PRINTED: 09/02/2022 FORM APPROVED

CENTERS FOI	R MEDICARE & MEDIC	AID SERVICES				OM	B NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155181	A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/10/2022	
	PROVIDER OR SUPPLIER			118 ME	ADDRESS, CITY, STATE, ZIP COD EDICAL DR EL, IN 46032		
(X4) ID PREFIX TAG F 0000 Bldg. 00	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION Recertification and State This visit included the	F 00	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) The plan of correction is to se as Carmel Health & Living's		(X5) COMPLETION DATE
	Investigation of Co. IN00379969 and IN Complaint IN00379 Federal/State deficiallegations are cited allegations are cited complaint IN00379 deficiencies related Complaint IN00383 deficiencies related Survey dates: Augustic Facility number: 00 Provider number: 1 AIM number: 1002 Census Bed Type: SNF/NF: 115 SNF: 4 Total: 119 Census Payor Type Medicare: 12 Medicaid: 97 Other: 10 Total: 119	mplaints IN00379657, N00385351. 2657 - Substantiated. encies related to the lat F880. 2969 - Substantiated. No to the allegations are cited. 5351- Substantiated. No to the allegations are cited. ast 1, 2, 3, 4, 5, 8, 9 and 10, 2022 20095 55181 90490			credible allegation of compliar Submission of this plan of correction does not constitute admission by Carmel Health & livings or its management company that the allegations contained in the survey report true and accurate portrayal of provision of nursing care and services in this facility. Nor do this provision constitute an agreement or admission of the survey allegations. The facility respectfully requests desk review for the following citations	an A is a is a other other es	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Quality review was completed on August 15, 2022.

TITLE

(X6) DATE

Any defiency statement 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 disclodays 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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED 08/10/2022	
		155181	B. WING			
		.00101			30/10/2022	
NAME OF I	PROVIDER OR SUPPLIE	R	STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	NO VIDER OR SUFFLIE	IX.	118 ME	EDICAL DR		
CARMEL	HEALTH & LIVING	G COMMUNITY	CARMI	EL, IN 46032		
(X4) ID	CHMMADV	STATEMENT OF DEFICIENCIE	ID	1	(X5)	
				PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		
PREFIX	`	NCY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCE	DATE	
F 0558	483.10(e)(3)					
SS=D	Reasonable Acco					
Bldg. 00	Needs/Preference	es				
	§483.10(e)(3) The	e right to reside and receive				
	services in the fac	cility with reasonable				
	accommodation of	of resident needs and				
	preferences exce	pt when to do so would				
	endanger the health or safety of the resident					
	or other residents	•				
		on, interview and record	F 0558	F558: The facility failed to ke	eep 08/26/2022	
			1 0336	the call light within the	08/20/2022	
	review, the facility failed to keep the call light within the resident's reach for 2 of 2 residents randomly observed for accommodation of needs.			resident's reach for 2 of 2		
				residents randomly observe		
	(Resident 69 and 4)	9)		for accommodation of needs	• •	
				1. What Corrective Action	· ·	
	Findings include:			will be accomplished for tho		
				residents found to have bee	n	
	-	vation, on 08/01/22 at 12:00		affected by the deficient		
	-	was not within reach of the		practice.		
	resident. The call li	ight was hanging on the wall.				
				i. Resident #69 & #	#49	
	During an observat	tion, on 08/02/22 at 10:09 a.m.,		without ill effects and call light	s	
	the call light was n	ot within reach of the resident.		were placed within resident re	each	
	The call light was l	hanging on the wall as		during survey.		
	previously observe			2. how other residents		
	<u> </u>			having the potential to be		
	During an observat	tion on 08/02/22 at 10:20 a.m.,		affected by the same deficie	nt	
	_	for the 400/500 unit gave the		practice will be identified an	I	
	_	ident to see if she was able to		what corrective action(s) wil		
		ne resident was able to push the		be taken;	'	
	call light button.	te resident was dore to push the		De lakeli,		
	can nghi button.			i. All residents hav		
	The man and four D	idant 60 vyga maria 1			-	
		ident 69 was reviewed on		the potential to be affected. For		
		n.m. Diagnoses included, but		house audit conducted on 8/1	1/22	
		, malignant neoplasm of cervix,		without further concerns.		
		e pulmonary disease, anxiety		3. what measures will be p		
	disorder and diarrh	ea.		into place and what systemic	C	
				changes will be made to		
	During an interview	w, on 08/01/22 at 12:00 p.m., the		ensure that the deficient		

resident stated she had been trying to get some

practice does not recur;

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 08/10/2022 155181 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 118 MEDICAL DR CARMEL HEALTH & LIVING COMMUNITY CARMEL. IN 46032 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE help, and since she could not reach the call light button, she started yelling for help. The resident All staff educated indicated she was able to use the call light system on the accommodation of needs to if desired. include call lights within reach. During an interview, on 08/01/22 at 12:30 p.m., Environmental LPN 1 indicated the call light button should have rounds to ensure call light been within reach of the resident and not on the placement per audit schedule. wall. how the corrective action(s) will be monitored to During an interview, on 08/02/22 at 10:20 a.m., the ensure the deficient practice Unit Manager for the 400/500 unit indicated the will not recur, i.e., what quality call light was supposed to be within reach of the assurance program will be put resident and it should not be hanging on the wall. into place; 2. During an observation, on 08/02/2022 at 10:21 The DON/designee a.m., Resident 49 who was alert and oriented was will be responsible for conducting sitting in a wheelchair next to the bed with the audits daily 5 days a week for 4 over-the-bed table in front of her. The resident's weeks, weekly for 4 weeks, hair was wet, and she indicated she had just had biweekly for 8 weeks, and monthly her hair washed. During the interview, the for 9 months. The results of the resident's call light was observed to be clipped to audit will be reviewed at the the bed sheets behind the resident's wheelchair. monthly quality assurance The resident indicated she did not want to stay up meeting until substantial too long and would ask staff to assist her when compliance is achieved and she was ready to go back to bed. When maintained. Changes may be questioned about her call light, the resident established to the auditing indicated she did not know where her call light process, based upon the results of was. The resident was informed the call light was the audits. clipped to the sheet on the bed behind her. The by what date the systemic resident indicated she could not reach the call changes for each deficiency will be completed. light. A facility policy, titled "Resident Rights," dated Completed by 06/06/2019 and provided by the Corporate 8/26/22 Support Nurse on 08/04/22 at 3:13 p.m., indicated "...Equal access to quality care, regardless of source payment, receive care in a manner and in an environment that promotes maintenance or

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enhancement of his or her quality of life...."

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155181		ľ ′	(X2) MULTIPLE CONSTRUCTION (X3) DATE SU A. BUILDING 00 COMPLET B. WING 08/10/20		
	PROVIDER OR SUPPLIER - HEALTH & LIVING		118	ET ADDRESS, CITY, STATE, ZIP COD MEDICAL DR MEL, IN 46032	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPF DEFICIENCY)	LD BE COMPLETION
F 0686 SS=D Bldg. 00	Ulcer §483.25(b) Skin Ir §483.25(b)(1) Pre Based on the coma resident, the fact (i) A resident receprofessional stand pressure ulcers are pressure ulcers ure condition demonstrated unavoidable; and (ii) A resident with necessary treatment with professional spromote healing, promote healing, pro	ssure ulcers. prehensive assessment of ility must ensure thatives care, consistent with lards of practice, to prevent and does not develop aless the individual's clinical trates that they were pressure ulcers receives ent and services, consistent standards of practice, to prevent infection and prevent	F 0686	F686: The Facility failed identity and provide need care in a timely manner 2 for a resident reviewed pressure ulcers. 1. What Corrective Act will be accomplished for residents found to have affected by the deficient practice. i. Resident #1 without ill effects. Compressioned assessment compressioned protocols followed. 2. how other residents having the potential to be affected by the same despractice will be identified.	eded for 1 of d etion(s) r those been t 6 ehensive eleted s pe

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	a. building <u>00</u>		00	COMPLETED	
		155181	B. W	ING _		08/10/	2022
		1		STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	₹			EDICAL DR		
CARME	. HEALTH & LIVING	S COMMUNITY			EL, IN 46032		
OAINWEL	TILALIII & LIVING		_	OMININE	, IN 70002		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	areas appeared clean and without drainage or				what corrective action(s) wil	I	
	odor. The wound beds appeared to be red in color				be taken;		
	and both areas appeared to have pink granulation tissue. During an interview, with the UM at this				i.		
					All residents have the potentia		
	· ·	she was unaware the resident			be affected. Full house skin a		
	had open areas and indicated she thought the				will be completed on all reside		
	resident had redness in the gluteal area. The UM				Pending assessment, will hav		
	applied DermaPhor ointment to the areas, which had been ordered by the physician on 06/28/2022 to apply to the resident's coccyx and gluteal area 3 times a day. She indicated she would notify the				wound documentation comple		
					and supported documentation		
					provided.		
					3. what measures will be p		
		for further orders and			into place and what systemic	C	
	treatment.				changes will be made to		
	TI 1C D	1 . 16			ensure that the deficient		
		dent 16 was reviewed on			practice does not recur;		
		p.m. Diagnosis included, but					
		anxiety disorder, Alzheimer's			i. All licensed nursi	·	
		on, diabetes mellitus,			staff will be educated on skin	care	
	fibrillation.	reflux disease and atrial			policy, to include timely		
	Hormation.				identification and treatment		
	The resident was de	ocumented to be incontinent of			intervention of skin issues/concerns.		
	bowel.	ocumented to be incontinent of			·		
	bowei.				4. how the corrective		
	A physician's order	, dated 11/18/2021, indicated			action(s) will be monitored to ensure the deficient practice		
		e skin inspection to completed			will not recur, i.e., what quali		
	•	urse. If any new areas are			assurance program will be p	- 1	
	` ' *	lete the change of condition			into place;	ut	
		on Thu (Thursday) 03:00 PM -			into piace,		
	11:00 PM".	en 111 0 (11 0 1000) 00100 1111			i. The DON/design	nee	
					will be responsible for conduc		
	An "Administration	History," received from the			audits daily 5 days a week for	-	
		urse (CSN) on 08/10/2022 at 4:37			weeks, weekly for 4 weeks,	-	
		resident had been documented			biweekly for 8 weeks, and mo	nthly	
	-	4/2022, 07/21/2022, 07/28/2022			for 9 months. The results of th	· ·	
		e CSN indicated the facility			audit will be reviewed at the		
		"by exception" indicating if			monthly quality assurance		
		ted to have concerns at the			meeting until substantial		
	time of the assessm	ent, the nurse would initiate a			compliance is achieved and		
	change of condition	n. Documentation was lacking			maintained. Changes may be		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155181		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 08/10/2022		
	PROVIDER OR SUPPLIER		118 ME	ADDRESS, CITY, STATE, ZIP CO EDICAL DR EL, IN 46032	D	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL . LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	the skin inspections The resident's most List Report," with a 08/02/2022 was reco Nurse on 08/10/202 Assessment" portion resident required ass in a way which coul refused care, the rese exposed to moisture history of pressure u conditions. A facility policy, tit dated 02/01/2019 ar 12:14 p.m. from the to providing quality includes ensuring th skin assessments on the residents' stayl completed by a licer and weekly thereaft	led "Skin Assessment Policy," and received on 08/09/2022 at CSN, indicated "is committed care to our residents which the completions of thorough and admission and throughout thead-to-toe skin assessment the completions of thorough the admission and throughout thead-to-toe skin assessment the nurse upon admission the completions of the throughout the doing the throughout through the throughout througho		established to the auditing process, based upon the the audits. 5. by what date the sign changes for each deficition will be completed i. Completed 8/26/22	ystemic	
F 0689 SS=D Bldg. 00	remains as free of possible; and	ents.				

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CENTERS FOR MEDICARE & MEDICAID SERVICES				OMB NO. 0938-039		
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPLETED	
		155181	B. WING		08/10/2022	
		100101		-	00/10/2022	
NAME OF F	PROVIDER OR SUPPLIEF	3	STREET	ADDRESS, CITY, STATE, ZIP COD		
TO HAVE OF T	NO VIDER OR SELLE		118 ME	EDICAL DR		
CARMEL	. HEALTH & LIVING	G COMMUNITY	CARMI	EL, IN 46032		
(X4) ID	CHMMADV	STATEMENT OF DEFICIENCIE	ID		(V5)	
				PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APPROPRIA		
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
		sion and assistance devices				
	to prevent accider	nts.				
	Based on observation	on, interview and record	F 0689	F689: The facility failed to	08/26/2022	
	review, the facility	failed to ensure medications		ensure medications were no	t	
	were not left at the	bed side without an order to		left at the bed side without a	n	
	self-administer med	lications for 1 of 1 resident		order to self-administer		
		for accidents. (Resident 58)		medications for 1 of 1 reside	nt	
		(observed for accidents.		
	Finding includes:			1. What Corrective Action((e)	
	i manig meraucs.				=	
	During on absor	ion on 08/00/2022 at 11.22		will be accomplished for those		
	During an observation, on 08/09/2022 at 11:33 a.m., Resident 58 who was alert and oriented was observed sitting in a lounge chair in her room			residents found to have been	'	
				affected by the deficient		
	_	_		practice.		
	_	. Sitting on the resident's				
		plastic medicine cup		i. Resident #58		
		pills and capsules inside. The		without ill effects.		
		he medications contained in				
	the cup were her me	orning medications which had		ii. New order may ke	еер	
	been delivered by the	he nurse earlier in the day.		meds at bedside.		
	Resident 58 was un	able to remember exactly what		2. how other residents		
	time the medication	ns had been delivered, but		having the potential to be		
	indicated at the time	e of the administration, she		affected by the same deficien	nt	
	"didn't feel like taki	ing them" due to having an		practice will be identified and		
		added the nurse had left the		what corrective action(s) will		
	_	structed the resident to take		be taken;		
	them.			,		
				i. All residents have	e	
	The record for Resi	dent 58 was reviewed on		the potential to be affected. If		
		2 p.m. Diagnosis included, but		meds are observed at bedside	_	
		, chronic obstructive pulmonary		medication will be removed ar		
	·	kness, hyperkalemia (high				
				comprehensive assessment w	'III	
		esophageal reflux disease,		be conducted.	4	
		ajor depressive disorder,		3. what measures will be p		
		disease, hypothyroidism (low		into place and what systemic	;	
	thyroid) and diabete	es mellitus.		changes will be made to		
				ensure that the deficient		
		ent 58's most recent MDS		practice does not recur;		
	`	t) assessment, dated				
	06/14/2022, indicat	ed the resident had a BIMS		i. The DON/design	ee	

(Brief Interview for Mental Status) score of 15

will provide education to all nursing

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
		155181	B. WING		08/10/2022	
		133101	D. WING		00/10/2022	
			STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIEF	₹		EDICAL DR		
CARME	HEALTH & LIVING	G COMMUNITY		EL, IN 46032		
OAINVIEL	. III-ALIII & LIVIIN		CARIVIE	, 10002		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	COMPLETION	
TAG	`	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
		resident was alert and		staff on medication administra		
	oriented.	resident was afert and		to include assessments and	idori,	
	oriented.					
		1 1 1 1 1 1 0		orders for self-administration.		
		s lacking in the record of a		4. how the corrective		
	physician's order fo			action(s) will be monitored to		
		dications, other than the		ensure the deficient practice		
	inhalers used by the	e resident.		will not recur, i.e., what qual	ity	
				assurance program will be p	ut	
	Review of the phys	ician's orders indicated the		into place;		
	resident was ordere	ed to receive the following				
	medications at the morning medication pass: a. Calcium with Vitamin D 500 mg (milligrams) 1			i. The DON/design	ee	
				will be responsible for conduc		
				audits daily 5 days a week for	•	
		day: Upon rising 7:00 a.m		weeks, weekly for 4 weeks,	T	
	11:00 a.m., beginni				nthly	
	_	_		biweekly for 8 weeks, and mo	•	
	· ·	edication to treat major		for 9 months. The results of th	le	
	-	c) capsule 20 mg 3 (three)		audit will be reviewed at the		
		y; Upon rising 7:00 a.m 11:00		monthly quality assurance		
	a.m., beginning 12/			meeting until substantial		
	· ·	min with folic acid) 400 mcg		compliance is achieved and		
		a day: Upon rising 7:00 a.m		maintained. Changes may be		
	11:00 a.m., beginni			established to the auditing		
	d. Farxiga (a medic	ation to treat diabetes mellitus)		process, based upon the resu	lts of	
	10 mg 1 tablet once	e a day: Upon rising 7:00 a.m		the audits.		
	11:00 a.m., beginni	ng 12/29/2021.		5. by what date the system	nic	
	e. Folic Acid (for v	itamin deficiency) 800 mcg 1		changes for each deficiency		
		Jpon rising 7:00 a.m 11:00		will be completed.		
	a.m., beginning 02/					
		dication to treat diabetes		i. Completed by		
	,	1 tablet twice a day: Upon rising		8/26/22		
		m., and before bedtime 6:00 p.m.		0,20,22		
		_				
	- 10:00 p.m., begins	_				
		Vitamin D3) 5000 units/125 mcg				
		ising 7:00 a.m 11:00 a.m.,				
	beginning 06/17/20					
		nin with folic acid 400 mcg 1				
		7:00 a.m 11:00 a.m., beginning				
	06/10/2021.					

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During an interview, on 08/09/2022 at 12:12 p.m.,

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	NT OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155181	(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION 00	COM	TE SURVEY MPLETED 10/2022	
	PROVIDER OR SUPPLIEF L HEALTH & LIVING		STREET ADDRESS, CITY, STATE, ZIP COD 118 MEDICAL DR CARMEL, IN 46032				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ORRECTION SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
	Manager (UM), the policy of the facility resident's room una the resident had a p self-administer her resident had a physother medications. I medications found room to be, "calcium (milliequivalent); M Fluoxetine 20 mg (1)	inhaler, however denied the ician's order to self-administer The DON identified the unattended in Resident 58's m with vitamin D 500/5mcq Metformin 1000 mg; Tab 2 Vit; 3 tabs); Farxiga 10 mg; Vit B12 tin 40 mg; Vit D3 5000 iu/125 1800 mcg".					
	Administration: Ge undated and received indicated "The nu should always remarkant the medication regularly scheduled refused or spit out, designee is to initial resident's MAR (M. Record), or electror provided for that do explanatory note is reverse side of the refore (when necessal are not allowed to sunless specifically as	neral Policies & Procedures," ed on 08/10/2022 at 3:55 p.m., arse or approved designee in with the resident to observe is swallowedIf a dose of medication is withheld, the nurse or approved I and circle the initials in the edication Administration nically document, in the space osage administration. An then to be entered on the record in the space provided arry) documentationResidents elf-administer any medication authorized to do so by the am (IDT) and the attending					
	3.1-45(a)(2)						
F 0693 SS=D Bldg. 00	483.25(g)(4)(5) Tube Feeding Mg §483.25(g)(4)-(5)	mt/Restore Eating Skills Enteral Nutrition					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 08/10/2022 155181 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 118 MEDICAL DR CARMEL HEALTH & LIVING COMMUNITY CARMEL. IN 46032 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE (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)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. Based on observation, interview and record F 0693 08/26/2022 F693: The facility failed to label review, the facility failed to label the enteral the enteral feeding bag with feeding bag with the feeding type and amount for the feeding type and amount 1 of 1 resident reviewed for tube feeding. for 1 of 1 resident reviewed for (Resident 89) tube feeding. What Corrective Action(s) Finding includes: will be accomplished for those residents found to have been

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During an observation, on 08/02/22 at 10:09 a.m.,

indicating the feeding type or amount of feeding poured into the bag. The feeding was in a water

the resident's feeding bag did not have a label

bag instead of an enteral feeding bag. 800 mls

(milliliters) of feeding was in the water bag.

The record for Resident 89 was reviewed on

08/02/22 at 11:30 a.m. Diagnoses included, but

were not limited to, intracranial injury with loss of

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practice.

ill effect.

affected by the deficient

placed on the enteral feeding.

having the potential to be

how other residents

If continuation sheet

Resident 89 without

Proper Label was

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 08/10/2022 155181 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 118 MEDICAL DR CARMEL HEALTH & LIVING COMMUNITY CARMEL. IN 46032 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE consciousness of unspecified duration, sequela, affected by the same deficient gastrostomy status and abdominal distension practice will be identified and (gaseous). what corrective action(s) will be taken; A physician's order, dated 05/09/2022, indicated to iii. administer Kate Farms Peptide 1.5 through the All residents with enteral feeding feeding pump at a rate of 55 ml/hr (milliliters/hour), have the potential to be affected. flush with water at 45 ml/hr and run for 20 hours House wide audit was conducted (off from 1:00 p.m., to 5:00 p.m.) for all tube feeding containers, no other deficiencies were notified During an interview, on 08/02/22 at 10:11 a.m., the what measures will be MDS (Minimum Data Set) Coordinator and the put into place and what 400/500 Unit Manager were present and indicated systemic changes will be made the nurse was supposed to label the feeding bag to ensure that the deficient with the formula name, write the amount to be practice does not recur; administered, date and time the bag was hung because the feeding was not in the original All Licensed nursing staff will be container. The MDS Coordinator indicated the educated on medication resident took Kate Farms Peptide 1.5 cal/ml administration to include enteral (calories/milliliter) and there was 325 ml in a feedings and proper labeling. container. how the corrective action(s) will be monitored to An undated document, titled "Administering an ensure the deficient practice enteral feeding through a GT/OG/NG Tube Skills will not recur, i.e., what quality Validations," provided by the Director of Nursing assurance program will be (DON) on 08/10/2022 at 1:12 p.m., indicated put into place; and "...Label bag and/or tubing with the date, time, and initials...." The DON/designee will be responsible for conducting During an interview, on 08/10/2022 at 1:12 p.m., audits daily 5 days a week for 4 the DON indicated the document she provided weeks, weekly for 4 weeks, was the facility's G-Tube Policy which was given biweekly for 8 weeks, and monthly to her by the corporate office. There was no other for 9 months. The results of the documentation or policy provided at the time of audit will be reviewed at the exit. monthly quality assurance meeting until substantial 3.1-44(a)(2) compliance is achieved and

maintained. Changes may be established to the auditing

process, based upon the results of

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155181	(X2) MULTIPLI A. BUILDING B. WING	E CONSTRUCTION G 00	(X3) DATE SURVEY COMPLETED 08/10/2022		
	PROVIDER OR SUPPLIER L HEALTH & LIVING		STREET ADDRESS, CITY, STATE, ZIP COD 118 MEDICAL DR CARMEL, IN 46032				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA	(X5) COMPLETION DATE		
				the audits. 5. by what date the system changes for each deficiency will be completed.			
				i. Compliance Date 8/26/22	e:		
F 0761 SS=E Bldg. 00	Drugs and biologic must be labeled in accepted profession the appropriate accepted instructions, and the applicable. §483.45(h) Storage §483.45(h)(1) In a Federal laws, the and biologicals in under proper temps	s and Biologicals ng of Drugs and Biologicals cals used in the facility n accordance with currently conal principles, and include ccessory and cautionary the expiration date when ge of Drugs and Biologicals accordance with State and facility must store all drugs locked compartments perature controls, and rized personnel to have					
	separately locked, compartments for listed in Schedule Drug Abuse Preve 1976 and other drexcept when the fackage drug dist	e facility must provide , permanently affixed storage of controlled drugs Il of the Comprehensive ention and Control Act of rugs subject to abuse, facility uses single unit tribution systems in which d is minimal and a missing ily detected.					
	Based on observation review, the facility	on, interview and record failed to label medications with o ensure mediations were	F 0761	F761: The facility failed to la medications were stored in their original containers, fail			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>			ETED
		155181	B. WING 0				2022
				STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIER	8			EDICAL DR		
CARMEI	HEALTH & LIVING	COMMUNITY			EL, IN 46032		
	1				1		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION		_	TAG	DEFICIENCY)		DATE
	stored in their original containers, failed to ensure				to ensure an insulin pen had	а	
	an insulin pen had a legible label and failed to discard a discontinued medication for 4 of 4 medication carts and 2 of 3 medication storage refrigerators reviewed for medication storage. (700				legible label and failed to		
					discard a discontinued		
					medication for 4 of 4		
					medication carts and 2 of 3		
	unit, 500 unit, Memory Care unit and the 400 unit) Findings include: 1. During an observation, of the 700-unit front				medication storage		
					refrigerators reviewed for medication storage.		
					1. What Corrective Action(· · ·	
					will be accomplished for those	-	
side medication cart, on 08/03/22 at 2:20 p.m., with				residents found to have been			
	RN 6 the following	-			affected by the deficient	'	
Tax o ma tono ning note note.				practice.			
	a. One open 5 milliliter (ml) bottle of Tuberculin (a solution used for tuberculosis testing) was found				pruotioo.		
					i. All un-dated ,		
		The bottle was not observed to			discontinued, unlabeled		
	have an open date of				medications were removed fro	m l	
					the medication storage areas.		
	2. In the 700-unit m	nedication storage refrigerator			2. how other residents		
	the following were	noted:			having the potential to be		
					affected by the same deficien	nt	
	a. Two open 5 ml b	ottles of Tuberculin were found			practice will be identified and	t t	
	stored in the medica	ation refrigerator. The bottles			what corrective action(s) will		
	did not have open d	lates on the containers.			be taken;		
	-	f Ativan (an anti-anxiety			i. All residents have	Э	
		und in the medication storage			the potential to be affected		
	_	ident 63. The bottle did not					
	have an open date of	on the container.			ii. All medication car	ts	
					were observed, cleaned out		
	_	vation, of the 500-unit			appropriately and all medication		
		08/02/22 at 2:33 p.m., with RN 4			were reviewed to ensure prop		
	the following were	noted:			labeling/dating. Any deficienci	es	
					found with medications were		
		single dose packets of			properly disposed.		
	-	ligrams (mg) found in the			3. what measures will be p		
		wer. The medications did not			into place and what systemic	;	
		ne and were not stored in their			changes will be made to		
	original container/b	OX.			ensure that the deficient		
	ĺ				practice does not recur;	l	

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155181	CENTERS FOI	R MEDICARE & MEDIC				OMB NO. 0938-039
AAME OF PROVIDER OR SUPPLIER CARMEL HEALTH & LIVING COMMUNITY (X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION b. A Humalog insulin pen was found in the medication cart. The label of the insulin pen was not legible and did not contain an open date. c. A Humalog insulin pen for Resident 99 was found open without a date to indicate when the medication had been opened/started. d. A single dose packet of aspirin 81 mg was found in the drawer. The medication did not have a resident's name on it and was not stored in its original container/box. 118 MEDICAL DR CARMEL, IN 46032 ID PROVIDERS PLAN OF CORRECTION (AS) COMPLETION TAG II PREFIX II II PROVIDERS PLAN OF CORRECTION (EACH OCRRECTIVE ACTION SHOULD BE COMPLETION SHOULD BE COMPLETED SHOUL				A. BUILDING		COMPLETED
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION b. A Humalog insulin pen was found in the medication cart. The label of the insulin pen was not legible and did not contain an open date. c. A Humalog insulin pen for Resident 99 was found open without a date to indicate when the medication had been opened/started. d. A single dose packet of aspirin 81 mg was found in the drawer. The medication did not have a resident's name on it and was not stored in its original container/box. PREFIX TAG PREFIX TAG PREFIX TAG I. All licensed nursing staff was educated on medication administration to include medication storage, drug labeling and a clean med cart. Signage will be placed in medication storage areas on proper medication storage protocols. 4. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put				118 ME	EDICAL DR	
i. All licensed nursing staff was educated on medication administration to include c. A Humalog insulin pen for Resident 99 was found open without a date to indicate when the medication had been opened/started. d. A single dose packet of aspirin 81 mg was found in the drawer. The medication did not have a resident's name on it and was not stored in its original container/box. i. All licensed nursing staff was educated on medication administration to include medication storage, drug labeling and a clean med cart. Signage will be placed in medication storage areas on proper medication storage areas on proper medication storage protocols. 4. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put	PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	COMPLETION
medication) 3 mg was found in the drawer. The medication did not have a resident's name on it and was not stored in its original container/box. i. The DON/designee will be responsible for conducting audits daily 5 days a week for 4 weeks, weekly for 4 weeks, biweekly for 4 weeks, biweekly for 8 weeks, and monthly for 9 months. The results of the audit will be reviewed at the monthly quality assurance meeting until substantial component. g. A bottle of hydromorphone liquid (a narcotic pain reliever) 1 mg/ml, for Resident 43 was found open without a date to indicated when it had been opened. 4. In the 500-unit medication storage refrigerator the following were noted: a. One bottle of lansoprazole suspension (a medication used for gastric reflux) 3 mg/ml, with 6 ounces remaining, for Resident 89, was found without an open date. b. One bottle of Ativan for Resident 100 was found open without a date to indicated when it		b. A Humalog insu medication cart. The not legible and did c. A Humalog insu found open without medication had been declared as resident's name of original container/been declared container for medication of the declared form of the declare	lin pen was found in the me label of the insulin pen was not contain an open date. lin pen for Resident 99 was to a date to indicate when the en opened/started. cket of aspirin 81 mg was to an anti-clotting was found in the drawer. The have a resident's name on it in its original container/box. chine solution (a narcotic pain ent 53 was found with 18 of 30 to popen and without a date to bottle had been opened. comorphone liquid (a narcotic /ml, for Resident 43 was found et to indicated when it had been medication storage refrigerator noted: asoprazole suspension (a regastric reflux) 3 mg/ml, with 6 for Resident 89, was found te. ivan for Resident 100 was		staff was educated on medical administration to include medication storage, drug label and a clean med cart. Signage be placed in medication storage protocols. 4. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quates assurance program will be printo place; i. The DON/design will be responsible for conduct audits daily 5 days a week for weeks, weekly for 4 weeks, biweekly for 8 weeks, and more for 9 months. The results of the audit will be reviewed at the monthly quality assurance meeting until substantial compliance is achieved and maintained. Changes may be established to the auditing process, based upon the results of each deficiency will be completed.	sing ation eling ge will age to e lity put nee cting or 4 conthly he elity of mic

had been opened.

STATEMEN	ATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>		COMPLETED	
		155181	B. WI	NG		08/10/	2022
	ROVIDER OR SUPPLIER			118 ME	ADDRESS, CITY, STATE, ZIP COD DICAL DR EL, IN 46032		
,							
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	1	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
TAG		v, on 08/02/22 at 2:49 p.m., RN 4		TAG			DATE
	_	ons should have been dated					
	5 During an observ	vation of the Memory Care Unit					
	medication cart, on 08/03/22 at 4:33 p.m., with						
	QMA 7 the following were noted:						
	a. A box of glucose control solution, opened, was						
	found stored with the eye drops in the top drawer						
	of the medication ca	art.					
	b. A round pink pill, without packaging, was found in the bottom of the drawer.						
	found in the bottom	of the drawer.					
	c. A small white oval pill, without packaging, was found in the bottom of a drawer.						
	d. A single dose pag	ckage of clopidogrel 75 mg					
		awer. The medication did not					
	have a resident's na original container/b	me and was not stored in its pox.					
	e. A single dose nad	ckage of melatonin 3 mg was					
		The medication did not have					
	a resident's name ar	nd was not stored in its original					
	container/box.						
	_	v, on 08/03/22 at 10:38 a.m., the					
	_	g indicated the glucose control to been stored with the					
	glucometer, not the						
	gracometer, not the	сус шорь.					
	6. During an observ	vation of the 400-unit					
		08/03/22 at 4:33 p.m., with RN 8					
	the following were	noted:					
	a. A red capsule wa bottom of the draw	s found, unpackaged, in the					
	oottom of the drawt	C1.					

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		JILDING	00		COMPLETED 08/10/2022	
		155181	B. W	ING		08/10/	/2022	
NAME OF F	PROVIDER OR SUPPLIEF	\			ADDRESS, CITY, STATE, ZIP COD			
CARMEL	. HEALTH & LIVING	COMMUNITY			DICAL DR EL, IN 46032			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	·		(X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	ATE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	DATE	
	_	packages of Divalproex						
	-	50 mg were found in the drawer.						
		not have a resident's name in its original container/box.						
	and were not stored	in its original container/box.						
	c. Two single dose	package of amitriptyline						
		g were found in the drawer.						
		not have a resident's name						
	and was not stored	in its original container/box.						
	d. A single dose pag	ckage of acetaminophen 325						
		e drawer. The medication did						
	_	s name and was not stored in						
	its original containe	er/box.						
	e. Two single dose packages of Meloxicam 15 mg were found in the drawer. The medication did not have a resident's name and was not stored in its original container/box.							
	f. A 5 ml bottle of prednisolone eye drops for Resident 48 was found open. It did not have a date to indicated when the medication had been opened.							
	g. An open bottle o	f morphine solution 100 mg/5						
		l, for Resident 14 was found						
	open in the narcotic	drawer. The bottle did not						
	have a date to indic	ated when it had been opened.						
	During an interview	v, on 08/05/22 at 10:40 a.m., the						
	_	; indicated when liquid						
	medications were o	pened, they were to be labeled						
	-	nd discontinued medications						
	were to be discarde	d.						
	were to be discarded. An undated facility policy, titled "Drug Storage," provided by the Director of Nursing on 08/05/22 at 11:05 a.m., indicated "Medications are to remain in the container in which they are							

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155181		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	COM	TE SURVEY IPLETED 10/2022	
	PROVIDER OR SUPPLIER		118 ME	ADDRESS, CITY, STATE, ZIP CO EDICAL DR EL, IN 46032	OD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AL DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 0812 SS=E Bldg. 00	storedseparately fi medicationsDisco medications should carts and refrigerate destroyInsulin and vials or pens must be daysDrugs shall be in cabinets, drawers (TB) vaccineneed vials should be discopen date" An undated facility Labeling," provided 08/05/22 at 11:05 accontainers having so illegible or confusind dispensing pharmace destroyed" 3.1-25(j) 3.1-25(o) 483.60(i)(1)(2) Food Procurement, Store §483.60(i) Food so The facility must - §483.60(i)(1) - Proapproved or consifederal, state or lo (i) This may included in the provision of the provisions. (ii) This provision of the provisi	be removed from medication be removed from medication be removed from medication be removed from medication be supposed of the multi-dose injectable be discarded after 28 be stored in an orderly manner or cartsInsulin and PPD to be dated when openedAll be arded within 28 days of the policy, titled "Medication by the Director of Nursing on m., indicated "Medication biled, damaged, incomplete, be labels are returned to the by for re-labeling or are pe/Prepare/Serve-Sanitary be after requirements. be cure food from sources dered satisfactory by cal authorities. be food items obtained by producers, subject to and local laws or does not prohibit or prevent by produce grown in facility				

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OF CORRECTION	IDENTIFICATION NUMBER	(X2) MULTIPLE CONS A. BUILDING		00	(X3) DATE SURVEY COMPLETED	
	155181	A. BU B. WI		00	08/10/2	
	100101	<i>D.</i> W1			00/10/	
PROVIDER OR SUPPLIEI	R					
L HEALTH & LIVING	G COMMUNITY					
SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
` `				CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
1			TAG	DEFICIENCE)		DATE
practices. (iii) This provision from consuming for facility. §483.60(i)(2) - Store serve food in accordance standards for food	does not preclude residents oods not procured by the ore, prepare, distribute and ordance with professional diservice safety.					
review, the facility thoroughly dried be unit, failed to ensur labeled/dated with identify what was i kitchens and 3 of 4 800 unit and 400 un	failed to ensure pans were efore being stored on a shelf re food items were open dates and failed to n the containers for 1 of 2 units. (main kitchen, 700 unit,	F 08	312	dried before being stored or shelf unit, failed to ensure for items were labeled/dated with open dates and failed to identify what was in the containers for 1 of 2 kitchen and 3 of 4 units.	n a cood th	08/26/2022
During an observat pantries and the Wo beginning at 9:07 a in attendance four i found to have clear outside. The pans v	oodland Kitchen, on 08/02/22 .m., with the Dietary Manager rectangular metal pans were fluid inside and on the vere stacked on a shelf for			will be accomplished for the residents found to have bee affected by the deficient practice. i. Pans with remin	ose n	
container of jalaper open, half full with container and a clea milliliters of red flu date on the container. In the 800-unit refr of whole milk, 34 fu open date. There we storage bag contains	no cheddar dip was found out a name or date on the ar 32 ounce container with 275 nid was found without a name or er. igerator, a one-gallon container ull, was found open without an as also a salad with a zip type ning a substance on top of the			food items were immediately discarded. 2. how other residents having the potential to be affected by the same deficie practice will be identified an what corrective action(s) will be taken; i. All residents have	ent Id II	
	SUMMARY (EACH DEFICIENT REGULATORY OF APPLICATION O	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview and record review, the facility failed to ensure pans were thoroughly dried before being stored on a shelf unit, failed to ensure food items were labeled/dated with open dates and failed to identify what was in the containers for 1 of 2 kitchens and 3 of 4 units. (main kitchen, 700 unit, 800 unit and 400 unit)	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview and record review, the facility failed to ensure pans were thoroughly dried before being stored on a shelf unit, failed to ensure food items were labeled/dated with open dates and failed to identify what was in the containers for 1 of 2 kitchens and 3 of 4 units. (main kitchen, 700 unit, 800 unit and 400 unit) Findings include: During an observation of the main kitchen, unit pantries and the Woodland Kitchen, on 08/02/22 beginning at 9:07 a.m., with the Dietary Manager in attendance four rectangular metal pans were found to have clear fluid inside and on the outside. The pans were stacked on a shelf for storage in the main kitchen. In the 700 Unit pantry refrigerator, a nine-ounce container of jalapeno cheddar dip was found open, half full without a name or date on the container and a clear 32 ounce container with 275 milliliters of red fluid was found without a name or date on the container. In the 800-unit refrigerator, a one-gallon container of whole milk, ¾ full, was found open without an open date. There was also a salad with a zip type storage bag containing a substance on top of the	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview and record review, the facility failed to ensure pans were thoroughly dried before being stored on a shelf unit, failed to ensure food items were labeled/dated with open dates and failed to identify what was in the containers for 1 of 2 kitchens and 3 of 4 units. (main kitchen, 700 unit, 800 unit and 400 unit) Findings include: During an observation of the main kitchen, unit pantries and the Woodland Kitchen, on 08/02/22 beginning at 9:07 a.m., with the Dictary Manager in attendance four rectangular metal pans were found to have clear fluid inside and on the outside. The pans were stacked on a shelf for storage in the main kitchen. In the 700 Unit pantry refrigerator, a nine-ounce container of jalapeno cheddar dip was found open, half full without a name or date on the container and a clear 32 ounce container with 275 milliliters of red fluid was found without a name or date on the container and a clear 32 ounce container with 275 milliliters of red fluid was found without a name or date on the container. In the 800-unit refrigerator, a one-gallon container of whole milk, ¾ full, was found open without an open date. There was also a salad with a zip type storage bag containing a substance on top of the	LHEALTH & LIVING COMMUNITY SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION applicable safe growing and food-handling practices. 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In the 700 Unit pantry refrigerator, a nine-ounce container and a clear 32 ounce container with 275 milliliters of red fluid was found without a name or date on the container. In the 800-unit refrigerator, a one-gallon container of whole milk, ½ full, was found open without an open date. There was also a salad with a zip type storage bog containing a substance on top of the	HEALTH & LIVING COMMUNITY SUMMARY STATEMENT OF DEFICIENCE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. 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For elluid was found without a name or date on the container of preceding the properties of the practice will be identified and what corrective action(s) will be taken; In the 800-unit refrigerator, a one-gallon container of whole milk, ¼ full, was found open without an open date. There was also a salad with a zip type storage bag containing a substance on top of the

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 08/10/2022 155181 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 118 MEDICAL DR CARMEL HEALTH & LIVING COMMUNITY CARMEL. IN 46032 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE or date and the zip storage bag did not contain a of food storage areas/dishware name of the substance it contained, a date or a storage areas completed to name. ensure there are no outdated or unlabeled food items. In the 400-unit refrigerator, a 16-ounce bottle of Italian dressing was found open without a date or Audit of all dishware name and one 340 milliliter bottle of a protein completed to ensure there are no shake was also found without an open date. pots or pans that were not completely dry prior to being At the end of the observations of the kitchens placed on the storage shelf. and unit food storage areas, the Dietary Manager 3. what measures will be put indicated there should have been names and open into place and what systemic dates on the items in the refrigerators and staff changes will be made to was not to store their items in those refrigerators. ensure that the deficient practice does not recur; An undated facility policy, titled "Food and Non-Food Storage," provided by the **Dietary Supervisor** Administrator on 08/05/22 at 4:46 p.m., indicated or designee will educate dining "...Foods that have been removed from their services staff on the Guidelines for original containers are clearly marked with Food Storage, Food Safety and contents, date that package was opened...." Handling to include drying of dishware and storage of dishware A facility policy, titled "Food and Non-Food and storage of food for Storage," dated 2012 and provided by the consumption. Administrator on 08/05/22 at 4:46 p.m., indicated how the corrective "...Subject: Storage of Unused Equipment and action(s) will be monitored to ensure the deficient practice Dishware...Dishware and utensils are thoroughly air dried prior to storage...." will not recur, i.e., what quality assurance program will be put 3.1-21(i)(3)into place; i. The DON/designee will be responsible for conducting audits daily 5 days a week for 4 weeks, weekly for 4 weeks, biweekly for 8 weeks, and monthly for 9 months. The results of the audit will be reviewed at the monthly quality assurance

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meeting until substantial

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CENTERS FO	OM	B NO. 0938-039				
		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155181	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/10/2022	
	PROVIDER OR SUPPLIER		118 ME	ADDRESS, CITY, STATE, ZIP COD EDICAL DR EL, IN 46032		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
				compliance is achieved and maintained. Changes may be established to the auditing process, based upon the resulthe audits. 5. by what date the system changes for each deficiency will be completed.		
F 0880 SS=D Bldg. 00	infection preventice designed to provide comfortable environthe development a communicable dissection of the development and communicable dissection of the development and comparts. The facility must be prevention and compart include, at a elements: §483.80(a)(1) A solid identifying, reporting the controlling infection diseases for all revisitors, and other services under a conducted according to provide the factorial diseases of	con & Control Control establish and maintain an on and control program de a safe, sanitary and comment and to help prevent and transmission of seases and infections. con prevention and control establish an infection entrol program (IPCP) that minimum, the following ystem for preventing, ng, investigating, and ons and communicable esidents, staff, volunteers, individuals providing contractual arrangement		i. Completed 8/26/	22	

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§483.80(a)(2) Written standards, policies, and procedures for the program, which must

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X1) PROVIDER/SUPPLIER/SU			JILDING	nstruction <u>00</u>	(X3) DATE COMPL 08/10/	ETED	
	NAME OF PROVIDER OR SUPPLIER CARMEL HEALTH & LIVING COMMUNITY			118 MEI	DDRESS, CITY, STATE, ZIP COD DICAL DR L, IN 46032		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	3 NATE	(X5) COMPLETION DATE
	identify possible of infections before to persons in the fact (ii) When and to we communicable distormed be reported; (iii) Standard and precautions to be of infections; (iv) When and how for a resident; incleased (A) The type and of depending upon the organism involved (B) A requirement the least restrictive under the circums (v) The circumstant must prohibit emploommunicable distormed beginner from direct their food, if direct disease; and (vi) The hand hygical followed by staff in contact. §483.80(a)(4) A strincidents identified and the corrective facility.	rveillance designed to communicable diseases or hey can spread to other illity; whom possible incidents of lease or infections should transmission-based followed to prevent spread visolation should be used uding but not limited to: duration of the isolation, he infectious agent or l, and that the isolation should be expossible for the resident trances. Incest under which the facility loyees with a lease or infected skin to contact will transmit the ene procedures to be exposed in direct resident wystem for recording diffunctions taken by the sease of the facility's IPCP actions taken by the sease of the spread					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 08/10/2022 155181 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 118 MEDICAL DR CARMEL HEALTH & LIVING COMMUNITY CARMEL. IN 46032 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, interview and record F 0880 F880: The facility failed to 08/26/2022 review, the facility failed to develop and develop and implement written implement written policies and procedures for policies and procedures for infection control, to contain the spread of infection control, to contain the infections and the Covid-19 virus, when the spread of infections and the facility failed to ensure staff used the appropriate Covid-19 virus, when the Personal Protective Equipment (PPE) while in an facility failed to ensure staff isolation room for 2 of 2 random observations. used the appropriate PPE (Resident 172 and 69) while in an isolation room for 2 of 2 random observations. Findings include: What Corrective Action(s) will be accomplished for those 1. During a random observation, on 08/02/22 at residents found to have been 8:20 a.m., LPN 1 was observed in an isolation room affected by the deficient administering medications to Resident 172, practice. wearing a surgical mask only. The room had an isolation bag, stocked, hanging on the door and Resident #172. #69 signs posted on the door indicating PPE to be without ill effect. Both residents used when entering the room. were on precautionary isolation per CDC guidance. Upon her exit from the room, LPN 1 indicated she 2. how other residents had asked which residents were in isolation that having the potential to be morning, she did not work on this unit and she affected by the same deficient was not paying attention. practice will be identified and what corrective action(s) will The record for Resident 172 was reviewed on be taken; 08/02/22 at 11:21 a.m. Diagnoses included, but were not limited to, weakness, unsteadiness on All residents have feet and type 2 diabetes. the potential to be affected. Full house audit was conducted, to A physician's order, dated 07/28/22, indicated include proper signage, orders, "...Droplet/contact isolation...." care plans. The ED/DON, Campus Infection Preventionist (IP), and A facility sign posted on Resident 172's door consultant Infection Preventionists indicated "...STOP...CONTACT PRECAUTIONS to complete a root cause analysis EVERYONE MUST...Put on gloves before room (RCA). Along with RCA, the same entry...Put on gown before room entry...." team will review the Long-Term

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
155181		B. WING 08/10/2022					
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	NAME OF PROVIDER OR SUPPLIER				EDICAL DR		
CARMEL	. HEALTH & LIVING	COMMUNITY			EL, IN 46032		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID		(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG	ì ·	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
					Care Facility Self-Assessment	t for	
	A facility sign posts	ed on Resident 172's door			determination of accuracy with	n	
	indicated "STOP.	DROPLET PRECAUTIONS			adjustments made as needed		
	EVERYONE MUS	TMake sure their eyesare			Additional education to be		
	fully covered before	e room entry" 2. The record			scheduled based on review of	the	
	for Resident 69 was	reviewed on 08/03/22 at 11:50			RCA and Facility		
	a.m. Diagnoses incl	uded, but were not limited to,			Self-Assessment.		
	_	of the cervix, chronic			3. what measures will be p	out	
		ary disease, anxiety disorder			into place and what systemic		
	and diarrhea.				changes will be made to		
					ensure that the deficient		
	A physician's order	, dated 08/04/2022, indicated			practice does not recur;		
	contact isolation. A	ll meals, activities, therapy and					
	services must be pro	ovided in room with isolation			i. All Licensed nurs	sing	
	precautions followe	d.			staff to be educated on infection	on	
					control practices to include:		
	A physician's order	, dated 08/05/2022, indicated to			isolation rooms and appropria	te	
	obtain stat lab for C	-Diff (Clostridium Difficile) and			PPE requirements. Nursing		
	a Urinalysis (UA).				leadership to conduct observa	ations	
					on isolation room.		
	A progress note ind	icated the resident was					
	positive for C-Diff.				ii. Reviewed and or		
					updated infection control		
	_	on, on 08/05/22 at 3:37 p.m.,			practices.		
		n at the door indicating the			4. how the corrective		
		tact isolation. The instruction			action(s) will be monitored to	0	
	_	n before room entry, discard			ensure the deficient practice		
	gown before room	exit"			will not recur, i.e., what quali	ity	
					assurance program will be p	ut	
	~	on, on 08/05/22 at 3:37 p.m.,			into place;		
	CNA 9 was at the resident's bedside providing peri-care.						
					i. The DON/design		
		r a protective gown and her			will be responsible for conduct	_	
	surgical mask was b	below her nose.			audits daily 5 days a week for	4	
		00/07/00			weeks, weekly for 4 weeks,		
		7, on 08/05/22 at 3:40 p.m.,			biweekly for 8 weeks, and mo	-	
		e did not realize the resident			for 9 months. The results of th	ie	
		ation precaution until she			audit will be reviewed at the		
		he should have went back			monthly quality assurance		
	outside and put on a	n protective gown when she			meeting until substantial		

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPI	LETED
		155181	B. W	NG		08/10	/2022
				CTDEET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF	NAME OF PROVIDER OR SUPPLIER				EDICAL DR		
CARME	CARMEL HEALTH & LIVING COMMUNITY				EL, IN 46032		
CAINILL	O THINE THE ACTION OF COMMONT			CAINIL			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	found out the resid	lent needed peri-care.			compliance is achieved and		
					maintained. Changes may be		
		w, on 08/05/22 at 4:00 p.m., the			established to the auditing		
		r (ED) indicated the only time			process, based upon the resu	lts of	
		to go into the resident's room			the audits.		
		f they were in isolation and an			5. by what date the systen		
		arise. The ED indicated the			changes for each deficiency		
		d to go back outside to put a			will be completed.		
	-	n when she realized the resident					
	needed peri-care.				i. Completed 8/26/	22	
	D	00/00/22 / 11 00 /1					
	_	w, on 08/08/22 at 11:00 a.m., the					
		g (DON) indicated the resident					
	1	C-Diff, had started treatments					
		e to be on contact isolation					
	precautions.						
	A facility policy t	itled "CarDon PPE COVID-19					
		Guide (ORG)," updated on					
		ided by the Director of Nursing					
	on 08/02/22 at 11:						
		Admission/Known Exposure					
		ingDoor Signage: PPE					
		Contact Precautions Droplet					
		w IsolationWear standard					
		Wear Gown, Goggle/Face Shield,					
		ks will be utilized in Yellow and					
		hield or Goggles must be worn					
		onnel (HCP) who provide					
		re within 6 feet of the resident					
	whenCaring for	a Resident in a yellow zone that					
	is a new admission	or re-admission"					
	A facility policy, t	itled "Cardon Infection Control					
		d as effective 10/2014 and					
	provided by the D	ON on 08/10/2022 at 1:12 p.m.,					
	indicated "A gov	vn and gloves must be worn at					
		ding to the resident in contact					
	isolation if any con	ntact is going to made with the					
1	resident or the env						

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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AND PLAN	IT OF DEFICIENCIES OF CORRECTION PROVIDER OR SUPPLIER HEALTH & LIVING		ILDING NG STREET A 118 ME	ADDRESS, CITY, STATE, ZIP COD DICAL DR EL, IN 46032	(X3) DATE COMPL 08/10	LETED
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APPROPRIAT		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
	3 1 3	led "Clostridium Difficile				
		ated as effective 6/6/2019 and				
		N on 08/10/2022 at 1:12 p.m.,				
		ust be used when handling				
	in the resident's roo	ff or any environmental object				
	in the resident's roo	m				
	This Federal tag rela	ates to Complaint IN00379657.				
	3.1-18 (b)					

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