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	01/23/2017

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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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00219093. Complaint IN00219093 - Substantiated. Federal/State deficiencies are cited at F282D, F314D and F328D. Survey dates: January 20 & 23, 2017 Facility number: 000095 Provider number: 155181 AIM number: 100290490 Census bed type: SNF/NF: 126 SNF: 6 Total: 132 Census payor type: Medicare: 15 Medicaid: 104 Other: 13 Total: 132 Sample: 5 These deficiencies reflect State findings cited in accordance with 410 IAC 16.1-3.1. Quality review completed on January 24,	F 0000	January 27, 2017 Kim Rhoades, Director Long-Term Care Division Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204 Re: Complaint #IN00219093 Dear Ms. Rhoades: Please find enclosed the Plan of Correction to the complaint survey conducted on January 20 and 23, 2017. This letter is to inform you that the plan of correction attached is to serve as Carmel Health and Living's credible allegation of compliance. We allege compliance on January 31, 2017. If you have any further questions, please do not hesitate to contact me at 317-819-8108. Sincerely,	

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

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	2017 by 29081.		Cindy Kump, HFA Administrator Carmel Health and Living Submission of this plan of correction in no way constitutes an admission by Carmel Health and Living or its management company that the allegations contained in the survey report/2567 is a true and accurate portrayal of the provision of nursing care or other services provided in this facility. The Plan of Correction is prepared and executed solely because it is required by Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the Complaint Survey on January 20-23, 2017. Please accept this plan of correction as Carmel Health and Living's credible allegation of compliance by January 31, 2017. This statement of deficiencies and plan of correction will be reviewed at the September Quality Assurance/Assessment Committee meeting.	
F 0282 SS=D Bldg. 00	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN			

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	(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. Based on record review and interview, the facility failed to ensure medications were given as ordered for 1 of 4 residents reviewed for medication administration. (Resident D) Findings Include: The record for Resident D was reviewed on 1/20/17 at 2:32 p.m. Diagnoses included, but were not limited to, major depression, acute respiratory failure, hypertension and chronic kidney disease. Physician orders dated 1/18/17 indicated orders for: Ipratropium-albuteral duoneb 4 times daily, Ducolax suppository 10 mg (milligrams) at bedtime, Metoprolol 25 mg, give 1/2 tab at bed time and Atorvastatin 20 mg at bed time. The January 2017 Medication Administration Record indicated the following medications were not given due to they were unavailable: Afternoon and bedtime:	F 0282	**F282** **It is the policy of the facility to provide services by a qualified person/per care plan.** **I The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** The admitting nurse was re-educated regarding entering orders into the EMR system, timing of delivery from pharmacy, and the expectation to pull medications not delivered from the pharmacy from the CUBEX system for new admissions.	01/31/2017

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	Ipratropium-albuteral, Bedtime: Ducolax suppository 10 mg (milligrams) , Bedtime: Metoprolol 25 mg Bedtime: Atorvastatin 20 mg The Cubex (emergency drug system) inventory form was received from the DON on 1/20/17 at 3:10 p.m., and deemed as current. The form indicated the residents Albuteral/Ipratropium, Ducolax suppository, Metroprolol 25 mg and Atorvastatin 20 mg was available in the Cubex. 1/23/17 at 10:24 a.m., during interview, the DON indicated several Resident D's medications that were not administered were available in the Cubex system for administration. She indicated she had educated the nurse involved and had started inservicing the staff. During an interview with LPN # 4 on 1/23/17 at 10:10 a.m. she indicated when a new admission arrived, the medications would be ordered from the pharmacy, then if they are not delivered for the time of administration, the medications available in the Cubex system would be utilized for administration. This Federal tag relates to complaint IN00219093.		Resident D's vital signs were all within normal range for the resident within the noted time range. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All new admissions to the facility have the potential to be affected by the alleged deficient practice. The DON audited the last 30 days of admissions to the facility to ensure residents received appropriate admission medications timely and provided education to staff as needed. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.**	

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	3.1-35(g)(2)		Licensed nurses were re-educated related to including but not limited to: ·Ordering medications for new admissions ·Entering medications into EMR system ·Delivery times of the Pharmacy and pharmacy ordering cut off times ·Utilizing Cubex emergency drug system for admission medications available when delivery times are after the time medication is due or medications were not delivered ·Following physician orders Corporate directed In-service conducted to re-educate Nurse Managers on the Medication Administration Compliance Report. **·IV. The facility will monitor the corrective action by implementing the following measures.** A nurse manager will audit new admission medication orders within 24 hours to ensure all medications have been input into EMAR accurately. A nurse manager will run the	

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			facility Medication Administration Compliance Report daily to ensure all medications were administered per order. DON/ADON/designee will conduct an additional audit of the new admissions medication orders and medication administration report daily x 30 days, 5 x Week x 4 Weeks, Weekly x 4 months, Monthly x 6 months. Results of this audit will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed. Staff will be re-educated up to and including termination. Facility Administrator will be responsible for ensuring	

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			compliance. **V. Plan of Correction completion date.** January 31, 2017	
F 0314 SS=D Bldg. 00	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, interview and record review the facility failed to ensure treatments were applied to pressure ulcers as ordered by the physician for 2 of 3 residents reviewed for pressure ulcer treatment. (Resident B and C)	F 0314	**F314** It is the policy of this facility to ensure treatment and services	01/31/2017

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	Findings Include: 1. The record for Resident B was reviewed on 1/20/17 at 10:14 a.m. Diagnoses included, but were not limited to, hemiplegia, end stage renal disease, diabetes mellitus, Fournier gangrene and debility. Admission orders dated 12/29/16 indicated orders to: Cleanse wound to sacrum with Normal Saline, pat dry, apply wound vac (negative pressure wound therapy using a vacuum dressing to promote healing) at 125 mmHg (millimeter of mercury) continuous, once a day on Tuesday, Thursday, Saturday and as needed. Event notes indicated: 12/29/16 at 3:15 p.m., open area coccyx measuring 6 centimeters (c)m by 3.6 cm by 4.3 cm with undermining/tunneling 3-5 (on the hands of the clock) of 3.8 cm, with 100 percent epithelial (deep pick to pearly pink) tissue with no odor. The Treatment Administration Record (TAR) for 12/29-12/31/16 lacked documentation of the routine placement of the wound vac and lacked documentation the wound vac was		are received by residents to ensure prevention and healing for pressure ulcers. **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Resident B no longer resides at the facility. Resident C's wound was assessed with noted improvement by the wound physician the next day 1-24-17. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** Residents with pressure ulcer treatments have the potential to be affected by the alleged deficient practice.	

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	applied to the residents wound on the as needed treatment. The as needed treatment record was blank of signatures for the administration of wound vac. On 1/20/17 at 1:40 p.m. information was requested from the DON regarding the initiation of the wound vac. At 2 p.m., during interview with the DON she provided information of the wound vac delivery and signature of the nurse who received the vac from (Name of Company) on 12/29/16. The DON indicated she interviewed the nurse who received the vac and she indicated the vac was received in the facility prior to the residents arrival on the second shift. During interview on 1/20/17 at 2:55 p.m., the DON indicated the second shift nurse did not place the wound vac the evening the resident was admitted and the nurse on second shift indicated she did not have time and passed the information onto the third shift on coming nurse. During interview on 1/23/17 at 12:05 p.m., the DON indicated the wound vac was not placed on the resident prior to his death on 12/31/17. She indicated the computerized TAR system would not populate the order onto a Treatment sheet until it was due to be signed and this		**III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** Licensed Nurses were re-educated on: ·Following physicians order ·Obtaining orders for pressure ulcers when identified or worsened ·Entering orders into EMAR system and how to time so orders populate to EMAR, including adding orders to check placement for wound vac every shift Notification of the physician if the order cannot be followed ·Documenting resident refusals or preference time of treatments ·Shift to shift communication of wounds and treatments follow up ·Initiating a change of condition event when identified Wound Treatment skills validations were completed on Licensed Nurses. **IV The facility will monitor the corrective action by implementing the following measures.** Nurse Managers will audit pressure area treatments for	

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	order was a Tuesday, Thursday and Saturday change so it was not on a treatment sheet for the nurses to reference in order to complete the wound vac application. The as needed TAR wound not have triggered the nurses to apply the wound vac. She indicated she had interviewed all the nurses working with this resident and they had not applied the wound vac as ordered. 2. During the initial tour with the DON on 1/20/17 at 9:15 a.m., Resident C was in bed and the DON indicated he had a pressure ulcer to his coccyx. At that time, his pressure ulcer dressing was observed to his coccyx and the dressing was dated 1/17/17. The record for resident C was reviewed on 1/20/17 at 11:01 a.m. An 11/21/16 Quarterly Minimum Data Set Assessment indicated a BIMS (Brief Interview of Mental Status) of 15, indicating no cognitive concerns. Physician orders dated 11/29/16 indicated: Clean coccyx with Normal Saline, pat dry, apply barrier cream to periwound, cover with IodoSorb gel, tuck fluffed gauze and cover with dry dressing. Change daily, evenings, and as needed.		accuracy and timeliness daily x 30 days, 5 days a week x 4 weeks, Weekly x 4 months, Monthly x 6 months. SDC or designee will perform random wound treatments skills validation tool on licensed nurses weekly x 12 weeks, Monthly x 3 months, then quarterly x 2, for a total of 12 months. Any identified concerns from the skills validations will be addressed immediately. DON/designee will review the facility administration compliance report daily to ensure documentation of completed treatments. DON or designee will audit residents at high risk, and those with current pressure ulcers and residents with new pressure ulcers for preventative interventions, documentation, assessment, treatment weekly for 4 weeks, then monthly for 2 months, then quarterly thereafter for a total of 12 months. Any identified concerns from the rounds will be addressed immediately. Staff not adhering to the education provided will be re-educated up to and including termination. Results of the reviews will be presented at the monthly Quality	

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	The TAR for 1/17-1/19 indicated the dressing was changed by (initials of nurse) as completed. There were no refusals documented. During a dressing change observation with LPN # 3 on 1/20/17 at 11:10 a.m., she indicated the current dressing was dated 1/17/17. In an interview during the dressing change, Resident C indicated his dressing had not been changed yesterday, he indicated he had a bowel movement and got cleaned up, and wanted to get up. He indicated the staff said they would do the dressing change later but never returned to do the dressing. During an interview on 1/23/17 at 10:30 a.m., the DON indicated the nurse had not changed the dressing on 1/19/17 but had now amended her documentation to reflect that the dressing had not been changed. A policy titled "Wound Management" was provided by the DON on 1/23/17 at 1:36 p.m., and deemed as current. The policy indicated: "Purpose: To provide clinical guidance and best practice for the management of skin conditions...The wound team:...each wound will be		Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed. Facility Administrator will be responsible for ensuring compliance. **V. Plan of Correction completion date.** January 31, 2017	

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	visualized by the wound team to provide oversight of the care plan interventions and ensure that each resident's condition is accurately assessed in a timely manner....New admissions with any skin conditions documented on admit...." This Federal tag relates to complaint IN00219093. 3.1-40(a)(2)			
F 0328 SS=D Bldg. 00	483.25(b)(2)(f)(g)(5)(h)(i)(j) TREATMENT/CARE FOR SPECIAL NEEDS (b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments (f) Colostomy, ureterostomy, or ileostomy care. The facility must ensure that residents who require colostomy, ureterostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. (g)(5) A resident who is fed by enteral			

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	means receives the appropriate treatment and services to … prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. (h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. (i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. (j) Prostheses. The facility must ensure that a resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, to wear and be able to use the prosthetic device.			
	Based on record review and interview, the facility failed to ensure respiratory assessment and treatment was completed as indicated for 1 of 3 residents reviewed for respiratory care. (Resident F) Findings include:	F 0328	F328 It is the policy of this facility to ensure residents receive	01/31/2017

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	The record for Resident F was reviewed on 1/23/17 at 10:45 a.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease and left hip fracture. A progress noted on 1/2/17 indicted the Respiratory Therapist (RT) was requested by nursing to see resident at 2:46 p.m. The resident had dyspnea (difficulty breathing) , 85 % Oxygen saturation, denied chest pain, had scattered rhonchi with expiratory wheezes. The RT increased the Oxygen to 3 liters and the resident was given an Albuterol nebulizer treatment. The resident stated relief. The RT indicated the resident had a moist week cough, "presents as aspiration," was on a puree diet with thin liquids, had failed modified swallow test at the hospital, but refused to change his diet. The RT recommend Albuteral nebulizer treatments every 2 hours for wheezing and duonebs every 6 hours ,and recommend monitoring for increased work of breathing, temperature and cough. A progress noted dated 1/2/17 at 3:33 p.m., indicated the resident was congested with crackles with 86 % to 93 % oxygen saturation on 2.5 liters of Oxygen. As needed pain medication was		treatment/care for special needs. **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Resident F no longer resides at the facility. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** Residents seen by respiratory therapy have the potential to be effected by the deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** The facility met with the respiratory vendor and implemented a communication form to ensure nurse managers	

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	given at this time. The record lacked progress notes after 3:33 p.m., for vital signs or respiratory assessments. The resident did receive his evening and bedtime medications, but no follow-up respiratory assessment was completed. A physician order was requested at 2:26 p.m., on 1/2/17 for the Albuteral every 2 hour nebulizer treatment as needed and the every 6 hour duoneb treatment for wheezing. The order was not verified until 6:34 p.m., on 1/2/17. The Medication Administration Record (MAR) for 1/2/17 indicated there were no as needed Albuteral nebulizer treatments given and the every 6 hour douneb was not administered when it was verified by the nurse. The MAR only had 12 a.m., and 6 a.m., times for administration, so the nurse did not have a visual trigger to give the 6 p.m., dose when the order was verified. On 1/23/17 at 12 p.m., during interview, the DON indicated the 12 p.m., and 6 p.m., duoneb nebulizer treatment did not pull through onto the treatment sheet since the order was not verified until 6:34 p.m. She indicated the nurse who verified the order did not administer the 6		are aware of all residents seen by RT, and new orders/treatments initiated. Licensed nurses were educated related to including but not limited to: ·Identifying changes in condition ·Notification of physician and family when change of condition occurs ·Focused assessment with change of condition ·Further assessment with continued decline. · Verifying respiratory treatment orders timely in the EMAR system so they populate to EMAR timely **IV The facility will monitor the corrective action by implementing the following measures.** The Nurse Manager reviews the facility Activity Report daily to review nurse progress notes, change of condition events and new physician orders. Any documentation requiring follow up will be addressed immediately by a nurse manager up to and including discipline/termination.	

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	01/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	p.m., ordered duoneb. She indicated she was unsure why the nurse did not administer the nebulizer treatment. During an interview with RT # 1 on 1/23/17 at 12:09 p.m., he indicate he had requested the Albuteral and duonebs for the residents wheezing and symptoms and the resident also had COPD. He indicated with the resident respiratory status he would expect to see every 4 hour respiratory assessments or at least with the administration of the routine and as needed nebulizer treatments. On 1/23/17 at 12:53 p.m., during an interview with RN # 2, she indicated if a resident was having respiratory concerns she would assess the resident at least every 2 hours or more depending on the status. She indicated when she comes on shift, and she checked the computerized MAR for resident orders for administration. If the resident has an order to be verified it would pop up on the computer screen first as a flag to get the order verified so it would populate onto the MAR. She indicated if the order was verified after the time of current administration, then the dose would populate at the next scheduled dose only. So if an order was every 6 hours and verified after 6 p.m., then the 6 p.m., dose would not populate and the 12 a.m., does		The RT communication log will be reviewed upon receipt and the DON/designee will review recommendations to ensure orders, changes in condition were initiated timely/accurately. The DON/designee will review the facility administration compliance report daily to ensure documentation of completed medications/treatments. The QAPI/QA committee will track trends during the monthly meeting to determine if further systemic changes are warranted. Facility Administrator will be responsible for ensuring compliance. **V. Plan of Correction completion date.** January 31, 2017	

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	would. She indicated she felt this was a "flaw" in the system. This Federal tag relates to complaint IN00219093. 3.1-47(a)(6)			