STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155817	A. BUILDING 00 B. WING	06/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BARRINGTON OF CARMEL, THE	1335 S GUILFORD ROAD CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 a Recertification and State Licensure Survey. This visit included a Non-Certified Comprehensive Survey. This visit included a State Residential Licensure Survey. Survey dates: June 7, 8 and 9, 2023 Facility number: 013212 Provider number: 155817 Census Bed Type: SNF: 17 Residential: 52 NCC: 19 Total: 88 Census Payor Type: Medicare: 3 Other: 14 Total: 17 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on June 21, 2023.	F 0000		
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for			

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

Kara Owen | Executive Director | 07/07/2023

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

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	each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. Based on observation, interview and record review, the facility failed to ensure residents sitting at the same table were all served before assisting other residents for 12 of 17 residents observed for dining. Finding includes:	F 0550	Submission of this plan of correction shall not constitute or be construed as an admission that The Barrington of Carmel provides anything other than a high quality of care to its residents. The Barrington of Carmel considers itself to be a partner with the	07/28/2023

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	During an observation, on 6/7/23 at 12:18 p.m., the cook carried two plates to a table of six residents sitting against the wall by the windows. The cook then carried two more plates to another table of six residents sitting at the entrance of the dining room. During an interview, on 6/7/23 at 12:20 p.m., Certified Nursing Assistant (CNA 2) indicated not all residents sitting at one table were served at the same time. During an interview, on 6/7/23 at 12:24 p.m., CNA 3 indicated one cook and two servers were preparing the food and serving the meal to the residents. The plates came out at different times and not all tables were served at the same time. During an interview, on 6/7/23 at 12:49 p.m., Server 4 indicated lunch was first come first served for the residents. The plates were delivered in no particular order, and they normally did not pass one table at a time. During the resident council meeting, on 6/7/23 at 2:05 p.m., the residents indicated they waited a long time for their meals and the tables did not get their food at the same time. One resident indicated she had to watch the other residents eat while waiting for her food. A current policy, titled "Resident Rights," not dated and received from the Associate Executive Director on 6/8/23 at 2:54 p.m., indicated "...The facility will inform the resident both orally and in writing, in a language that the resident understands, of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility...All residents will be treated equally regardless of age,		Indiana State Department of Health and other entities in an ongoing effort to continually improve the services provided in long-term care facilities. We believe that any feedback provided to us should be taken very seriously, and we are committed to using our resources to make any adjustments necessary to achieve better outcomes for residents. As required, the facility submits the following plan of correction: **F550 – Residents Rights** **Immediate action taken for the resident(s) found to have been affected include:** The dining staff involved were immediately in-serviced on the proper procedures for maintaining resident rights during meal service. **Identification of other residents having the potential to be affected was accomplished by:** The facility has determined that all residents eating in the dining room have the potential to be affected. **Actions taken/systems put into place to reduce the risk of future occurrences include:** All facility nursing and dining staff were in-serviced (Attachment A) on regulations pertaining to residents' rights and the guide for Promoting/Maintaining Resident Dignity During Mealtimes (Attachment B). **How the corrective action(s)**	

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	race, ethnicity, religion, culture...The resident has a right to be treated with respect and dignity...." The facility did not have a dining policy at the time of the exit conference. 3.1-3(t)		**will be monitored to ensure the practice will not recur:** The Dietary Manager, or designee, will conduct random mealtime observations to ensure facility procedure for Promoting/Maintaining Resident Dignity During Mealtimes is followed. These random audits will occur weekly for four (4) weeks, and monthly thereafter until no deficient practices have been observed over 90 days (Attachment C). Observation reports will be reviewed by the Quality Assurance Committee to ensure compliance has been achieved, as determined by the committee. All corrections for this tag will be completed by July 28, 2023.	
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;			

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	§483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on observation, interview and record review, the facility failed to notify the MD (medical doctor) about a greater than 5% weight loss in 3 days according to the order for 1 of 2 residents reviewed for nutrition. (Resident 7) Finding includes: During an interview, on 06/07/23 at 1:34 p.m., Resident 7's daughter indicated the resident was getting food which was against her gluten-free diet, and it was giving her diarrhea. The record for Resident 7 was reviewed on 06/08/2023 at 9:35 a.m. Diagnoses included, but were not limited to, moderate protein-calorie malnutrition, celiac disease (an immune reaction to eating gluten), age-related physical debility, unspecified dementia, and need for assistance with personal care. A physician's order, dated 05/19/2023, indicated to weigh the resident every Monday during the day shift. A care plan, dated 04/10/2023, indicated the resident was at risk for malnutrition and the facility was to report a significant weight loss of greater than 5% of body weight in 1 month to the MD. The resident's weights were: a. On 05/29/2023, the resident's weight was 104.4 pounds.	F 0692	Submission of this plan of correction shall not constitute or be construed as an admission that The Barrington of Carmel provides anything other than a high quality of care to its residents. The Barrington of Carmel considers itself to be a partner with the Indiana State Department of Health and other entities in an ongoing effort to continually improve the services provided in long-term care facilities. We believe that any feedback provided to us should be taken very seriously, and we are committed to using our resources to make any adjustments necessary to achieve better outcomes for residents. As required, the facility submits the following plan of correction: **F692 – Nutrition/Hydration Status Maintenance** **Immediate action taken for the resident(s) found to have been affected include:** The Licensed Nurse involved was immediately in-serviced on *the Weight Monitoring* and *Notification of Changes* policies (Attachment D). Resident 7 was re-weighed on 6/1/2023 and the weight on 5/29/2023 was determined to be	07/28/2023

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	b. On 06/01/2023, the resident's weight was 98.8 pounds which was a significant weight loss of 5.4% in 3 days. A progress note, dated 06/2/2023 at 8:52 a.m., indicated the facility notified the RDN (Registered Dietary Nutritionist). Her weight was recognized as a 1.8% weight loss in 30 days. The EHR (Electronic Health Record) did not indicate the facility re-weighed the resident after there was a significant weight loss. The progress notes did not indicate the facility contacted the MD. During an interview, on 06/09/23 at 11:56 a.m., the ADON (Assistant Director of Nursing) and the RDN indicated the facility would re-weigh the resident to ensure there was not an error. A current policy, titled "Notification of Changes," dated as reviewed in 2022 and received from the Assistant Executive Director on 06/08/2023 at 3:14 p.m., indicated "...The facility must inform the resident, consult with the resident's physician and/or notify the resident's family member or legal representative when there is a change requiring such notification...Significant change in the resident's physical, mental, or psychosocial condition such as deterioration in health, mental or psychosocial status...." A current policy, titled "Weight Monitoring," dated as reviewed in 2022 and received from Assistant Executive Director on 06/09/2023 at 10:57 a.m., indicated "...Weight Analysis: The newly recorded resident weight should be compared to the previously recorded weight. A significant change in weight is defined as: a. 5%		erroneous. **Identification of other residents having the potential to be affected was accomplished by:** The facility has determined that all residents have the potential to be affected. **Actions taken/systems put into place to reduce the risk of future occurrences include:** All facility licensed nursing staff were in-serviced (Attachment E) on the regulations and the facility policies on *Weight Monitoring* and *Notification of Changes* policies. **How the corrective action(s) will be monitored to ensure the practice will not recur:** The Director of Nursing, or designee, will conduct a random audit to observe adherence to *Weight Monitoring* and *Notification of Changes* policies weekly for four (4) weeks, and monthly thereafter until no deficient practices have been observed over 90 days (Attachment F). Audits will be reviewed by the Quality Assurance Committee to ensure compliance has been achieved as determined by the committee. All corrections for this tag will be completed by July 28, 2023.	

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	change in weight in 1 month (30 days)...." 3.1-46(a)(1)			
F 0727 SS=D Bldg. 00	483.35(b)(1)-(3) RN 8 Hrs/7 days/Wk, Full Time DON §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. Based on interview and record review, the facility failed to ensure a Registered Nurse was in the facility for 8 hours during a 24-hour period for 2 days of the second quarter reviewed for sufficient staffing. (March 11 and 12, 2023) Finding includes: A Payroll-Based Journal (PBJ) Staffing report, for the second quarter of 2023, indicated the facility failed to have licensed nurse coverage for 2/11, 2/12, 2/19, 2/25, 2/26, 3/4, 3/11, 3/12, 3/18, 3/19, 3/25 and 3/26/2023. During an interview, on 6/8/23 at 10:15 a.m., the Director of Nursing (DON) indicated she did not believe the facility went twelve days without Registered Nurse (RN) coverage. They always	F 0727	Submission of this plan of correction shall not constitute or be construed as an admission that The Barrington of Carmel provides anything other than a high quality of care to its residents. The Barrington of Carmel considers itself to be a partner with the Indiana State Department of Health and other entities in an ongoing effort to continually improve the services provided in long-term care facilities. We believe that any feedback provided to us should be taken very seriously, and we are committed to using our resources to make any adjustments necessary to	07/28/2023

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	work with at least two nurses each shift. The facility scheduled a RN daily. During an interview, on 6/8/23 at 10:20 a.m., the Facility Scheduler indicated she normally scheduled a RN daily and did not know why a RN was not on the schedule. During an interview, on 6/8/23 at 11:18 a.m., the DON indicated the facility did not have RN coverage for the weekend of 3/11 and 3/12/23. They should have had RN coverage and did not know why an RN was not on the schedule. During a record review, on 6/8/23 at 11:20 a.m., the actual worked staffing schedule indicated there was no RN coverage for 3/11 and 3/12/23. A current policy, titled "Nursing Services and Sufficient Staff," not dated and received from the DON on 6/8/23 at 2:51 p.m., indicated "...It is the policy of this facility to provide sufficient staff with appropriate competencies and skill sets to assure resident safety and attain or maintain the high practicable physical, mental and psychosocial well-being of each resident. The facility's census, acuity and diagnoses of the resident population will be considered based on the facility assessment...The facility will supply services by sufficient numbers of each of the following personnel types on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans...The facility is required to provide licensed nursing staff 24 hours a day, 7 days a week...The facility is responsible for submitting timely and accurate staffing data through the CMS Payroll-Based Journal (PBJ) system...Except when waived, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week...."		achieve better outcomes for residents. As required, the facility submits the following plan of correction: **F727 – RN Coverage** **Immediate action taken for the resident(s) found to have been affected include:** Weekly schedules were reviewed by the Director of Nursing to confirm that appropriate RN coverage was in place. **Identification of other residents having the potential to be affected was accomplished by:** The facility has determined that all residents residing in the skilled nursing facility have the potential to be affected. **Actions taken/systems put into place to reduce the risk of future occurrences include:** Since the date of the observed deficiency, the facility now has additional Registered Nurses employed full-time. Additionally, a backup on-call schedule and procedure with RN nursing management has been devised. Nursing staff, including the nursing scheduler, were in-serviced on the requirement (Attachment G). The existing facility policy on RN Coverage (Attachment H) was reviewed and meets regulatory requirements. **How the corrective action(s) will be monitored to ensure the practice will not recur:** The Director of Nursing, or	

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	3.1-17(b)(3)		designee, will audit the weekly schedule to verify RN coverage for four (4) weeks, and monthly thereafter until no deficient practices have been observed over 90 days (Attachment I). Schedule audits will be reviewed by the Quality Assurance Committee to ensure compliance has been achieved as determined by the committee. All corrections for this tag will be completed by July 28, 2023.	
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions,			

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	unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on interview and record review, the facility failed to ensure staff knew how to monitor residents for the serious side effect of EPS (extrapyramidal side effects) which can be caused by antipsychotic medications for 2 of 5 residents reviewed for unnecessary medications (Resident 14 and 4). Findings include: 1. The record for Resident 14 was reviewed on 6/8/23 at 9:54 a.m. Diagnoses included, but were not limited to, psychotic disorder with hallucinations due to a known physiological condition, Parkinson's disease, and dementia without behavioral disturbance.	F 0758	Submission of this plan of correction shall not constitute or be construed as an admission that The Barrington of Carmel provides anything other than a high quality of care to its residents. The Barrington of Carmel considers itself to be a partner with the Indiana State Department of Health and other entities in an ongoing effort to continually improve the services provided in long-term care facilities. We believe that any feedback provided to us should be taken very seriously, and we are committed	07/28/2023

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	A physician's order, dated 5/22/23, indicated quetiapine (an antipsychotic) 25 mg (milligram) give one half tablet at bedtime related to the psychotic disorder with hallucinations due to a known physiological condition. A physician's order, dated 5/22/23, indicated to monitor for the antipsychotic medication side effects of dry mouth, constipation, blurred vision, disorientation, confusion, hypotension, dark urine, yellow skin, nausea, vomiting, lethargy, drooling, EPS symptoms, tremors, disturbed gait, increased agitation, restlessness and involuntary movements of the mouth or tongue. A care plan, dated 5/24/23, indicated the resident was at a risk for behavior problems related to the psychotic disorder with hallucinations. The interventions included, but were not limited to, administer medications as ordered and monitor for side effects and effectiveness. The MAR (Medication Administration Record), dated 5/22/23 through 5/31/23, indicated LPN 5 had observed for antipsychotic side effects including EPS on 5/23/23, 5/24/23, 5/25/23 and 5/31/23 and LPN 6 on 5/26/23. The MAR did not include if the resident had any of the side effects being monitored. The MAR, dated 6/1/23 through 6/7/23, indicated LPN 5 had observed for antipsychotic side effects including EPS on 6/3/23, 6/4/23 and 6/7/23 and LPN 6 on 6/2/23 and 6/5/23. The MAR did not include if the resident had any of the side effects being monitored.		to using our resources to make any adjustments necessary to achieve better outcomes for residents. As required, the facility submits the following plan of correction: **F758 – Free from Unnecessary Psychotropic Medications** **Immediate action taken for the resident(s) found to have been affected include:** The Licensed Nurses involved were immediately in-serviced on monitoring antipsychotic side effects, including EPS. **Identification of other residents having the potential to be affected was accomplished by:** The facility has determined that any residents on psychotropic medications have the potential to be affected. **Actions taken/systems put into place to reduce the risk of future occurrences include:** The facility policy was updated (Attachment J) to include the AIMS assessment for all residents upon admission and quarterly thereafter. All licensed nursing staff were in-serviced on the monitoring for psychotropic side effects (Attachment K). **How the corrective action(s) will be monitored to ensure the practice will not recur:** The Director of Nursing, or designee, shall conduct audits to ensure that AIMS assessments are being completed according to	

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	During an interview, on 6/8/23 at 11:14 a.m., the MDS (Minimum Data Set) Coordinator indicated the side effect monitoring was on the MAR. If the MAR triggered any side effects, then an AIMS (Abnormal Involuntary Movement Scale) would be initiated. During an interview, on 6/8/23 at 11:37 a.m., LPN 5 indicated when monitoring for antipsychotic medication side effects they would look for behaviors, any changes in bowel habits, dryness of mouth or eyes, increased thirst, and mental changes. LPN 5 did not know what EPS was. When asked to look at the MAR for an explanation of EPS, LPN 5 indicated they still did not know what EPS was. During an interview, on 6/9/23 at 9:50 a.m., LPN 6 indicated for antipsychotic medications the side effects to monitor included dry mouth, increased confusion, restlessness, and to look for worsening behaviors. LPN 6 did not know what EPS was and stated they would have to figure it out. LPN 5 and LPN 6 had signed the MAR, for May 2023 and June 2023, to indicate they had monitored for EPS, and they did not know what EPS included. An In-Service attendance record dated 3/22/23 at 1:30 p.m., for antipsychotic medication conducted by the pharmacy did not include LPN 5 and LPN 6. The facility in-service handout for Monitoring for Adverse Effects of Antipsychotics, dated 2023, indicated to observe for EPS and consider the use of objective rating tools such as an AIMS assessment. Symptoms to monitor included, but were not limited to, tremors, muscle rigidity,		schedule on two random residents weekly for four (4) weeks, and monthly thereafter until no deficient practices have been observed over 90 days (Attachment L). These audits shall be reviewed by the Quality Assurance Committee to ensure compliance has been achieved as determined by the committee. All corrections for this tag will be completed by July 28, 2023.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155817	A. BUILDING 00 B. WING	06/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	shuffled gait, painful and acute muscle contracture commonly in the neck, eyes and trunk, restlessness, fidgeting, pacing, and rocking. The current Nursing Drug Handbook indicated quetiapine could cause EPS. Consider stopping the medication for signs or symptoms of tardive dyskinesia (a type of EPS with stiff jerky movements of the face and body which could not be controlled and could be permanent). Another extrapyramidal side effect was NMS (neuroleptic malignant syndrome which was a rare reaction to antipsychotic medications which causes a high fever, muscle stiffness, sweating, fast or abnormal heartbeat, quick breathing). NMS could cause kidney failure, heart and lung failure, lack of oxygen in the body, and infection in the lungs. 2. The record for Resident 4 was reviewed on 06/08/23 at 10:46 a.m. Diagnoses included, but were not limited to, morbid (severe) obesity due to excess calories, essential (primary) hypertension, weakness, dyspnea, depression, hypothyroidism, age-related physical debility, muscle weakness (generalized), and unsteadiness on feet. A physician's order, dated 03/09/2023, indicated quetiapine (an antipsychotic) 25 milligram tablet, take 1/2 tablet (12.5 milligrams) by mouth daily for a mood stabilizer. A care plan, dated 03/20/2023, indicated the resident received a psychotropic medication and was at a risk for adverse consequences. The interventions included, but were not limited to, administer medications as ordered and monitor for side effects and effectiveness. The MAR did not include if the resident had any of the side effects being monitored.			

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	During an interview, on 06/09/23 at 10:09 a.m., the Administrator indicated the facility did not complete routine AIMs testing, and they only did this if needed after monitoring for side effects. During an interview, on 06/09/23 at 11:06 a.m., LPN 6 indicated they monitored for adverse effects of antipsychotic/antidepressant medications such as dry mouth, constipation, and restless. When asked what EPS symptoms were, LPN 6 did not know what Extrapyramidal (EPS) was or what the side effects were. An AIMS assessment was not located in resident's medical record. A current policy, titled "Use of Psychotropic Medication," undated and received from the MDS Coordinator on 06/08/2023 at 11:56 a.m., indicated "...residents who receive a psychotropic medication will have Abnormal Involuntary Movement Scale (AIMS) test performed if triggered by anti-psychotic monitoring...." 3.1-48(a)(3)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included at Recertification and State Licensure. This visit included a Non-Certified Comprehesive Survey. Survey dates: June 7, 8 and 9, 2023 Facility number: 013212 Residential Census: 52	R 0000		

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	The Barrington of Carmel was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey. Quality review was completed on June 21, 2023.			