablet in the evening, and monitor for adverse impact...."</p> <p>During an interview on 6/8/15 at 6:13 p.m., the Administrator indicated there was not much documentation on behaviors for Resident #38.</p> <p>A request was made on 6/8/15 at 4:00 p.m., for any behavior tracking or documentation for Resident #38. As of the exit conference at 8:16 p.m., no behavior documentation was provided regarding any tracking for delusions.</p> <p>3.1-48(a)(3)</p> <p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. Based on observation, interview and record review, the facility failed to keep the medication error rate at less than 5%</p>	F 0332	<p>receiving antipsychotics,antianxiety, and antidepressant medication, with emphasis on monitoring, weekly x 4 weeks.</p> <p>Staff will be re-educated upto and including termination.</p> <p>Results of these audits willbe reviewed at the monthly Quality Assurance Committee meeting and frequencyand duration of reviews will be adjusted as needed.</p> <p>Facility Administrator will be responsible forensuring compliance.</p> <p>V.Plan of Correction completion date.</p> <p>Plan of Correction date is June 30, 2015.</p> <p>I. The corrective actions to be</p>	06/30/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155181		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 06/08/2015	
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>for 1 of 2 residents observed during medication pass. 2 errors were observed during 27 opportunities for errors in medication administration. This resulted in a medication error rate of 6.66%. (Resident #35)</p> <p>Findings include:</p> <p>On 6/5/15 at 8:15 am, during the medication pass observation, LPN # 3 gave Resident #35 eight units of Novolog insulin (a medication to control blood sugars) subcutaneous (underneath the first layer of skin) via flexpen. The resident also received Sevelamar Carbonate (a medication used to lower high blood phosphorus levels for severe kidney disease) 800 milligrams 2 tablets.</p> <p>On 6/5/15 at 9:15 a.m., the resident had his breakfast in front of him and he indicated he would not eat right now. LPN #3 had not encouraged the resident or educated the resident regarding taking of insulin and his kidney medication and needing to eat.</p> <p>During an interview on 6/8/15 9:50 a.m., the Clinical Specialist indicated she would have wanted the nurse to have educated the resident or encouraged the resident to eat when given insulin.</p>				<p>accomplished for those residents found to have been affected by the deficient practice.</p> <p>LPN #3 interviewed and stated she gave Resident #35 the insulin and Sevelamar Carbonate @ 9:15 after she removed him from his PD, and that the resident had his breakfast tray in front of him. Resident #35 with a BIMS scores of 14 cognitively intact. Resident #35 6/5/15 amount of breakfast consumed was documented as 75-100%. Surveyor reported to Clinical Specialist and Corporate RN that when she returned to the Room of Resident #35 at 10:15am the breakfast tray was no longer in the room. Resident #35 had a Blood Sugar of 295 before the lunch meal on 6/5/15.</p> <p>LPN #3 has been educated on the General Non-Compliance Policy.</p> <p>II. The facility will identify other residents that may potentially be affected by the deficient practice.</p> <p>Residents that receive insulin or Sevelamar Carbonate have the potential to be affected.</p> <p>III. The facility will put into</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155181	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/08/2015
--	---	---	---

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 Physician's Order Report indicated:</p> <p>5/5/15- Sevelamer Carbonate 800 milligrams 2 tablets orally. Special Instructions: Must be taken with meals.</p> <p>5/11/15- Novolog insulin 2 units subcutaneous three times daily. Special Instructions: 2 units in addition to sliding scale with meals.</p> <p>2010 Nursing Spectrum Drug Handbook Novolog Administration Guidelines indicated to give by subcutaneous route only 5-10 minutes before a meal.</p> <p>3.1-25(b)(9)</p>		<p>place the following systematic changes to ensure thatthe deficient practice does not recur.</p> <p>Licensed nurses will be re-educated on administeringmedications with special instructions, to give with meal.</p> <p>Licensed nurses will be re-educated on the GeneralNon-Compliance Policy.</p> <p>IV Thefacility will monitor the corrective action by implementing the followingmeasures.</p> <p>DON or designee will audit random nursemedication pass of residents that receive medications with meals 3 times perweek x 4 weeks, weekly x 4weeks.</p> <p>Results of this audit will bereviewed at the monthly Quality Assurance Committee meeting and frequency andduration of reviews will be adjusted as needed.</p> <p>Staff will be re-educated upto and including termination.</p> <p>Facility Administrator will be responsible forensuring</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 06/08/2015	
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			
F 0356 SS=C Bldg. 00	<p>483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: <ul style="list-style-type: none"> - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> o Clear and readable format. o In a prominent place readily accessible to residents and visitors. <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>Based on observation, interview and record review, the facility failed to ensure</p>	F 0356	<p>compliance.</p> <p>Date of completion June 30, 2015</p> <p>I. The corrective actions to be</p>	06/30/2015			

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 06/08/2015
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>timely posting of nursing staff information for 3 of 9 days observed during the annual survey. This deficient practice had the potential to affect 132 of 132 residents residing in the facility. (May 31, June 1 and June 5, 2015)</p> <p>Findings include:</p> <p>During the initial tour observation on 5/31/15, at 6:10 p.m., the posted "Daily Nurse Staffing" report was dated and included nursing staffing information for 5/29/15.</p> <p>During an observation on 6/2/15 at 10:00 a.m., the posted "Daily Nurse Staffing" report was dated and included nursing staffing information for 6/1/15.</p> <p>During an observation on 6/7/15 at 11:36 a.m., the posted "Daily Nurse Staffing" report was dated and included nursing staffing information for 6/5/15.</p> <p>During an interview on 6/7/15 at 11:36 a.m., the Administrator indicated the receptionist was responsible for switching the "Daily Nurse Staffing" Sheets to the new staffing sheets for that day first thing in the morning.</p> <p>3.1-13(g)(4)</p>		<p>accomplished for those residents found to have been affected by the deficient practice.</p> <p>The required nurse staffing information was corrected when the Administrator was aware.</p> <p>II. The facility will identify other residents that may potentially be affected by the deficient practice.</p> <p>Resident's residing in the facility have the potential to be affected.</p> <p>III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.</p> <p>The scheduler, reception staff, and nurse managers will be re-educated on the importance and timeliness of the staffing posting.</p> <p>IV The facility will monitor the corrective action by implementing the following measures.</p> <p>Administrator or designee will utilize and audit tool to ensure staffing posted daily x 4 weeks,</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 06/08/2015
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	
F 0425 SS=D Bldg. 00	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.		theweekly x 4 weeks. Locationof nurse staffing information will be reviewed in resident council monthly x 3months Results of these audits willbe reviewed at the monthly Quality Assurance Committee meeting and frequencyand duration of reviews will be adjusted as needed. Staff will be re-educated upto and including termination. Facility Administrator will be responsible forensuring compliance. V. Plan of Correction completion date. Plan of Completion date is June 30, 2015.		

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 06/08/2015
--	---	--	---

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 facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on interview and record review, the facility failed to ensure a resident received his medications in a timely manner for 1 of 6 residents being reviewed for pharmacy delivery services. (Resident #174).</p> <p>Findings include:</p> <p>Resident #174's record was reviewed on 6/04/15 at 3:26 p.m. Diagnoses included, but were not limited to, paralytic ileus, constipation, aspiration pneumonia, dysphasia, and altered mental status.</p> <p>The resident's Electronic Medication Administration Record (EMAR) included, but were not limited to, the following orders: 5/9/15--Fleets enema Extra (laxative given rectally) 197 ml (milliliters) administer 197 ml rectally Stat (immediately) for constipation. 5/12/15--Magnesium Citrate Solution (laxative) 75 mg (milligrams) given by</p>	F 0425	<p>F425</p> <p>I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.</p> <p>Resident #174 received a Fleets enema on 5/9/15 prior to Noon, per nurse upon interview Resident #174 had a large BM on 5/9/15</p> <p>Resident #174 received Magnesium Citrate on 5/12/15 at 9am, nurse documented that she charted late when signing off the medication in EMAR at 5/12/15 at 11:53 am. Resident #174 had a medium BM on 5/13/15</p> <p>Resident #174 received Magnesium Citrate on 5/15/15 at 5:00 pm Resident #174 received KUB on</p>	06/30/2015

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 06/08/2015	
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>gastric tube (G tube) twice daily for constipation (Discontinued on 5/24/15).</p> <p>The resident's EMAR indicated the following medications were given at the following dates and times and the resident's progress notes indicated the following:</p> <p>On 5/9/15 a Fleets enema Extra 197 ml administer rectally was ordered Stat. The Fleets enema was given on 5/9/15 at 3:55 p.m.</p> <p>On 5/9/15 5:02 a.m., the physician was notified of the KUB results and an order for a fleets enema times one was given. The Fleets enema was ordered Stat. The nurse was unable to locate the fleets enema in the EDK (Emergency Drug Kit) system. The Skilled pharmacy was called to follow-up on the medication and to ensure that the medication was sent Stat. On 5/9/15 at 4:05 p.m., the Fleets enema was administered when the item arrived from the pharmacy.</p> <p>The physician progress note dated 5/11/15 at 6:15 p.m., indicated the resident had a colonic ileus. The KUB showed decreasing but persistent colonic ileus with large stool burden. The physician indicated he would be giving Magnesium Citrate twice daily through the resident's G-tube.</p>		<p>5/20/15 with results of no bowel obstruction and resident sent to ST. Vincent ER and returned with no new orders and statement that resident did not have ileus.</p> <p>Resident #174 received Magnesium Citrate on 5/22/15 upon rising</p> <p>Resident #174 was sent to ER on 5/24/15 and returned with order to increase Magnesium Citrate to 150ml. Resident #174 had a medium BM on 5/24/15</p> <p>II. The facility will identify other residents that may potentially be affected by the deficient practice.</p> <p>Residents that reside in the facility with STAT orders for medication have the potential to be affected.</p> <p>III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.</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 06/08/2015
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>On 5/11/15 at 9 p.m., the physician order was obtained for Magnesium Citrate twice daily until a bowel movement (BM) was observed. 5/12/15--Magnesium Citrate 75 ml by gastric tube daily for constipation. Started on 5/12/15 at 11:53 a.m.</p> <p>The physician progress note dated 5/13/15 at 3:41 p.m., a persistent colonic ileus, with no BM yet. The physician indicated the resident had received his first dose of Magnesium Citrate this morning due to delays obtaining medication from pharmacy per nursing. He indicated the resident's abdomen was distended, had tympanic to percussion, was nontender with diminished bowel sounds and less distended with slight improvement from Monday. The KUB x-ray showed decreasing, but persistent colonic ileus with large stool burden. The physician indicated to continue the Magnesium Citrate twice a day through the G tube</p> <p>5/15/15 at 9 a.m.--Magnesium Citrate 75 ml by gastric tube daily for constipation was not administered because RN #5 documented the resident had not received that dose of medication from the pharmacy. 5/21/15 at 8:53 a.m.--Magnesium Citrate 75 ml by gastric tube daily for</p>		<p>Licensed nurses will be re-educated on the STATOrder Pharmacy Policy and procedures when pharmacy does not deliver timely.</p> <p>IV The facility will monitor the corrective action by implementing the following measures.</p> <p>STATorders will be audited 5 x weekly x 4 weeks, then weekly x 4 weeks.</p> <p>Results of this audit will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed.</p> <p>Staff will be re-educated up to and including termination.</p> <p>Facility Administrator will be responsible for ensuring compliance.</p> <p>V. Plan of Correction completion date.</p> <p>Plan of Completion date is June 30, 2015</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 06/08/2015
--	---	--	---

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>constipation was not administered because LPN #6 documented the resident had not received that dose of medication from the pharmacy.</p> <p>5/23/15 at 8:42 p.m.--Magnesium Citrate 75 ml by gastric tube daily for constipation was not administered because LPN #6 documented the resident had not received that dose of medication from the pharmacy.</p> <p>A review of a current undated EDK lists provided by the Clinical Specialist on 6/8/15 at 1:05 p.m., indicated the Fleets enema and Magnesium Citrate were not listed as medications available in the EDK.</p> <p>During an interview on 6/08/15 3:17 p.m., the Clinical Specialist indicated the facility's pharmacy should have delivered the medications the resident needed in a timely manner to be administered to the resident.</p> <p>A current policy dated 7/2009, titled "Stat Orders" provided by the Clinical Specialist on 6/8/15 at 1:05 p.m., indicated "Policy: A stat medication order is defined as a drug necessary to be given by the next scheduled dose... Once the order has been confirmed, the delivery protocol for the medications is four hours... Procedure:...4. If physician</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 06/08/2015
--	---	--	---

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>prescribes a medication not available in the facility emergency supply, inform the physician that the medication is not readily available. Be sure the physician is aware that his/her order will not be available until it is confirmed with the pharmacy and the timeframe may exceed two-hours... 7. The medication will be delivered within the agreed upon timeframe once the order has been confirmed."</p> <p>3.1-25(a)</p>			