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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00246566, IN00246656, IN00246980, IN00247460, IN00248377 and IN00248496. Complaint IN00246566-Substantiated. No deficiencies related to the allegations were cited. Complaint IN00246656-Substantiated. No deficiencies related to the allegations were cited. Complaint IN00246980-Substantiated. No deficiencies related to the allegations were cited. Complaint IN00247460-Substantiated. No deficiencies related to the allegations were cited. Complaint IN00248377-Substantiated. Federal/State deficiencies related to the allegations are cited at F684. Complaint IN00248496-Substantiated. Federal/State deficiencies related to the allegations are cited at F684. Survey dates: December 13, 14, 15 and	F 0000	**This plan of correction is to serve as Carmel Health and Living's credible allegation of compliance.** **Submission of this plan of correction does not constitute an admission by Carmel Health and Living or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations. We respectfully request a desk review, in lieu of a post-survey review.**	

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

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	18, 2017 Facility number: 000095 Provider number: 155181 AIM number: 100290490 Census bed type: SNF: 9 SNF/NF: 136 Total: 145 Census payor type: Medicare: 10 Medicaid: 108 Other: 27 Total: 145 This deficiency reflects state findings cited in accordance with 410 IAC 16.2-3.1. Quality Review was completed on December 20, 2017.			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to			

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	facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, interview and record review, the facility failed to collaborate resident care between the hospice company and the facility for 1 of 3 residents reviewed for hospice (Resident F) and lacked non-pressure skin condition assessments to determine the progress of bruises for 2 of 3 residents reviewed for non-pressure wound assessments (Residents G and N). Findings include: 1. Resident F's record was reviewed on 12/13/17 at 2:45 p.m. Diagnoses included, but were not limited to, Parkinson's disease, atopic dermatitis, spinal stenosis with melanoma with mets, acute kidney failure and malignant melanoma on his right lower limb. The resident had an Electronic Medication Administration Record (EMAR) dated November 2017, which included, but was not limited to, the following orders: 10/29/17--Morphine liquid 20 mg/ml Give five mg (milligrams) Sublingually every three	F 0684	**I.** **·Resident F no longer resides in the community.** **·Resident G has a current skin assessment with current measurements of non- pressure areas. The non- pressure areas are being measured weekly.** **·Resident N has a current skin assessment with current measurements of non- pressure areas. The non- pressure areas are being measured weekly.** **II.** **·All hospice residents receiving morphine have the potential to be affected by the alleged deficient practice. All hospice residents with morphine orders have been reviewed with the ordering physician to determine the medication order is for the correct dose.** **·All residents with non-pressure areas have the potential to be affected by the alleged deficient practice. All**	12/29/2017

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	hours as needed (Discontinued 11/9/17). 10/29/17--Oxycodone (a narcotic pain medication in the pill form tablet 20 mg give one tablet twice daily (Discontinued 11/11/17). 11/09/17--Morphine liquid 20 mg/ml Give 10 ml (200 mg) sublingually every three hours as needed (Discontinued 11/11/17). A progress note dated 11/9/17 at 3:50 p.m., indicated "Per MD [medical doctor] Hospice can increase Morphine to 10 ml q 3 hours. Contact [Name of Hospice] and explain per MD Rx [script] has to be sent over to pharmacy from hospice...." A progress note dated 11/11/17 at 2:43 p.m., indicated "Resident given PRN [as needed] Morphine as ordered. Call to hospice to clarify order as written, Morphine 20mg/1 ml give 10 ml q [every] 3 hrs [hours]. [Name of Hospice nurse] notified , and she stated that [Name of Hospice] MD [Medical Director] would not give noted strength as order...Husband also stated that he believes that same dose was given on Thursday...." The resident had a care plan dated 10/30/17, which addressed the problem she required (Name of Hospice Company) for services related to her current health and		**residents with non- pressure areas have been reviewed and have current measurements of the area and they will be followed weekly.** **III.** **·Education has been provided to all licensed nurses regarding clarification of morphine orders when a hospice nurse makes a recommendation to change a medication dose. Education has been provided to all contracted hospice providers on recommendations of medication changes. The systemic change includes the hospice nurse will document their recommendation for medication changes in the medical record and the recommendation will be clarified with the resident's physician prior to ordering the medication.** **·Education has been provided to all licensed nurses on the facility skin policy including measuring non-pressure areas weekly. The systemic change includes the unit manager will verify weekly all non-pressure areas are measured and tracked on the facility wound report.**	

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	status and a terminal diagnosis as ordered with six months or fewer to live. The approaches for the resident included, but were not limited to, "...10/30/17- -Coordinate plan of care with hospice to promote comfort with care...." A current document titled "Nursing Facility and Hospice Services Agreement" dated 5/15/14, contained the following "...1.9 Plan Of Care (POC) means a written care plan established, maintained, reviewed and modified, if necessary at intervals identified by the IDG. The POC must reflect the Hospice Patient's and family's goals and interventions based on the problems identified in the hospice patient assessments. The POC will reflect the participation of the Hospice, the Facility and the Hospice Patient and family to the extent possible. Specifically, the POC includes: (a) an identification of the Hospice Services, including interventions for pain management and symptom relief, needed to meet the Hospice Patient's needs and the related needs of the Hospice Patient's family; (b) a detailed statement of the scope and severity of the Hospice Services: (c) measurable outcomes anticipated from implementing and coordinating the POC; (d) drugs and treatment necessary to meet the Hospice Patient's needs; (e) medical supplies and		**IV.** **·DON or designee will audit all residents with new orders for accuracy of Morphine orders daily for 4 weeks; then, monthly thereafter totaling 12 months.** **·DON or designee will audit all residents with non-pressure areas using the facility wound report for weekly measurements weekly for 12 months of monitoring.** **Results of these audits will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed.** **Facility Administrator will be responsible for ensuring compliance.**	

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	appliances necessary to meet the Hospice Patient's needs and (f) the IDG's documentation of the Hospice Patient's or representative's level of understanding, involvement and agreement with he POC. The Hospice and the Facility will jointly develop and agree upon a coordinated POC which is consistent with the Hospice's philosophy and is responsible for performing the respective functions that have been agreed upon and included in the POC. The Facility shall establish and implement its own POC in accordance with State and federal requirements and the Facility's assessment and care planning policies and procedures...." During an interview on 12/13/17 at 3:00 p.m., the Director of Nursing indicated when Resident F was given 200 mg (milligrams) (10 milliliters) of Morphine (a narcotic pain medication) she thought LPN 3 had committed a medication error until she started investigating the incident and she concluded the order had been written and signed by a physician for the resident to have that amount of Morphine. During a confidential interview on 12/13/17 at 3:51 p.m., an anonymous person indicated Resident F was administered 200 mg (milligrams) of liquid Morphine (a			

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	narcotic pain medication). The person indicated the resident's previous Morphine order had been to give 5 mg sublingually (given under the tongue) every three hours as needed. When Hospice Nurse 1 visited the resident on 11/9/17, the resident had uncontrollable pain. She recommended to LPN 4 that Resident F's Morphine needed to be increased from 5 mg every three hours as needed to 10 mg every three hours, but instead there was an order written for Morphine 10 ml (milliliters) (200 mg) every three hours. During an interview on 12/13/17 at 4:35 p.m., Physician 5 indicated his understanding of the Morphine order was the Hospice Nurse indicated to the facility nurse caring for Resident F to obtain an order to increase her Morphine from 5 mg every three as needed to 10 mls (200 mg) every three hours as needed. The facility nurse clarified with the Hospice nurse several times, that she wanted an order for 10 mls (200 mg) Morphine every three hours as needed ordered. He indicated Physician 6 was unable to write orders in the Bridge Communication system (a confidential system used between the Physician 5's office and the facility to communicate concerns regarding residents and the Physicians write orders to the facility using this system.), so			

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	the Physicians in his office had to write the orders. He indicated the facility Physicians did not intercede with Hospice orders, but with an order like the Morphine order,which was requested the Physician should have questioned it as well as a nurse administering the medication. He indicated his office had no way of contacting the Hospice company. During an interview on 12/13/17 at 5:07 p.m., Hospice Nurse 1 indicated she made a followup visit from the day before due to Resident F's condition was declining. She received an update of the resident's condition from LPN 4, she spoke to the husband and completed her assessment of the resident. She indicated the resident was complaining of pain all over, not being controlled with her current dose of Morphine, which was 5 mg (0.25 ml) every three hours as needed. She indicated she spoke to LPN 4 regarding the resident's pain and followed up on her Ativan (a medication used to treat nervousness) needed to be changed to a liquid. Hospice Nurse 1 was going to call Resident F's facility Physician to obtain the order for the increase in the Morphine, but LPN 4 indicated to her, Hospice Nurse 1 would not have been able to contact the resident's physician. LPN 4 indicated the facility Physicians had to be contacted through the			

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	confidential Bridge communication system and only facility staff members had access to that system. LPN 4 indicated she would obtain the order from the resident's Physician when she notified him about the Ativan, which needed to be changed to a liquid. Hospice Nurse 1 indicated LPN 4 asked her several times if she wanted the Morphine increased from 5 mg (0.25 ml) to 10 mg (0.5 ml) every three hours as needed. During an interview on 12/13/17 at 5:18 p.m., Hospice Director 7 indicated the receptionist at their office received a phone call on 11/9/17 in the afternoon from LPN 4, which she asked for Hospice Nurse 1 to return her call. The receptionist sent a message to Hospice Nurse 1 to return LPN 4's call, but Hospice Nurse 1 did not receive the message, so she did not return her call. During an interview on 12/13/17 at 5:34 p.m., the Director of Nursing (DON) indicated (Name of the Hospice Company) denied Hospice Nurse 1 told LPN 4 to obtain an order for 10 mls instead of 10 mg for the dosage and indicated she wrote the Morphine order incorrectly. During an interview on 12/13/17 at 5:39 p.m., LPN 4 indicated Hospice Nurse 1			

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	wanted Resident F's liquid Morphine order to be increased from 5 mg (0.25 ml) to 10 mls (200 mg). She indicated Hospice Nurse 1 was unable to contact the resident's Physician because they have to be contacted by the facility's confidential bridge communication system. She indicated she told Hospice Nurse 1 she would obtain the order from the Physician, since she had to contact the Physician about the Ativan. LPN 4 indicated she contacted Physician 8 who was on call for Physician 5 through the Bridge communication system. She indicated the Physician indicated the dosage was fine, but she was not going to write the order, so LPN 4 did not write the order and called (Name of the Hospice Company) in an attempt to reach Hospice Nurse 1 to clarify the order. She indicated she had not verified the order by the time her shift was over that day, so she past along in report to the afternoon nurse LPN 9, the Morphine order was not verified yet and she had a call out for Hospice Nurse 1. She indicated all the nurses can see the residents' information pending in the Bridge Communication System. She did not know what happened with the Morphine order after she left the facility and went home. During an interview on 12/13/17 at 5:49 p.m., the DON indicated the Hospice DON			

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	indicated Hospice Nurse 1 documented Morphine ten 10 mg every three hours as the order she told LPN 4 to obtain from the Physician. She indicated LPN 4 perceived the Morphine order Hospice Nurse 1 wanted ordered as 10 mls every three hours as needed. LPN 9 misunderstood he was supposed to get a call back from Hospice Nurse 1 regarding the clarification of the Morphine order. During an interview on 12/14/17 at 8:28 a.m., Physician 8 indicated the facility Physicians did not change the hospice orders. She indicated they did not know what Morphine concentration the resident was being administered, so they would not order the dosage change. She indicated if a resident's controlled substance dosage was changed, the Physician had to write a new script. The script is the order for the scheduled narcotics. She indicated she indicated the 10 ml dose of Morphine could be given but she was not giving the order because she had indicated the hospice nurse would need to get the script for the Morphine and the Ativan. She indicated the Hospice nurses were supposed to request changes in the medication orders for the Hospice residents from the Hospice Medical Director. She indicated a script being written for a hospice resident for a			

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	scheduled narcotic is different than one being written for other residents. A scheduled narcotic being written on a script had to be written on a script, indicated "This prescription is for a Hospice Patient." She indicated by her being a Medical Physician she could not have written that high of a dose of Morphine. (Name of Pharmacy) would have placed a red flag on the order because it was not written on the correct script During an interview on 12/14/17 at 12:09 p.m., Pharmacist 11 indicated a Physician should have sent a new script with the dosage change to the Pharmacy because the script is the order for the controlled substance. The Pharmacy did not receive the new order at the Pharmacy until 11/13/17 at 10:33 a.m., after the resident passed away. During an interview on 12/14/17 at 2:45 p.m., Physician 6 indicated if the Hospice resident in a facility needed a change in orders and their primary facility Physician could not be located, then he would write the order for the medication the resident needed. He indicated he was not able to write orders for residents in the Bridge communication system, so he gave a verbal order to the Hospice Nurse and she placed			

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	it inside the resident's record and/or he faxed the order to the Pharmacy if it was a prescription that could be sent by fax machine. 2. During an interview on 12/14/17 at 12:55 p.m., a family member indicated she was notified Resident G had new bruises on her. She indicated the unit manager for her mother's unit called and informed her Resident G was going to be transferred with a Hoyer lift due to the unit manager thought the bruises were caused by being transferred. The record review for Resident G was completed on 12/15/17 at 1:33 p.m. Diagnoses included, but were not limited to, heart failure, pain in her right arm, osteoporosis, chronic kidney disease and dementia without behavioral disturbances. The quarterly MDS (Minimum Data Set) assessment dated 12/2/17, indicated the resident's functional ADL's (Activities of Daily Living) indicated transfers required extensive assist of two people. A "Change in Condition" report dated 12/8/17 at 4:26 p.m., indicated a bruise was observed on the residents left knee. The bruise measured 7.0 cm (centimeters) x 6.2			

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	cm. A "Change in Condition" report dated 12/8/17 at 4:35 p.m., indicated a bruise was observed on the resident's left lower leg. The bruise measured 2.3 cm x 1.3 cm. A "Change in Condition" report dated 12/8/17 at 4:36 p.m., indicated a bruise was observed on the resident's right lower leg. The bruise measured 9.0 cm x 3.0 cm. A "Change in Condition" dated 12/8/17 at 4:37 p.m., indicated a bruise was observed on the resident's right upper arm. The bruise measured 8.0 cm x 5.8 cm. The resident's record was reviewed and no further non-pressure wound assessments were found in Resident G's record for the bruises located to her left knee, left lower leg, right lower leg and right upper arm from the date of discovery, which was 12/8/17. On 12/18/17 at 11:42 a.m., LPN 13, CNA's 14 and 15 were observed transferring Resident G to be with a Hoyer lift. The transfer was completed appropriately with appropriately support of the resident's feet to prevent her feet and legs from being hit on the Hoyer lift machine. LPN 13 indicated at that time, the resident			

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	recently had Geri sleeves applied to her arms and her legs have tubi grips to protect them. She indicated there had not been any new bruises since the Geri sleeves had been applied. At that time, the resident was observed to have bruises noted to her right upper arm approximately the size of a quarter and was a greenish yellow color. The left knee bruise was observed to be approximately the size of a tennis ball and was a purplish wine color. The left lower leg had two bruises, which were observed to be approximately the sizes of a nickel and a dime and were a reddish wine color. The right lower leg bruise was observed to be approximately the size of a hot dog and was a reddish purple color. 3. During an interview while doing the Entrance tour started on 12/13/17 at 10:37 a.m., LPN 16 indicated Resident N fell and received a hematoma to her left breast. The record review for Resident N was completed on 12/18/17 at 4:29 p.m. Diagnoses included, but were not limited to, history of falling, cerebral infarction, difficulty in walking, generalized muscle weakness, and cognitive communication deficit. The resident's admission MDS assessment dated 12/1/17, indicated her BIMS (Brief			

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	12/18/2017

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

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	Interview Mental Status)=14. The resident's functional ADL's indicated her transfer status required extensive assist of one person. A "Change in Condition" report dated 12/6/17 at 11:21 p.m., indicated the resident was observed to have a bruise to her left breast related to a fall on 12/5/17. The bruise measured 11.5 cm x 12 cm and was a purplish red color. The resident's record was reviewed and no further non-pressure wound assessments were found in Resident N's record for the breast bruise from the date of discovery, which was 12/6/17. During an interview on 12/18/17 at 5:00 p.m., the DON indicated there were no further non-pressure wound assessments. She indicated these assessments were not being completed weekly and they should have been until the area was healed. On 12/18/17 at 5:10 p.m., with the DON in attendance, Resident N's left breast was observed to be a purplish color and it covered the entire lateral side of her left breast and extended onto the top of her breast. The DON palpated her breast and indicated she had a knot where the bruise			

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	was located. The resident indicated the area was tender. These Federal tags relate to Complaints IN00248377 and IN00248496. 3.1-37(a)			