

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 10/30/2013
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NAME OF PROVIDER OR SUPPLIER CARMEL HEALTH & LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 118 MEDICAL DR CARMEL, IN 46032
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F000000	<p>This visit was for the Investigation of Complaints IN00138858, IN00138083, and IN00136581.</p> <p>Complaint IN00138858- unsubstantiated due to lack of evidence.</p> <p>Complaint IN00138083- substantiated, federal deficiencies related to the allegations are cited at F323.</p> <p>Complaint IN00136581- unsubstantiated due to lack of evidence.</p> <p>Unrelated deficiency cited.</p> <p>Survey dates: October 28, 29 and 30, 2013</p> <p>Facility number: 000095 Provider number: 155181 AIM number: 100290490</p> <p>Survey team: Rita Mullen, RN, TC Sandra Nolder, RN</p> <p>Census bed type: SNF/NF: 123 SNF: 18</p>	F000000	<p>Submission of this plan of correction does not constitute an admission by Carmel Health and Living or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations. This provider respectfully requests that the 2567 plan of correction be considered as the letter of credible allegation and request a desk review on or after 11/19/13.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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	<p>Total: 141</p> <p>Census payor type: Medicare: 19 Medicaid: 100 Other: 22 Total: 141</p> <p>Sample: 8</p> <p>These deficiencies also reflects State findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review was completed by Tammy Alley RN on November 4, 2013.</p>				

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F000323 SS=D	<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 interview and record review the facility failed to ensure proper positioning of a resident's feet during transportation with a wheelchair, which resulted in two falls within thirty minutes causing an abrasion and a hematoma to his head during the second fall for 1 of 4 residents reviewed for falls in a sample of 8. (Resident #F)</p> <p>Findings include:</p> <p>The record for Resident #F was reviewed on 10/29/13 at 9:55 A.M. Diagnoses included, but were not limited to, dementia, acute renal failure, acute pain, mental status altered, urinary tract infection, muscular atrophy, and thrombosis, cerebral with infarction.</p> <p>The resident had returned from the hospital on 10/2/13 after being admitted for urinary retention and acute renal failure. He was being treated with Augmentin (antibiotic) for a urinary tract infection upon returning</p>	F000323	F323 483.25(h) FREE OF ACCIDENT HAZARDS / SUPERVISION / DEVICES It is the practice of this provider to 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. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident # F no longer resides in the facility.LPN # 1 was terminated for failure to comply with the Fall Policy, prior to the complaint survey. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Nurse managers completed new Fall Risk Assessments for residents with falls over the past 30 days to determine an updated Fall Risk Score.The Interdisciplinary Team (Nursing, Social Service, Therapy, Activities) reviewed the above residents for appropriate fall interventions by 11/18/2013.The resident's orders, care plans, and	11/19/2013			

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	<p>to the facility.</p> <p>The resident's fall risk score on admission was 16.0 (high risk for falls). He had a care plan dated 9/10/13, stated, "Resident is at risk for falls related to: confusion and weakness s/p (status/post) surgery.</p> <p>Goal with Target date 12/10/13: Resident will remain free from injury related to falls.</p> <p>Approaches start date: 9/10/13</p> <ol style="list-style-type: none"> 1. Assist with ADL's as needed 2. Bed alarm at all times when in bed. Check function and placement every shift. 3. Cue and remind him to use his call light to ask for assistance as needed. 4. Keep call light within reach at all times. 5. Keep personal items and frequently used items within reach. 6. Move closer to nursing station. 7. Play "big band" music when resident is agitated 8. Scoop mattress 9. Personal alarm to chair. Check placement and function every shift. <p>He was extensive assist with one person physical assist for locomotion on and off the unit.</p>		<p>assignment sheets were updated, as needed. The charge nurse notifies a nurse manager immediately after a resident fall to ensure an immediate intervention is initiated and the resident's plan of care is updated to prevent future falls. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? Nurse managers were re-educated by the Director of Nursing Services, by 11/18/13, and ongoing, regarding the Fall Management Policy, including notification of a fall to a nurse manager immediately to ensure an immediate intervention is initiated, the root cause of the fall is determined, and appropriate paperwork is initiated at the time of the fall (including accurate time of fall occurrence, and accurate fall documentation). Facility staff was re-educated on the Fall Policy by the Director of Nursing Services, or designee, on November 12, 2013, and ongoing. Nursing employees were re-educated by the Director of Nursing, or designee, by 11/18/13, and ongoing, on utilizing the Fall Investigation Form, to assist the staff in determining the "root cause" of a fall and implementing an "immediate intervention" to prevent future falls, as well as common fall interventions for high risk residents. Licensed nurses were re-educated by the Director</p>				

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	<p>A progress note dated 10/9/13 at 5:03 A.M., indicated date of occurrence was 10/8/13 at 5:30 P.M. The record indicated the resident was sitting up in the TV lounge/dining room area while a mattress was being changed on his bed. LPN #1 was moving him in his wheelchair towards the table when the resident put his legs down, and he went forward from the wheelchair and fell onto the floor. After he was assessed a small raised area (quarter size) was observed on the left side of his head. He was placed back into his wheelchair by 3 staff members and LPN #1 started moving him toward the table again and he rolled forward bumping his head and shoulder, but no new areas were observed. The resident was assisted to his wheelchair by 3 staff members after being assessed he was taken to his room and transferred to bed.</p> <p>A document titled "Safety Events-Fall Event" dated 10/9/13 at 3:05 A.M., indicated the resident had a witnessed fall on 10/8/13 at 5:30 P.M. in the dining room with a head injury. The record indicated the head injury was a bump with swelling and the resident had pain of a level 2. The range of motion of all extremities was moving as usual with grimaces and</p>		<p>of Nursing, or designee, by 11/18/13, and ongoing, on accurate documentation of resident falls, including time of the fall, assessment of the resident and completion of the appropriate forms, including the Fall Event. The charge nurse notifies a nurse manager immediately after a resident fall to ensure an immediate intervention is initiated and the resident's plan of care is updated to prevent future falls. The Director of Nursing, or designee, reviews the resident's preadmission assessment to determine the resident's fall risk and what interventions need to be in place at admission to prevent falls. This is communicated to the Interdisciplinary Team and the staff on the unit where the resident will reside through an Admission Alert form. The Interdisciplinary Team (nursing, social services, therapy) reviews the fall the following business day on the unit where the resident resides with direct care-givers, to further discuss root cause, review the resident's environment, and determine if additional interventions are necessary to prevent future falls. The resident's plan of care is updated, as needed. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Interdisciplinary Team will review 100% of falls, 5</p>		

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	<p>moans, which is normal for this resident.</p> <p>The document indicated the first aid treatment measures that had been taken was an ice pack was applied to the affected area, but the resident would not keep the ice pack on. The level of consciousness indicated the resident was in a stupor (aroused only by intense stimuli). His facial muscle movements were weak and the nurse was unable to complete the extremity and grasp movements due to he was not following commands. Pupils were reactive and his speech was unclear and slurred with mumbled words. He responded to his name and pain and there was no change in his mental status after the fall.</p> <p>An interview with the Director of Nursing (DON) on 10/29/13 at 12 P.M., she indicated on 10/8/13 between 5 P.M. to 5:30 P.M., Resident #F had fallen out of his wheel chair two times while being transported in the 700 unit dining room by LPN #1 and there was no immediate intervention put into place to prevent the second fall.</p> <p>An interview with the Administrator on 10/29/13 at 3:45 P.M., she indicated</p>		<p>x week during clinical meetings to ensure the root cause of the fall is determined, an immediate intervention was implemented, documentation was completed, as well as updating changes to the plan of care. The Assistant Director of Nursing, or designee, reviews 100% of resident falls utilizing a CQI form after the fall event. Any identified concerns from audits will be addressed immediately, including re-education or disciplinary action, up to and including termination. The Assistant Director of Nursing, or designee, tracks and trends resident falls monthly and reports to the Quality Assurance Committee for review. The results of these audits will be discussed at the monthly facility Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed.</p> <p>Compliance Date: 11/19/13</p>		

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	<p>she was walking down the hallway towards the 700 unit dining room on 10/8/13 and she witnessed LPN #1 pushing Resident #F in his wheelchair with his feet dragging on the floor. She stated, "He rolled onto the floor like a rag doll."</p> <p>She indicated he was assessed by nurses for injuries then assisted into his wheelchair and the same nurse (LPN #1) started pushing him with his feet dragging on the floor again and she stated, " He rolled out" of his wheelchair the second time. She indicated he was assessed for injuries then assisted into his wheelchair. He was transported back to his room in his wheelchair with a staff member in front of his wheelchair who was assisting him to sit up to prevent him from falling out of the wheelchair.</p> <p>She indicated LPN #1 could have taken the resident back to bed with assistance after the first fall or placed foot pedals on the wheelchair to try to prevent the falls.</p> <p>A document titled "Conduct Notice" with a signature by the DON dated 10/9/13 was provided by the Administrator on 10/29/13 at 3:45 P.M. The document indicated LPN #1 was counseled on 10/9/13 then</p>						

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	<p>terminated on 10/13/13 for Resident Care Standards. The document indicated LPN #1 was pushing a dependent resident with his feet dragging causing a fall and she did not correct the problem and the resident fell again. LPN #1 indicated she agreed with the document and she should have done something different after the first fall to prevent the second fall such as; place foot pedals on the wheelchair. LPN #1 indicated the falls were her fault and should not have happened. LPN #1 stated, "I was in too big of a hurry. I needed to slow down and make safety first."</p> <p>An untitled document written by the DON dated 10/9/13 regarding LPN #1 indicated a hospice resident was up in his wheelchair while a new mattress was being placed on his bed. The resident's feet was dragging on the wheelchair and LPN #1 pushed the resident forward and the resident's foot was caught under the wheelchair and he fell forward. The DON indicated the resident was assessed and assisted back into his wheelchair and LPN #1 pushed the resident forward again, but she did not correct the previous issue. The resident fell forward and hit his head, which caused a small abrasion and a</p>				

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	<p>hematoma. She indicated no immediate intervention was put into place.</p> <p>A policy provided by the Assistant Director of Nursing on 10/30/13 at 2:02 P.M., titled "Fall Management Program" undated and deemed current stated, "Purpose: To reduce the number of falls and minimize injuries related to falls... Following each resident fall: Complete an Incident Report... Complete Fall Event to include immediate measures taken. Complete IDT Post Fall Observation to identify Root Cause Analysis...."</p> <p>This Federal tag relates to complaint IN00138083.</p> <p>3.1-45(a)(2)</p>				

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F000514 SS=D	<p>483.75(I)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on interview and record review the facility failed to ensure the documentation for the fall event dated 10/8/13 was complete and accurate for 1 of 8 residents reviewed for complete and accurate documentation in a sample of 8. (Resident #F)</p> <p>Findings include:</p> <p>The record for Resident #F was reviewed on 10/29/13 at 9:55 A.M. Diagnoses included, but were not limited to, dementia, acute renal failure, acute pain, mental status altered, urinary tract infection, muscular atrophy, and thrombosis, cerebral with infarction, and resident was admitted to hospice on 10/7/13.</p>	F000514	F514 483.75(I)(1) RESIDENT RECORDS-COMPLETE/ACCURATE/ACCESSIBLE It is the practice of this provider to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record shall contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State and progress notes. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident F no longer resides in the facility.LPN # 1 was terminated	11/19/2013			

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	<p>1. A progress note dated 10/9/13 at 6:51 P.M., indicated the date of occurrence was 10/8/13 at 5:30 P.M. The record indicated the resident's NP (Nurse Practitioner) and wife was notified of falls.</p> <p>2. A progress note dated 10/9/13 at 5:03 A.M., written by LPN #1, indicated the date of occurrence was 10/8/13 at 5:30 P.M. The record indicated the resident was sitting up in the TV lounge/dining room area while a mattress was being changed on his bed. LPN #1 was moving him in his wheelchair towards the table when the resident put his legs down, and he went forward from the wheelchair and fell onto the floor. After he was assessed a small raised area (quarter size) was observed on the left side of his head. PROM (Passive Range of Motion) was consistent with his usual ROM (Range of Motion). There was no crepitation (Crackling noise) when joints are moved. He was placed back into his wheelchair by assist of three staff members.</p> <p>The progress note indicated LPN #1 started to move the resident toward the table and he rolled forward again bumping his head and shoulder. PROM was performed and the</p>		<p>for failure to comply with the Fall Policy, prior to the complaint survey. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Nurse managers completed new Fall Risk Assessments for residents with falls over the past 30 days to determine an updated Fall Risk Score. The Interdisciplinary Team (Nursing, Social Service, Therapy, Activities) reviewed the above residents for appropriate fall interventions by 11/18/2013. The resident's orders, care plans, and assignment sheets were updated, as needed.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? Nurse managers were re-educated by the Director of Nursing Services, by 11/18/13, and ongoing, regarding the Fall Management Policy, including notification of a fall to a nurse manager immediately to ensure an immediate intervention is initiated, the root cause of the fall is determined, and appropriate paperwork is initiated at the time of the fall (including accurate time of fall occurrence, and accurate fall documentation). Facility staff was re-educated on the Fall Policy by the Director of Nursing Services, or designee, on November 12, 2013, and ongoing. Nursing employees were</p>		

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	<p>resident moved his extremities as usual. He was assessed and no new injuries were observed on his head. He was assisted back into his wheelchair by three staff members and transported back to his room. He was transferred back to bed and a skin assessment was completed and no new bruises were observed, no open or raised areas other than the one on the left side of his head. An ice pack was applied to his head for five minutes and removed due to he would not leave it on. The resident had delayed swallowing and his mouth was dry so oral care was given. His skin is cool and pale, capillary refill is greater than three seconds, but no distress is observed.</p> <p>3. A document titled "Safety Events-Fall Event" dated 10/9/13 at 3:05 A.M., written by LPN #1 indicated the resident had a witnessed fall on 10/8/13 at 5:30 P.M., in the dining room with a head injury. The record indicated the head injury was a bump with swelling and the resident had pain of a level 2. The range of motion of all extremities was moving as usual with grimaces and moans, which is normal for this resident.</p> <p>The document indicated first aid</p>		<p>re-educated by the Director of Nursing, or designee, by 11/18/13, and ongoing, on utilizing the Fall Investigation Form, to assist the staff in determining the "root cause" of a fall and implementing an "immediate intervention" to prevent future falls, as well as common fall interventions for high risk residents. Licensed nurses were re-educated by the Director of Nursing, or designee, by 11/18/13, and ongoing, on accurate documentation of resident falls, including time of the fall, assessment of the resident and completion of the appropriate forms, including the Fall Event. The charge nurse notifies a nurse manager immediately after a resident fall to ensure an immediate intervention was initiated and the root cause of the fall was determined, as well as all paperwork is initiated at the time of the fall (including accurate time of fall occurrence, and accurate fall documentation. The Interdisciplinary Team (nursing, social services, therapy) reviews the fall the following business day on the unit where the resident resides with direct care-givers, to further discuss root cause, review the resident's environment, and determine if additional interventions are necessary to prevent future falls. The fall documentation is reviewed at this time and if incomplete, the initiating charge nurse, or</p>		

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	<p>treatment measures that had been taken was an ice pack was applied to the affected area, but the resident would not keep the ice pack on. The level of consciousness indicated the resident was in a stupor (aroused only by intense stimuli). His facial muscle movements were weak and the nurse was unable to complete the extremity and grasp movements due to he was not following commands. Pupils were reactive and his speech was unclear and slurred with mumbled words. He responded to his name and pain and there was no change in his mental status after the fall.</p> <p>4. A progress noted dated 10/9/13 at 2:37 A.M., written by LPN #2 indicated the date of occurrence was 10/8/13 at 10 P.M. The record indicated Resident #F had a witnessed fall in the rehabilitation dining room at 5:00 p.m. and was lying in the supine position with his arms extended out as well as his bilateral extremities. The resident's color was pale with sallow eyes with a blank stare. The resident had "Cheyne's stoke" (type of breathing) and intermittent apneic episodes with cyanotic finger tips. He was taken to his room at 5:15 P.M., and placed in bed and the doctor was called. The</p>		<p>designee, completes the documentation and the resident's plan of care is updated, as needed. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Interdisciplinary Team will review 100% of falls, 5 x week during clinical meetings to ensure the root cause of the fall is determined, an immediate intervention was implemented, documentation was completed, as well as updating changes to the plan of care. The Assistant Director of Nursing, or designee, reviews 100% of resident falls utilizing a CQI form after the fall event to ensure all documentation is accurate and complete. Any identified concerns from audits will be addressed immediately through re-education and/or disciplinary action up to and including termination. The results of these audits will be discussed at the monthly facility Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed. Compliance Date: 11/19/13</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 10/30/2013
NAME OF PROVIDER OR SUPPLIER CARMEL HEALTH & LIVING COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 118 MEDICAL DR CARMEL, IN 46032		
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	<p>resident was placed on oxygen at 5:30 P.M.</p> <p>5. An untitled document written by the DoN (Director of Nursing) dated 10/9/13 regarding LPN #1 indicated a hospice resident was up in his wheelchair while a new mattress was being placed on his bed. The resident's feet were dragging on the floor and LPN #1 pushed the resident forward and the resident's foot was caught under the wheelchair and he fell forward. The DoN indicated the resident was assessed and assisted back into his wheelchair and LPN #1 pushed the resident forward again, but she did not correct the previous issue. The resident fell forward and hit his head, which caused a small abrasion and a hematoma. She indicated no immediate intervention was put into place to correct the resident from dragging his feet. She also indicated LPN #1 did not complete the second fall event.</p> <p>6. An interview on 10/30/13 at 2 P.M., the DoN indicated the documentation regarding Resident #F's falls and medical status was confusing.</p> <p>7. A policy provided by the Assistant Director of Nursing on 10/30/13 at</p>				

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	<p>2:02 P.M., titled "Fall Management Program" undated and deemed current stated:</p> <p>"Purpose: To reduce the number of falls and minimize injuries related to falls... Following each resident fall: Complete an Incident Report... Complete Fall Event to include immediate measures taken. Complete IDT Post Fall Observation to identify Root Cause Analysis...."</p> <p>3.1-50(a)(1) 3.1-50(a)(2)</p>				