STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155181	A. BUILDING 00 B. WING	09/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARMEL HEALTH & LIVING COMMUNITY	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	This visit was for the Investigation of Complaints IN00182272 and IN00182300. Complaint IN00182272 - Substantiated. Federal/State deficiencies related to the allegations are cited at F157, F309, F314, F325 and F327. Complaint IN00182300 - Substantiated. No deficiencies related to the allegations are cited. Survey dates: September 21, 23 & 24, 2015 Facility Number: 000095 Provider Number: 155181 AIM Number: 100290490 Census Bed Type: SNF: 12 SNF/NF: 122 Total: 134 Census Payor Type: Medicare: 8 Medicaid: 108 Other: 18 Total: 134	F 0000	Submission ofthis plan of correction in no way constitutes an admission by Carmel Health andLiving or its management company that the allegations contained in the surveyreport is a true and accurate portrayal of the provision of nursing care orother services provided in this facility. The Plan of Correction is prepared and executed solely because it isrequired by Federal and State Law. ThePlan of Correction is submitted in order to respond to the allegation ofnoncompliance cited during the Complaint Survey on September 24, 2015. Please accept this plan of correction asCarmel Health and Living's credible allegation of compliance by October 20,2015 Thisstatement of deficiencies and plan of correction will be reviewed at the OctoberQuality Assurance/Assessment Committee meeting. Response to Survey Ending **September24, 2015**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Sample: 5 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality Review completed by 21662 on October 1, 2015.			
F 0157 SS=D Bldg. 00	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in			

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	§483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on record review and interview the facility failed to ensure a resident's physician was notified of significant weight loss and volume depletion after a nasogastric feeding tube was removed and the resident was started on a mechanically altered diet with thickened liquids for 1 of 3 residents reviewed for notification of physician for timely interventions. (Resident "B") This resulted in the resident being transported and admitted to the local area hospital due to a change in mental status, scant urinary output and abnormal blood work. Findings include: The record for Resident "B" was reviewed on 09-21-15 at 12:00 p.m. Diagnoses included, but were not limited to, Diabetes Mellitus, cerebral vascular disease, dysphagia, hypertension, dementia and speech/language deficit's. These diagnoses remained current at the time of the record review.	F 0157	**F157** **Notify of Changes** It is thepractice of this provider to ensure that the resident's physician andresponsible party are promptly notified regarding a significant change incondition. **Whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice?** ·Resident B does not reside in thefacility any longer. How willyou identify other residents having the potential to be affected by the samedeficient practice and what corrective action will be taken? ·All residents with a change incondition have the potential to be effected by the alleged deficient practice. ·Residents with current changes ofcondition, including significant weight changes and signs/symptoms ofdehydration were reviewed and confirmed that MD was notified.	10/20/2015

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	At the time of admission, the resident weighed 179 lbs. (pounds), and was admitted to the facility with a NG (naso-gastric) feeding tube in place for nutrition and hydration. A physician order dated 08-16-15, instructed the nursing staff to weigh the resident daily. The order included a notation which instructed the nursing staff to "notify MD [Medical Doctor] of a weight gain of 2 lbs. in one day or 5 lbs. in a week." The Dietitian's Nutrition assessment, dated 07-31-15, indicated the resident received nothing by mouth, had physician orders included Glucerna 1.2 at 65 ml; (milliliters) over 24 hours and estimated fluid needs of 2025 ml. A review of the record indicated the nursing staff received physician orders to remove the feeding tube on 09-01-15. The record further indicated the resident had physician orders to receive a "pureed diet with honey thickened liquids" for nutrition and "required dependent assist with feeding." The resident also had physician orders for Speech Therapy related to the appropriate diet and the resident's chewing and swallowing abilities.		**Whatmeasures will be put into place or what systemic changes you will make toensure that the deficient practice does not recur?** ·Progress notes, daily weights, and fluid intake arereviewed daily in clinical meeting by Interdisciplinary Team (IDT) to identifychanges Monday through Friday and by the Weekend manager on Saturday andSunday. Any changes in conditionincluding significant weight loss and signs/symptoms of dehydration will bereviewed for physician notification. ·IDT team received Corporate directed re-education onClinical meeting expectations including reviewing progress notes, daily weightreport, and fluid intake report for changes in condition. ·Licensed nursing staff received corporate directedre-education on identifying and reporting changes in resident condition withemphasis on weight loss and signs/symptoms of dehydration. **How willthe corrective action(s) be monitored to ensure the deficient practice will notrecur, i.e., what quality assurance program will be put into place?** ·An audit tool will be used by DON/Admin/designeedaily to ensure change of condition, significant weight change, and residentswith signs and symptoms of dehydration are	

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	A review of the Speech Therapist treatment notations, once the resident's NG feeding tube had been removed and began to consume food and liquids by mouth indicated the following: "09-01-15 - Patient lethargic and fatigued on this date. NG tube removed by nursing while SLP [Speech Language Pathologist] present during afternoon session. Patient with significant delay in swallow... Signs and symptoms of aspiration throughout PO [by mouth] trials... delayed coughing times 10, throat clearing times 2, and labored breathing times 1." "09-02-15 Aid staff feeding pt. [patient] when SLP began therapy session. Pt presented with running nose and running eyes. SLP educated aid on s/s [signs and symptoms] of aspiration and [sic] 'dry swallow, double swallow and max cueing to swallow. Pt with increase lethargy throughout PO intake. Pt. warranted max cues throughout meal consumption to swallow. Pt with wet vocal quality times 2 with HTL [honey thickened liquid] consumption. SLP cued pt to cough. Pt. did not respond to cueing and did not cough. SLP completed dry swallow with spoon. Pt. with meal consumption about 50 % SLP discussed with nsg. [nursing] staff to order pt. Ensure [a supplement]		identified daily and MD is notifiedtimely. ·Anyidentified concerns from audits will be addressed immediately. ·Nurse consultant will randomly audit identifiedchanges in condition, significant weight changes, and residents with signs/symptomsof dehydration, upon weekly visits x 4 weeks, monthly x 2 months. ·Employeesnot adhering to policy will be re-educated up to and including termination. ·Theresults of these audits will be discussed at the monthly facility QualityAssurance Committee meeting for a minimum of 6 months and frequency andduration of reviews will be adjusted as needed. **FacilityAdministrator is responsible for ensuring compliance.** **Compliance Date: October 20, 2015**	

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	and thicken to a appropriate viscosity due to increase lethargy during meal consumption; resulting in reduced consumption amount." "09-03-15 Pt. with consumption of puree and HTL in dining room during meal. Pt. with intermittent wet vocal quality throughout meal consumption. Pt. warranted mod [moderate] - max [maximum] verbal/tactile cueing to swallow and complete double swallow. Pt. discussed with nsg. staff to check pt lungs periodically throughout day due to upgraded diet." "09-04-15 ... Pt. pocketing food in oral cavity. Max cues to not talk with food in oral cavity. Pt. with overt s/s of aspiration times 6 in form of cough and times 4 wet vocal quality. Average hold during oral phase was about 15 seconds... Pt. reported being full after about 10 % meal consumption." "09-07-15 Pt. being fed by an aid. Pt. with increased lethargy and distraction throughout meal consumption. Pt. with oral phase hold of an average of about 15 seconds. Pt. began spitting out food and refusing meal. Pt. with 10% meal consumption." "09-09-15 Pt. seen bedside this date			

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	during lunch. Pt. [spouse] present during therapy session and reported pt. did not sleep all night. Pt. [spouse] reported pt was coughing and moaning in pain. Pt. wife reported pt did not eat AM meal due to increased lethargy. Pt. with increased lethargy this date throughout therapy session and less verbalization than typical. Pt. warranted max verbal cueing to swallow bolus. Oral phase average time 12 - 15 seconds with puree consumption... Pt. with reduced hypolargyneal excursion and increased weakness... Nsg. staff gave pt medication with HOB [head of bed] lowered. SLP educated on importance of raising HOB when providing medication in bed." A review of the meal consumption documentation indicated the following: "09-01-15 Dinner 1 - 25% consumed, 09-02-15 No documentation for Breakfast or the lunch meal, Dinner 26 - 50 % consumed, 09-03-15 Breakfast 1 - 25% consumed, Lunch 26 - 50 % consumed, Dinner 1- 25 % consumed, 09-04-15 Breakfast 1 - 25 % consumed, Lunch 1 - 25 % consumed, Dinner 76 - 100 % consumed., 09-05-15 Breakfast 26 - 50 % consumed, 51 - 75 % consumed, 51 - 75 % consumed,			

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	09-06-15 No documentation for the Breakfast or Lunch meal, Dinner 26 - 50 % consumed, 09-07-15 No documentation for the Breakfast or Lunch meal, Dinner 76 - 100 % consumed, 09-08-15 No documentation for the Breakfast or Lunch meal, Dinner 1 - 25 % consumed, 09-09-15 Breakfast 'None' consumed, Lunch 'None' consumed, Dinner 26 - 50 % consumed." A review of the fluid consumption documentation indicated the following fluid intake after the NG feeding tube had been removed: 09-01-15 1710 c.c. (cubic centementer or milliliter) 09-02-15 1200 c.c. 09-04-15 1500 c.c. 09-05-15 1680 c.c. 09-07-15 1940 c.c. 09-08-15 1320 c.c. 09-09-15 1680 c.c. A review of the resident's daily weights, from the time the NG feeding tube was removed until 09-10-15 when the resident was transported to the local area hospital indicated the following: "09-01-15 178 lbs.,			

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	09-02-15 178.7 lbs., 09-03-15 178 lbs., [09-04-15 no documentation], 09-05-15 178.9 lbs., 09-06-15 161.6 lbs., 09-07-15 177.2 lbs, 09-08-15 169.8 lbs., 09-10-15 161.2 lbs." A review of the Physician Progress notes indicated the following: "09-03-15 Patient denies any complaints, still with significant "L" [left] side hemiparesis. Tolerating NG feeds; however NG tube got clogged and nothing worked in regards to attempts at unclogging it. Will trial a PO [by mouth] diet and monitor intake. Speech Therapy. Apparently was not a candidate for a PEG [Percutaneous endoscopic gastrostomy feeding tube] tube in hospital. If problems with dysphagia or PO intake poor, will consider PEG tube." "09-08-15 "L" side hemiparesis unchanged. Swallow function improved and NG removed, has poor PO intake." "09-10-15 [Spouse] at bedside with many concerns regarding his overnight care and also states minimal PO intake past 2 days. She insists on sending him to ED [Emergency Department] despite multiple attempts to offer immediate IV			

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	[intervenous] placement... Pt is more lethargic than baseline." At the time the resident presented to the local hospital Emergency Room on 09-10-15, the hospital record indicated the resident was drooling, somulent and weighed 162 lbs. The record indicated the resident originally presented with "altered mental status" and "clear dehydration." The record further indicated a laboratory test for a BUN (blood urea nitrogen level) of 52 (normal range of 8 - 26). The Hospital Nursing notations indicated the resident was "dehydrated with scant urine, oliguria." The resident was admitted to the hospital Medical Unit from the Emergency Room Department. The record lacked documentation the physician was notified of the poor fluid intake, and weight loss as documented in the clinical record and a change in mental alertness for the resident from the time the NG tube was removed until 09-08-15. A review of the facility policy on 09-21-15 at 11:00 a.m., titled "Change in a Resident's Condition or Status," dated as "revised October 2010," indicated the following: "Policy Statement - Our facility shall promptly notify the resident, his or her			

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	attending physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status (e.g. changes in level of care, billing payments, resident rights, etc.)." "Policy Interpretation and Implementation - 1. The Nurse Supervisor/Charge Nurse will notify the resident's Attending Physician or On-Call Physician when there has been: ...d. A significant change in the resident's physical/emotional/mental condition; e. A need to alter the resident's medical treatment significantly. 2. A "Significant change" of condition is a decline or improvement in the resident's status that: a. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions (is not "self-limiting"). b. Impacts more then one area of the resident's health status; and c. Requires interdisciplinary review and/or revision to the care plan." This Federal tag relates to Complaint IN00182272. 3.1-5(a)			
F 0309 SS=D Bldg. 00	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING			

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	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. Based on observation, record review and interview the facility failed to ensure a resident who had the potential for aspiration received the prescribed mechanically altered diet and necessary interventions as instructed by the speech therapist to avoid possible aspiration and an additional resident who had an ulcer, and was assessed by a local wound care specialist, the nursing staff failed to provide the necessary care and treatment to promote healing. This deficient practice affected for 2 of 5 sampled resident's. (Residents "E" and "D"). Findings include: 1. The record for Resident "E" was reviewed on 09-23-15 at 1:25 p.m. Diagnoses included, but were not limited to, dementia, dysphagia, hypertension, gastroesophageal reflux disease and pneumonia. These diagnoses remained current at the time of the record review. During an interview on 09-23-15 at 10:00 a.m., the Speech Therapist identified	F 0309	**F309** **Provide Care/Services for highest wellbeing** It is thepractice of this provider to ensure that residents receive the necessary careand treatment to maintain the highest practicable physician well-being. **Whatcorrective action(s) will be accomplished for those residents found to have beenaffected by the deficient practice?** ·Resident E resides in thefacility with assistive meal instructions. ·Nursing staff have been educatedby ST on the therapeutic diet plan ·Resident E remains on restorativetherapy at meal times. ·Resident D resides in thefacility and the wound treatment was done per order. ·Resident D orders have beenupdated for her wound ·Resident D continues to be seenby Wound Specialist ·Licensed nurses have beenre-educated/disciplined on applying and documenting wound treatments per order.	10/20/2015

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	Resident "E" as currently on her "case load." The therapist further indicated the resident received a pureed diet with honey thickened liquids and had to be fed by the nursing staff. The therapist indicated she had to instruct the nursing staff not to place a plate of food in front of the resident unless they were ready to feed the resident due to the risk of the resident attempting to self feed and aspiration. A review of the Speech Therapy Plan of Care, dated 08-31-15 indicated, "reason for referral: Patient referred by nursing staff due to s/s [signs and symptoms] of aspiration with intake at meal in dining room. Patient would benefit form ST [speech therapy] services to determine safest PO [by mouth] diet and decrease risk of aspiration with intake. Therapy necessary for oropharyngeal dysphagia. Without therapy patient at risk for aspiration, pneumonia and functional decline." Further review of the speech therapy daily notations indicated the following: "08-31-15 Bedside dysphagia evaluation completed. ... Diet downgraded to puree with HTLs [honey thickened liquids] due to s/s [signs and symptoms] of aspiration		How willyou identify other residents having the potential to be affected by the samedeficient practice and what corrective action will be taken? ·All residents who have strategicfeeding plans could be affected by the alleged deficient practice. ·Current resident on strategicfeeding plans were reviewed and nursing staff have been educated on theseplans. ·All residents who have woundscould be affected by the alleged deficient practice. ·Current residents with woundtreatments were reviewed to ensure treatment orders and appropriate treatment wasin place. **Whatmeasures will be put into place or what systemic changes you will make toensure that the deficient practice does not recur?** ·Therapy services director/designee attend Clinicalmeeting daily Monday through Friday and will discuss residents that will betransitioning from Therapy to nursing restorative/activities of daily living(ADL)/strategic feeding programs. ·Therapy services will provide training/in-servicesto nursing staff for restorative/ADL/strategic feeding programs prior totransition from therapy to nursing programs.	

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	with NTL's [nectar thickened liquids]." "09-01-15 ... Patient impulsive with cup sips and required feeding assistance to decrease rate of intake. Patient minimally able to complete labial and lingual exercises on this date despite cues and clinical model." "09-03-15 ... Patient with recent diagnosis of double lung pneumonia. Pt was given regular tray and NTL at meal time. SLP [speech therapist] educated kitchen staff of pt. [patient] diet and reported to therapy supervisor. Kitchen staff voiced understanding." "09-04-15 ... Pt. [patient] with overt s/s of aspiration in form of cough times 3 and min. [minimum] watering eyes. SLP educated kitchen staff on HTL status and no straw status. Kitchen staff voiced understanding." "09-08-15 ... SLP educated kitchen staff of pt HTL diet and no straw status. Kitchen staff voiced understanding. SLP to discuss adding 'no straw' to pt ticket with therapy supervisor as updated ticket includes HTL change but no 'no straw' update." "09-09-15 ... Pt. with food placed in front of her and no one there to assist with		·A corporate directed in-service was held with thetherapy department to develop better strategies for transitions to the nursingdepartment when residents are discharged from caseload. ·Strategic feeding plans will be attached to thenurse aide assignment sheets. ·Staff Development/Unit Manager/or designee willprovide additional training to nursing staff for restorative/ADL/strategicfeeding programs post Therapy training ·Certified Dietary Manager (CDM) attends Clinicalmeeting daily Monday through Friday to identify new orders for therapeutic diet/fluidchanges and then update diet tickets to reflect appropriate diet orders ·Nursing Weekend supervisor will notify Dietary ofany new diet orders on Saturdays/Sundays. ·Dietary and Nursing staff have been re-educated onfollowing therapeutic diet and fluid orders during meal pass. ·A corporate directed in-service was provided to licensednurses on application and documentation of physician orders for woundtreatments and the Skin Management Program. **How willthe corrective action(s) be monitored to ensure the deficient practice will notrecur, i.e., what quality assurance program will be put into place?**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155181	A. BUILDING 00 B. WING	09/24/2015

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

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	feeding. SLP educated kitchen staff to not place food in front of pt prior to staff to assist. Kitchen staff voiced understanding." "09-11-15 ... Pt. given cream of wheat and staff has been asked to avoid cream of wheat due to thinner consistency. Pt. presented with two coughs and two delayed coughs during meal this date." "09-14-15 ... Pt. with no overt s/s of aspiration occurred during HTL via spoon or puree via spoon." "09-15-15 ... Aid reported pt had food placed in front of her during lunch meal with no one there to assist with feeding. Therefore, pt was attempting to feed self and was coughing. SLP voiced understanding and will inform therapy supervisor." "09-21-15 ... Pt. had food in front of her when SLP entered dining room and was attempting to feed self. Pt with overt s/s of aspiration in form of wet cough times 1 immediately following HTL." "09-23-15 ... SLP educated kitchen staff to change pt meal ticket regarding kennedy cut. Pt meal ticket still reads special instruction as kennedy cup. However pt with decreased safety with		·Anaudit tool will be utilized by the Therapy Services Director/designee dailyMonday through Friday x 4 weeks, weekly x 4 weeks, monthly x 1 month to ensureall restorative/ADL/strategic feeding programs have been communicated duringClinical Meeting ·Anaudit tool will be utilized by the CDM daily Monday through Friday and theWeekend Nursing Supervisor Saturday/Sunday to ensure diet order changes arecommunicated to the dietary department for changes to be made to the mealtickets. ·Anaudit tool will be utilized by Department Managers and Nursing Management to overseedining rooms to ensure strategic meal plans are followed and appropriate dietsare served daily x 4 weeks, weekly x 4 weeks, then monthly x 5 months. ·Anaudit tool will be utilized by DON/Designee to ensure appropriate woundtreatment is applied and documented appropriately weekly x 12 weeks, monthly x3 months. ·Anyidentified areas from audits will be addressed immediately. ·Employeesnot adhering to policy will be re-educated up to and including termination. ·Theresults of these audits will be discussed at the monthly facility QualityAssurance Committee meeting for a	

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	155181	A. BUILDING 00 B. WING	09/24/2015

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	utilization of straws. Therefore HTL to be given via spoon. Kitchen staff voiced understanding." During an observation on 09-23-15 at 12:15 p.m., the resident was observed seated at a table in the assist dining room, with two glasses filled with a green colored item, and a red colored item. The licensed nurse was over heard stating the liquid in the glasses was "thickened juice." The licensed nurse walked toward the steam table and returned to the place setting with the resident's lunch meal, and informed the resident "it was time of lunch." The licensed nurse provided the resident with 1 spoonful of food, followed by two more spoonfuls of food. The resident was observed chewing repeatedly. The licensed nurse picked up one of the glasses of thickened juice and gave the resident a drink followed by another drink. The resident continued with a chewing motion. The nurse then gave the resident another spoonful of food, while the resident continued to chew, gave 6 additional spoonfuls of food." During an interview on 09-23-15, the Therapy Manager indicated the resident had specific swallowing strategies developed. The Therapy Manager provided a copy of the strategies for the		minimum of 6 months and frequency andduration of reviews will be adjusted as needed. **FacilityAdministrator is responsible for ensuring compliance.** **Compliance Date: October 20, 2015**	

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	resident at 1:30 p.m. A review of the "Swallowing Strategies for [name of resident] indicated the following: [Resident name] needs TOTAL [bold type] assist during meal consumption !! PLEASE DO NOT SIT TRAY IN FRONT OF [RESIDENT NAME] UNTIL SOMEONE IS THERE TO HELP !!!" "NO STRAWS !! [BOLD TYPE] [Resident name] needs to utilize spoon for eating and drinking." "SLOW RATE [BOLD TYPE] [Resident name] loves to eat ! However she needs a slower rate of consumption !!" "Make sure [Resident name] mouth is clear before giving next bite !!" "Encourage [Resident name] to cough when she begins (as you know she tries not to cough and hold her breath)." "[Resident name] has increased secretions. Make sure secretions are clear before provided next bite !!" "ALTERNATE [BOLD TYPE] bites and sips during meal consumption !!"			

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	155181	A. BUILDING 00 B. WING	09/24/2015

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CARMEL HEALTH & LIVING COMMUNITY	118 MEDICAL DR CARMEL, IN 46032

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	During the Exit Conference on 09-24-15 at 12:00 p.m., the Director of Nurses indicated the nursing staff were unaware of the developed strategies for Resident "E". 2. The record for Resident "D" was reviewed on 09-21-15 at 2:05 p.m. Diagnoses included, but were not limited to, trauma/abrasion/ulcer to right lower leg, chronic pain, muscle weakness, dementia and cerebral vascular accident. These diagnoses remained current at the time of the record review. A review of the resident's current plan of care dated 09-10-15, indicated the resident had a right lower extremity abscess. Interventions to this plan of care included, "Treatment as ordered, observe for signs of increased redness, drainage, warmth, fever, document abnormal findings and notify the MD [Medical Doctor] and notify MD or worsening or unchanged condition of abscess." A review of the facility report identified the resident with "hematoma." However, the resident was assessed by a local Wound Care Specialist, who determined the resident "presented with lower extremity ulcer."			

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	155181	A. BUILDING 00 B. WING	09/24/2015

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

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	Weekly wound rounds indicated the area measured 3.0 centimeters in length by 2 centimeters in width on 09-01-15. The resident was seen by the Wound Care Specialist weekly and on 09-15-15, the area measured 3.0 centimeters in length by 1.5 centimeters width by 0.1 centimeters in depth. The physician orders, dated 09-15-15 instructed the nursing staff to "Cleanse right lower extremity ulcer with normal saline and pat dry. Apply Dermaseptine to surrounding skin and hydrogel soaked gauze to the open area - cover with ABD pad and secure. Change daily." On 09-25-15 at 9:05 a.m., the resident agreed to an assessment of the area. The resident was transported to her room, and Licensed Nurse #8 raised the resident's right pant leg. The dressing was observed wrapped around the resident's ankle. As the nurse continued to raise the pant leg to approximately the resident's knee an ulcer was observed on the lateral aspect of the resident's leg. The area appeared to be with a dark brown scab. The nurse unwrapped the dressing and indicated the date on the dressing was 09-21-15 for the 3:00 p.m. to 11:00 p.m. shift. As the nurse continued to unwrapped the			

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	155181	A. BUILDING 00 B. WING	09/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	dressing a small 4 by 4 gauze was observed within the dressing. The Unit Manager entered the resident's room and verified the dressing was dated 09-21-15. A review of the most recent Wound Care Specialist notation, dated 09-22-15 indicated the area received a status of "not healed," and instructed the nursing staff to "Continue with the hydrogel to maintain a moiste [sic] healing environment and promote breakdown of remaining clot." During an interview on 09-25-15 at 10:30 a.m., the Director of Nurses verified the dressing had not been changed as ordered by the physician, and the date on the dressing was 09-22-15 and not 09-21-15. The Director of Nurses indicated the area measured 3.5 centimeters in length by 0.7 centimeters in width and 0.1 centimeters in depth. This Federal Tag relates to Complaint IN00182272. 3.1-37(a)			
F 0314 SS=D Bldg. 00	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			

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	155181	A. BUILDING 00 B. WING	09/24/2015

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CARMEL HEALTH & LIVING COMMUNITY	118 MEDICAL DR CARMEL, IN 46032

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	pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on observation, record review and interview the facility failed to ensure a resident received treatment and services to prevent pressure sores from developing for 1 of 3 residents reviewed for skin concerns in a sample of 5. (Resident "B"). Findings include: The record for Resident "B" was reviewed on 09-21-15 at 12:00 p.m. Diagnoses included, but were not limited to, diabetes mellitus, cerebral vascular disease, dysphagia, hypertension, dementia and speech/language deficit's. These diagnoses remained current at the time of the record review. At the time of admission, the resident weighed 179 lbs. (pounds) and was admitted to the facility with a NG (naso-gastric) feeding tube in place for nutrition and hydration. A review of the Admission - skin risk assessment, dated 07-30-15 indicated the	F 0314	**F314** **I. The corrective actions to be accomplished forthose residents found to have been affected by the deficient practice.** ·ResidentB no longer resides at the facility and was at high risk for pressure ulcersupon admission 7/30/15 as evidenced by diagnosis of DM, CVA with hemiplegia ofLE, Dysphagia, muscular atrophy, MS, hx of embolism, CHF, and dementia ·ResidentB 7/31/15 Care plan for At Risk for Skin Breakdown initiated and includedinterventions ·Turn and reposition q2 hours and prn ·Weekly skininspection ·Pressure reducingmattress when in bed ·Pressure reducingcushion when in wheelchair ·ResidentB Skin breakdown prevention orders were initiated upon admission for 7/30/15and included ·Turning andRepositioning ·Nursing signed offevery shift ·Elevate/Offload heelswhile	10/20/2015

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	resident needed assistance to reposition, did not move in a way that could cause friction or shearing, did not sit up for more than 2 hour periods of time, did not refuse care and did not have a history of pressure ulcers or other skin condition." A review of the resident's Minimum Data set assessment, dated 08-11-15, indicated the resident was dependent upon staff for activities of daily living, including bed mobility. At the time of admission to the facility and the assessment the resident was identified at risk for the development of pressure ulcers. A review of the resident's current plan of care, dated 07-31-15 indicated the "resident is at risk for skin breakdown related to limited mobility and diabetes." Interventions to this plan of care included, "CNA [Certified Nurse Aide] to do skin check with shower and notify licensed nurse of abnormals, diet/supplements as ordered, encourage 75 to 100 % meal/fluid consumption and monitor consumption, pressure risk assessment and weekly skin checks by licensed nurse." The record indicated the resident's naso-gastric tube was removed on 09-01-15 and the physician ordered a mechanically altered pureed diet with		in bed ·Nursing signed offevery shift ·Weekly head to toeskin inspection ·Resident B weeklyskin inspection completed 9/7/15 with no new areas identified **II. The facility willidentify other residents that may potentially be affected by the deficientpractice.** ·Residentsat high risk for pressure ulcers may potentially be affected by the deficientpractice. ·Residentsare reviewed upon admission, quarterly, and with significant change for risk ofpressure ulcers ·Careplans are initiated with preventive interventions for residents at high riskfor skin breakdown. ·Headto toe skin inspections initiated and completed to ensure all residents thathave pressure wounds have been assessed, treatment obtained, care plan updated,and assignment sheet updated. **III. The facilitywill put into place the following systematic changes to ensure that thedeficient practice does not recur.** ·Corporateclinical directed re-education provided to nursing	

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	155181	A. BUILDING 00 B. WING	09/24/2015

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	honey thickened liquids. A review of the resident's daily weights, from the time the NG feeding tube was removed until 09-10-15 when the resident was transported to the local area hospital indicated the following: "09-01-15 178 lbs., 09-02-15 178.7 lbs., 09-03-15 178 lbs., 09-04-15 no documentation, 09-05-15 178.9 lbs., 09-06-15 161.6 lbs., 09-07-15 177.2 lbs, 09-08-15 169.8 lbs., 09-10-15 161.2 lbs." The record indicated the resident's condition declined from 09-01-15 through 09-10-15 and the resident's concerned family member requested the resident be transported to the local area hospital. A review of the Speech Therapist notations indicated the following decline in the resident's condition: "09-01-15 - Patient lethargic and fatigued on this date. Patient with significant delay in swallow... Signs and symptoms of aspiration throughout PO [by mouth] trials... delayed coughing times 10,		staff on pressure ulcerprevention, daily and weekly skin inspections, reporting pressure ulcers, MDnotification, and obtaining treatment for pressure ulcers. ·Awound prevention checklist will be utilized by nursing staff and initiated forresidents upon admission and with significant change to ensure preventionmeasures in place reflect resident's condition/risk. **IV The facility will monitor the correctiveaction by implementing the following measures.** ·Anaudit tool will be utilized by DON/Designee to ensure residents at high riskfor pressure ulcers have preventive measures in place weekly x 12 weeks,monthly x 3 months. · Any identified areas from audits will beaddressed immediately. ·Employeesnot adhering to policy will be re-educated up to and including termination. ·Resultsof these audits will be reviewed at the monthly Quality Assurance Committeemeeting for a minimum of 6 months and frequency and duration of reviews will beadjusted as needed. **Facility Administrator will be responsible for ensuring compliance.** **V. Plan of Correction**	

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	155181	A. BUILDING 00 B. WING	09/24/2015

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CARMEL HEALTH & LIVING COMMUNITY	118 MEDICAL DR CARMEL, IN 46032

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	throat clearing times 2, and labored breathing times 1." "09-02-15 Aid staff feeding pt. [patient] when SLP began therapy session. Pt presented with running nose and running eyes. SLP educated aid on s/s [signs and symptoms] of aspiration... Pt with increase lethargy throughout PO intake. Pt. warranted max cues throughout meal consumption to swallow. Pt with wet vocal quality times 2 with HTL [honey thickened liquid] consumption. SLP cued pt to cough. Pt. did not respond to cueing and did not cough... SLP discussed with nsg. [nursing] staff to order pt. Ensure [a supplement] and thicken to a appropriate viscosity due to increase lethargy during meal consumption; resulting in reduced consumption amount." "09-03-15 Pt. with intermittent wet vocal quality throughout meal consumption. Pt. discussed with nsg. staff to check pt lungs periodically throughout day due to upgraded diet." "09-04-15 ... Pt. pocketing food in oral cavity. Pt. with overt s/s of aspiration times 6 in form of cough and times 4 wet vocal quality... Pt. reported being full after about 10 % meal consumption."		**completion date.** Plan of Completion date is October 20, 2015.	

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	155181	A. BUILDING 00 B. WING	09/24/2015

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	"09-07-15 Pt. being fed by an aid. Pt. with increased lethargy and distraction throughout meal consumption. Pt. began spitting out food and refusing meal. Pt. with 10% meal consumption." "09-09-15 Pt. seen bedside this date during lunch. Pt. [spouse] present during therapy session and reported pt. did not sleep all night. Pt. [spouse] reported pt was coughing and moaning in pain. Pt. wife reported pt did not eat AM meal due to increased lethargy. Pt. with increased lethargy this date throughout therapy session and less verbalization than typical." A review of the hospital record indicated the resident arrived at the Emergency Room on 09-10-15 with "clear dehydration, somulent and drooling." The record also indicated the resident had a "Decubitus Ulcer" and was evaluated by the hospital wound care nurse on 09-10-15. A review of the hospital "Wound/Skin Evaluation," dated 09-10-15, indicated the resident had a "suspected deep tissue injury to the right heel." The documentation indicated, "area measured 1 centimeter in length by 1.4 centimeters in width - etiology: pressure Pt. [patient] has intact skin with a brown/darker			

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	155181	A. BUILDING 00 B. WING	09/24/2015

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	brown colored skin on the back of pt's heel." During an interview on 09-24-15 at 2:45 p.m., Licensed Nurse #3 indicated she provided care for Resident "B" but was unaware of the suspected deep tissue injury to the resident's heel. A review of the Treatment Administration record, the resident was last assessed for skin concerns on 09-07-15 by Licensed Nurse #3. This Federal tag relates to Complaint IN00182272. 3.1-40(a)(1) 3.1-40(a)(2)			
F 0325 SS=G Bldg. 00	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. Based on record review and interview the facility failed to ensure a resident with a	F 0325	**F325** **Maintain Nutrition Status**	10/20/2015

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	155181	A. BUILDING 00 B. WING	09/24/2015

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CARMEL HEALTH & LIVING COMMUNITY	118 MEDICAL DR CARMEL, IN 46032

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	recent removal of a nasogastric (NG) tube was assessed and interventions implemented to prevent a significant weight loss of 17 lbs. (pounds) in 9 days for 1 of 3 residents sampled for weight loss. (Resident "B"). This deficient practice resulted in the resident transported to the local area hospital and admitted for a change in mental status, weight loss and dehydration which required physician interventions to include intravenous fluids. (Resident "B"). Findings include: The record for Resident "B" was reviewed on 09-21-15 at 12:00 p.m. Diagnoses included, but were not limited to, diabetes mellitus, cerebral vascular disease, dysphagia, hypertension, dementia and speech/language deficit's. These diagnoses remained current at the time of the record review. At the time of admission, the resident weighed 179 lbs, and was admitted to the facility with a NG (naso-gastric) feeding tube in place for nutrition and hydration.. A physician order dated 08-16-15, instructed the nursing staff to weigh the resident daily. The order included a		**UnlessUnavoidable** It is the practiceof this provider to ensure that residents maintain acceptable parameters ofnutritional status unless the resident's clinical condition demonstrates thatthis is not possible. **Whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice?** ·Resident B no longer resides atthe facility. How willyou identify other residents having the potential to be affected by the samedeficient practice and what corrective action will be taken? ·All residents who have naso-gastric tubes removed have the potential to be affected. ·No other residents reside at thefacility with a naso-gastric tube or have had a naso-gastric tube removed. **Whatmeasures will be put into place or what systemic changes you will make toensure that the deficient practice does not recur?** ·Residentswith naso-gastric tubes will be referred to RD post naso-gastric tube removalfor nutritional re-assessment and weight loss prevention interventions	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155181	A. BUILDING 00 B. WING	09/24/2015

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

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	notation which instructed the nursing staff to "notify MD [Medical Doctor] of a weight gain of 2 lbs. [pounds] in one day or 5 lbs. in a week." A review of the record indicated the nursing staff received physician orders to remove the feeding tube on 09-01-15. The record further indicated the resident had physician orders to receive a "pureed diet with honey thickened liquids" for nutrition and hydration and also "required dependent assist with feeding." The resident also had physician orders for Speech Therapy related to the appropriate diet and the resident's chewing and swallowing abilities. Further review of the resident's record lacked a plan of care to reflect a change in nutrition for the resident from receiving nutrition through a NG tube to a mechanically altered diet. A review of the Speech Therapist treatment notations, once the resident's NG feeding tube had been removed and began to consume food and liquids by mouth indicated the following: "09-01-15 - Patient lethargic and fatigued on this date. NG tube removed by nursing while SLP [Speech Language Pathologist] present during afternoon		·Residentswith naso-gastric tubes will have care plans updated to reflect nutritionalinterventions ·Daily weights are reviewed daily in clinical meetingby Interdisciplinary Team (IDT) to identify significant changes Monday throughFriday and by the Weekend manager on Saturday and Sunday. Any significant weight loss will be reviewedfor physician notification. ·CDM/designeeattends clinical meeting daily Monday through Friday, is responsible for theWeight Management Program and will notify RD of significant weight losses. ·ConsultingRD will make recommendations for residents with significant weight losses. ·Nursingstaff will follow up with MD regarding RD recommendations and provide responseswithin 3 business days. ·Corporateclinical directed in-service has been provided to nursing staff and IDT team onthe Weight Management Program. ·Therapy services will provide training/in-servicesto nursing staff for restorative/ADL/strategic feeding programs prior totransition from therapy to nursing programs. ·A corporate directed in-service was held with thetherapy department to develop better strategies for transitions to the nursingdepartment when residents are discharged from	

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	155181	A. BUILDING 00 B. WING	09/24/2015

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	session. Patient with significant delay in swallow... Signs and symptoms of aspiration throughout PO [by mouth] trials... delayed coughing times 10, throat clearing times 2, and labored breathing times 1." "09-02-15 Aid staff feeding pt. [patient] when SLP began therapy session. Pt. presented with running nose and running eyes. SLP educated aid on s/s [signs and symptoms] of aspiration and [sic] 'dry swallow, double swallow and max cueing to swallow.' Pt. with increase lethargy throughout PO intake. Pt. warranted max cues throughout meal consumption to swallow. Pt. with wet vocal quality times 2 with HTL [honey thickened liquid] consumption. SLP cued pt to cough. Pt. did not respond to cueing and did not cough. SLP completed dry swallow with spoon. Pt. with meal consumption about 50 % SLP discussed with nsg. [nursing] staff to order pt. Ensure [a supplement] and thicken to a appropriate viscosity due to increase lethargy during meal consumption; resulting in reduced consumption amount." There was no physician order for the administration of Ensure for the resident to increase his calorie intake. "09-03-15 Pt with consumption of puree		caseload. ·Strategic feeding plans will be attached to thenurse aide assignment sheets. ·Staff Development/Unit Manager/or designee willprovide additional training to nursing staff for restorative/ADL/strategicfeeding programs post Therapy training ·Certified Dietary Manager (CDM) attends Clinicalmeeting daily Monday through Friday to identify new orders for therapeutic diet/fluidchanges and then update diet tickets to reflect appropriate diet orders ·Nursing Weekend supervisor will notify Dietary ofany new diet orders on Saturdays/Sundays. ·Dietary and Nursing staff have been re-educated onfollowing therapeutic diet and fluid orders during meal pass. **How willthe corrective action(s) be monitored to ensure the deficient practice will notrecur, i.e., what quality assurance program will be put into place?** ·Anaudit tool will be utilized by the Therapy Services Director/designee dailyMonday through Friday x 4 weeks, weekly x 4 weeks, monthly x 1 month to ensureall restorative/ADL/strategic feeding programs have been communicated duringClinical	

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	155181	A. BUILDING 00 B. WING	09/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	and HTL in dining room during meal. Pt. with intermittent wet vocal quality throughout meal consumption. Pt warranted mod [moderate] - max [maximum] verbal/tactile cueing to swallow and complete double swallow. Pt. discussed with nsg. staff to check pt lungs periodically throughout day due to upgraded diet." "09-04-15 ... Pt pocketing food in oral cavity. Max cues to not talk with food in oral cavity. Pt with overt s/s of aspiration times 6 in form of cough and times 4 wet vocal quality. Average hold during oral phase was about 15 seconds... Pt reported being full after about 10 % meal consumption." "09-07-15 Pt being fed by an aid. Pt with increased lethargy and distraction throughout meal consumption. Pt with oral phase hold of an average of about 15 seconds. Pt began spitting out food and refusing meal. Pt with 10% meal consumption." "09-09-15 Pt seen bedside this date during lunch. Pt [spouse] present during therapy session and reported pt did not sleep all night. Pt [spouse] reported pt was coughing and moaning in pain. Pt. wife reported pt did not eat AM meal due to increased lethargy. Pt with increased		Meeting ·Anaudit tool will be utilized by the CDM daily Monday through Friday and theWeekend Nursing Supervisor Saturday/Sunday to ensure diet order changes arecommunicated to the dietary department for changes to be made to the mealtickets. ·Anaudit tool will be utilized by Department Managers and Nursing Management tooversee dining rooms to ensure strategic meal plans are followed andappropriate diets are served daily x 4 weeks, weekly x 4 weeks, then monthly x5 months. ·An audit tool will be used by DON/Admin/designeedaily to ensure significant weight losses are identified and MD is notifiedtimely. ·Anaudit tool will be used by the CDM/designee to ensure weights are accurate andRD is notified of significant weight losses weekly x 12 weeks, and monthly x 3months. ·Anyidentified areas from audits will be addressed immediately. ·Employeesnot adhering to policy will be re-educated up to and including termination. ·Theresults of these audits will be discussed at the monthly facility QualityAssurance Committee meeting for a minimum of 6 months and frequency andduration of reviews will be adjusted as needed. **FacilityAdministrator will be**	

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	155181	A. BUILDING 00 B. WING	09/24/2015

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

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	lethargy this date throughout therapy session and less verbalization than typical. Pt warranted max verbal cueing to swallow bolus. Oral phase average time 12 - 15 seconds with puree consumption... Pt with reduced hyolargyneal excursion and increased weakness... Nsg. staff gave pt medication with HOB [head of bed] lowered. SLP educated on importance of raising HOB when providing medication in bed." A review of the meal consumption documentation indicated the following: "09-01-15 Dinner 1 - 25% consumed, 09-02-15 No documentation for Breakfast or the lunch meal, Dinner 26 - 50 % consumed, 09-03-15 Breakfast 1 - 25% consumed, Lunch 26 - 50 % consumed, Dinner 1- 25 % consumed, 09-04-15 Breakfast 1 - 25 % consumed, Lunch 1 - 25 % consumed, Dinner 76 - 100 % consumed., 09-05-15 Breakfast 26 - 50 % consumed, 51 - 75 % consumed, 51 - 75 % consumed, 09-06-15 No documentation for the Breakfast or Lunch meal, Dinner 26 - 50 % consumed, 09-07-15 No documentation for the Breakfast or Lunch meal, Dinner 76 - 100 % consumed,		**responsible for ensuring compliance**. **Compliance Date: October 20, 2015**	

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	155181	A. BUILDING 00 B. WING	09/24/2015

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

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	09-08-15 No documentation for the Breakfast or Lunch meal, Dinner 1 - 25 % consumed, 09-09-15 Breakfast 'None' consumed, Lunch 'None' consumed, Dinner 26 - 50 % consumed." A review of the resident's daily weights, from the time the NG feeding tube was removed until 09-10-15 when the resident was transported to the local area hospital indicated the following: "09-01-15 178 lbs., 09-02-15 178.7 lbs., 09-03-15 178 lbs., 09-04-15 no documentation, 09-05-15 178.9 lbs., 09-06-15 161.6 lbs., 09-07-15 177.2 lbs, 09-08-15 169.8 lbs., 09-10-15 161.2 lbs." A review of the Physician Progress notes indicated the following: "09-10-15 [Spouse] at bedside with many concerns regarding his overnight care and also states minimal PO intake past 2 days. She insists on sending him to ED [Emergency Department] despite multiple attempts to offer immediate IV [intravenous] placement... Pt is more lethargic than baseline." At the time the resident presented to the			

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	155181	A. BUILDING 00 B. WING	09/24/2015

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

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	local hospital on 09-10-15, the Emergency Room record indicated the resident was drooling, somulent and had an actual weight of 162 lbs. The resident was admitted to the hospital with diagnoses which included "hypernatremia, dehydration, failure to thrive, and acute renal failure." The record lacked documentation the physician or dietitian were notified of the weight loss as documented in the clinical record and a change in the mental alertness of the resident. A review of the facility policy on 09-23-15 at 12:00 p.m., titled "Clinical Signs of Dehydration," and Risk Factors that may lead to Dehydration," dated March 2015, indicated the following: "Risk Factors - Weight loss - rapid loss is attributed mostly to loss of fluid, not foods, ADL [Activities of Daily Living] decline; dependence on staff for fluid intake; dysphagia and/or refusing liquids, limited fluid intake or decreased thirst sensation, medications such as diuretics, laxatives, Diagnosis: dehydration, malnutrition, renal disease, cancer, COPD [Chronic Obstructive Pulmonary Disease." "Intake Assessment: If fluid needs are			

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	155181	A. BUILDING 00 B. WING	09/24/2015

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

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	not being met, determine the root cause by examining risk factors as above." A review of the facility "Weight Management Policy," on 09-23-15 at 1:00 p.m., and dated 02-17-2015, indicated the following: "Policy Statement: Purpose - This policy is meant to provide guidance to the community on obtaining weights and addressing significant weight changes." "It is considered to be a "best practice" for each community to develop a weight team that will ensure weights are obtained in the same manner for each resident by the same staff members to ensure accuracy. ... If the resident has a previous weight n the medical record that weight will be compared to the current weight being obtained to ensure that a reweight is done immediately if there is a significant change in weight. ... If the resident weighs 101 lbs. r more and there is a weight change from the previous weight of +/- [plus or minus] 5 lbs., then he/she will be reweighed." "Significant weight loss/gain protocol (for weekly admission weights and routine monthly weight monitoring and any other weight change the IDT [Interdisciplinary Team] determines to be			

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	155181	A. BUILDING 00 B. WING	09/24/2015

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

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	at risk) - Family/physician/RD [Registered Dietitian] notification will be documented in the medical record. The RD will be notified to assess/review the resident for recommendations on his/her next visit. ... Initiate or update care plan to include: ...expected weight changes, risks affecting weight changes, RD consult and recommendations, Resident compliance, intake records for fluid and fluids, nurse aide communication matches the care plan interventions when applicable." Weight loss worsens: Notify MD [Medical Doctor], family and staff, Review of the care plan/MD order(s)/nurse aide sheet to ensure they reflect current interventions and status." This Federal tag relates to Complaint IN00182272. 3.1-46(a)(2)			
F 0327 SS=G Bldg. 00	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. Based on record review and interview the facility failed to ensure a resident with a	F 0327	**F327** **Sufficient Fluid to maintain hydration**	10/20/2015

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	155181	A. BUILDING 00 B. WING	09/24/2015

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CARMEL HEALTH & LIVING COMMUNITY	118 MEDICAL DR CARMEL, IN 46032

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	recent removal of a nasogastric (NG) tube was assessed and interventions implemented to prevent dehydration for 1 of 3 residents sampled for hydration (Resident "B"). This deficient practice resulted in the resident transported and admitted to the local area hospital for a change in mental status and dehydration which required physician interventions to include intravenous fluids. (Resident "B"). Findings include: The record for Resident "B" was reviewed on 09-21-15 at 12:00 p.m. Diagnoses included, but were not limited to, diabetes mellitus, cerebral vascular disease, dysphagia, hypertension, dementia and speech/language deficit's. These diagnoses remained current at the time of the record review. At the time of admission, the resident weighed 179 lbs (pounds), and was admitted to the facility with a NG (naso-gastric) feeding tube in place for nutrition. A physician order dated 08-16-15, instructed the nursing staff to weigh the resident daily. The order included a notation which instructed the nursing		It is thepractice of this provider to ensure that residents receive sufficient fluidintake to maintain proper hydration and health. **Whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice?** ·Resident B does not reside in thefacility any longer. How willyou identify other residents having the potential to be affected by the samedeficient practice and what corrective action will be taken? ·All residents who have naso-gastric tubes removed have the potential to be affected. ·No other residents reside at thefacility with a naso-gastric tube or have had a naso-gastric tube removed. **Whatmeasures will be put into place or what systemic changes you will make toensure that the deficient practice does not recur?** ·Residentswith naso-gastric tubes will be referred to RD post naso-gastric tube removalfor fluid needs re-assessment and dehydration prevention	

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	155181	A. BUILDING 00 B. WING	09/24/2015

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

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	staff to "notify MD [Medical Doctor] of a weight gain of 2 lbs. [pounds] in one day or 5 lbs. in a week." The Dietitian's Nutrition assessment, dated 07-31-15, indicated the resident received nothing by mouth, had physician orders included Glucerna 1.2 at 65 ml; (milliliters) over 24 hours and estimated fluid needs of 2025 ml. A review of the record indicated the nursing staff received physician orders to remove the feeding tube on 09-01-15. The record further indicated the resident had physician orders to receive a "pureed diet with honey thickened liquids" for nutrition and hydration and "required dependent assist with feeding." The resident also had physician orders for Speech Therapy related to the appropriate diet and the resident's chewing and swallowing abilities. A review of the fluid consumption documentation indicated the following fluid intake after the NG feeding tube had been removed: "09-01-15 1710 c.c., 09-02-15 1200 c.c... 09-04-15 1500 c.c., 09-05-15 1680 c.c... 09-07-15 1940 c.c.,		interventions ·Residentswith naso-gastric tubes will have care plans updated to reflect hydration needsand interventions ·Corporate clinical directed re-education provided toIDT team and nursing staff on Hydration Management program ·IDT team will review fluid intake daily in clinicalMonday through Friday and Nursing Weekend supervisor on Saturday/Sunday. ·Residentsthat do not meet fluid recommendations will be reviewed for root cause todetermine need for dehydration assessment. ·If adehydration assessment completed and resident shows signs/symptoms ofdehydration the MD will be notified. **How willthe corrective action(s) be monitored to ensure the deficient practice will notrecur, i.e., what quality assurance program will be put into place?** ·Anaudit tool will be utilized by the IDT team, including CDM/DON/ADON/RD, Mondaythrough Friday to ensure residents with fluid intake less than recommendationsand with signs/symptoms of dehydration are notified to the MD and RD weekly x12 weeks, monthly x 3 months. ·Anyidentified areas from audits will be addressed immediately.	

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	155181	A. BUILDING 00 B. WING	09/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	09-08-15 1320 c.c., 09-09-15 1680 c.c." A review of the Speech Therapist treatment notations, once the resident's NG feeding tube had been removed and began to consume liquid by mouth indicated the following: "09-01-15 - Patient lethargic and fatigued on this date. Patient with significant delay in swallow... Signs and symptoms of aspiration throughout PO [by mouth] trials... delayed coughing times 10, throat clearing times 2, and labored breathing times 1." "09-02-15 Aid staff feeding pt. [patient] when SLP began therapy session. Pt. presented with running nose and running eyes. SLP educated aid on s/s [signs and symptoms] of aspiration and [sic] 'dry swallow, double swallow and max cueing to swallow. Pt. with increase lethargy throughout PO intake. Pt. with wet vocal quality times 2 with HTL [honey thickened liquid] consumption. SLP cued pt to cough. Pt. did not respond to cueing and did not cough. SLP completed dry swallow with spoon." "09-03-15 Pt with consumption of puree and HTL in dining room during meal. Pt. with intermittent wet vocal quality		·Employeesnot adhering to policy will be re-educated up to and including termination. ·Theresults of these audits will be discussed at the monthly facility QualityAssurance Committee meeting for a minimum of 6 months and frequency andduration of reviews will be adjusted as needed. **FacilityAdministrator will be responsible for ensuring compliance** **Compliance Date: October 20, 2105.**	

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	155181	A. BUILDING 00 B. WING	09/24/2015

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	throughout meal consumption." "09-07-15 Pt being fed by an aid. Pt with increased lethargy and distraction throughout meal consumption. Pt with 10% meal consumption." "09-09-15 Pt. wife reported pt did not eat AM meal due to increased lethargy. Pt with increased lethargy this date throughout therapy session and less verbalization than typical. Pt warranted max verbal cueing to swallow bolus." "09-10-15 Pt has demonstrated increased difficulty over the past several sessions. Pt has been less responsive and required an increased amount of cueing, especially for swallowing. Pt's wife and staff educated on current concerns due to increased need for cuing [sic], increased delay in or lack of swallow, and possible dehydration. Staff and family demonstrated understanding at this time and wife reported possible need for Pt. to go to the hospital. His consumption has been poor, which mean [sic]...hydration have likely not been satisfactory." A review of the Physician Progress notes indicated the following: "09-03-15 Patient denies any complaints, still with significant "L" [left] side hemiparesis. Tolerating NG feeds;			

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	155181	A. BUILDING 00 B. WING	09/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	however NG tube got clogged and nothing worked in regards to attempts at unclogging it. Will trial a PO diet and monitor intake. Speech Therapy. Apparently was not a candidate for a PEG [Percutaneous endoscopic gastrostomy feeding tube] tube in hospital. If problems with dysphagia or PO intake poor, will consider PEG tube." "09-08-15 "L" side hemiparesis unchanged. Swallow function improved and NG removed, has poor PO intake." "09-10-15 [Spouse] at bedside with many concerns regarding his overnight care and also states minimal PO intake past 2 days. She insists on sending him to ED [Emergency Department] despite multiple attempts to offer immediate IV [intravenous] placement... Pt is more lethargic than baseline." The resident was transported to the local hospital on 09-10-15, through the Emergency Room Department and admitted to the hospital. The record indicated at the time the resident presented to the Emergency Room, the resident was "drooling and somulent." The Hospital record indicated, "Impression: Hypernatremia, Acute Renal Failure, Atrial Fibrillation and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155181	A. BUILDING 00 B. WING	09/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	Dysphagia." The resident was started on Intravenous fluids in the Emergency room to "correct the hypernatremia." The record indicated the resident originally presented with "altered mental status" and "clear dehydration." The record further indicated a laboratory test for a BUN (blood urea nitrogen level) of 52 [normal range of 8 - 26] and a serum sodium level of 169 [normal range of 136 - 145]. The Hospital Emergency Room Nursing notations indicated the resident was "dehydrated with scant urine, oliguria." During an interview on 09-23-15 at 12:30 p.m., the facility Dietitian indicated she had not been informed the resident's nutrition had been changed from a tube feeding to a mechanical altered diet. The Dietitian further indicated she would have needed to reassess the resident for his nutrition and hydration status, and the total amount of fluids needed. The Dietitian indicated that when a resident was on a pureed diet and thickened liquids they were at risk for dehydration. A review of the facility policy on 09-23-15 at 12:00 p.m., titled "Clinical Signs of Dehydration," and Risk Factors that my lead to Dehydration," dated March 2015, indicated the following:			

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	"Dehydration - Rapid decrease in weight, elevated serum sodium > (greater than 148) and/or BUN and or BUN:Creatinine > (greater than 25:1, diminished urine output, postural hypotension and/or weak rapid pulse." This Federal tag relates to Complaint IN00182272. 3.1-46(b)			