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	07/31/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00178546. This visit included the investigation of Complaint IN00178092 Complaint IN00178546 Substantiated. Federal/State findings cited at F157 and F315. Survey dates: July 29, 30 & 31, 2015 Facility Number: 013212 Provider Number: 155817 Aim Number: NA Census Bed Type: SNF: 35 Other: 67 Total: 102 Census Payor Type: Medicare: 11 Other: 24 Total: 35 Sample: 3 These deficiencies reflect state findings cited in accordance with 410 IAC	F 0000	Please accept this 2567 Plan of Correction as a Provider's Letter of Credible Allegation. This provider respectfully requests consideration for paper compliance in lieu of a revisit survey. The creation and submission of this plan of correction does not constitute an admission of any conclusion set forth in the statement of deficiencies of any violations of regulations. This Plan of Correction is offered as our allegation of compliance.	

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

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	07/31/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	16.2-3.1.			
F 0157 SS=D Bldg. 00	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or			

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	07/31/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	interested family member. Based on observation, record review and interview the nursing staff failed to ensure the concerns of an interested family member were addressed by the Medical Director when there was lack of response by the Nurse Practitioner to the concerns the family member related to the nursing staff on multiple occasions for 1 of 3 resident's reviewed with an indwelling catheter in a sample of 3. (Resident "B"). Findings include: The record for Resident "B" was reviewed on 07-29-15 at 2:00 p.m. Diagnosis included, but were not limited to, history of a fractured hip, urinary retention, constipation, sleep apnea, a personal history of falls, hypertension and anemia. These diagnoses remained current at the time of the record review. The record indicated the resident was admitted to the facility with an indwelling Foley catheter. A review of the Resident's current plan of care indicated, the resident "has an Indwelling/Intermittent/Suprapubic catheter use with potential for infection." Interventions to this plan of care	F 0157	**F157 Notify ofchanges (injury/decline/room, etc)—The Community will inform the resident;consult with the resident's physician; and if known, notify the resident'slegal representative or an interested family member when there is an accidentinvolving the resident which results in injury and has the potential forrequiring physician intervention; a significant change in the resident'sphysical, mental, or psychosocial status; a need to alter treatmentsignificantly; or a decision to transfer or discharge the resident from thefacility. The Community respectfullydisputes the allegation that the fail was not notified.** **What correctiveaction (s) will be accomplished for those residents found to have been affectedby the deficient practice:** ·Resident B's family was and will be notified ofany changes. Resident B's family andphysician were notified of change of condition on 7-21-2015 when symptomssuspicious of urinary tract infection were identified. **How otherresidents having the potential to be affected by the same deficient practicewill be identified and what corrective action(s) will be taken:** ·All residents with indwelling	08/28/2015

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	07/31/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	included, "Maintain closed drainage system, secure catheter to leg to avoid tension on urinary meatus, change catheter and/or drainage bag(s) per facility protocol or as ordered by PCP [Primary Care Physician] to assure patency, monitor for signs of UTI [urinary tract infection] such as change in color or consistency, a foul odor, or blood in urine, suprapubic, flank or abdominal pain, fever, assess for adequate output, color and odor of urine." During an interview on 07-31-15 at 9:00 a.m., Resident "B" was observed seated in his wheelchair and he indicated a nursing staff member told him it was time to eat. The resident further indicated he told her the bag (in reference to the catheter drainage bag), was full and that she told him it would be all right. The resident then indicated the nursing staff member pushed him to the dining room anyway. The resident indicated he was aware the bag was full and that it "felt heavy" and thought it was "sliding down his leg." The resident further indicated he was afraid the bag was going to break open while he was in the dining room so he transported himself back to his room room "because I had to use the toilet. The bag was all the way down and this [pointing to the catheter] was out. I pushed the button for help. I couldn't do		catheters have thepotential to be affected by the alleged deficient practice. A comprehensive review of all residents withindwelling catheter's will be completed to identify any resident with catheterrelated complications whose physician and/or resident's legal representativehad not been notified. No residents wereidentified as exhibiting symptoms of urinary tract infections. **What measures willbe put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** ·Nurses will be re-educated on notification of physicianfor signs and symptoms of indwelling catheter urinary tract infection by Director of Nursing Services or her designee. ·Licensed nurses will be re-educated on theprocedure to follow when resident's exhibit signs of a urinary tractabnormality, by the Director of Nursing Services or her designee. ·The Director of Nursing Services or her designeewill monitor the acute change status daily (M-F excluding holidays) forphysician follow up to nursing concerns. ·Nurses have been re-educated to call thephysician with the resident's symptoms, duration of symptoms, and any	

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	07/31/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	anything. I was lost. I did have pain right afterwards, but not now." During an interview on 07-29-15 at 8:12 a.m., the concerned family member indicated the resident informed the nursing staff his catheter bag was full and the aide made him go to the dining room anyway. She indicated he was afraid it was going to break open so he went back to his room and the catheter came out and "blood was everywhere so he called for help." She further indicated when she came in t the facility and when she turned the bed covers down, "the sheets were covered in blood." The family member indicated she was aware of what happens with the resident and the catheter and "he gets prone to infection, so after it happened and [name of resident] started to complain of lower abdominal pain, I asked the nurse [licensed nurse #16] to request a doctor's order for a ua [urinalysis]. [Name of resident] doesn't show typical signs of a urinary tract infection but on that Friday night he had blood in his depends and yellowish something that looked like pus." The family member indicated the request was made four times, before the the Nurse Practitioner ordered it. "By that time it was too late. They had to send [name of resident] to the hospital. When he got to the hospital they told me in the		otherpertinent information concerning the resident. They will then document this information in the clinical record alongwith any new orders. If no orders areobtained, the clinical record will also reflect that. ·If resident's condition or symptom persist, thelicensed nurse will contact the physician with updates on the resident statusand document such in clinical record. Ifthe physician still does not respond to the nurses concerns, the nurses willcontact the Community medical director for assistance in the situation. The nurse will also notify the Director ofNursing Services or her designee of this situation for additional followup. **How the correctiveaction (s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place:** ·The Director of Nursing Services or her designeewill conduct a change of condition audit on four residents weekly for fourweeks, monthly for three months and then quarterly thereafter for 12 months. ·Findings of the audit will be monitored by theQuality Assurance (QA) meeting until such time consistent substantialcompliance has been met.	

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	07/31/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Emergency Room that bag and brief were filled with pus and blood. He has been at risk for kidney failure and previously had a history of sepsis. The hospital determined he had a urinary tract infection and the blood and pus coming from his penis." During an interview on 07-30-15 at 2:30 p.m., licensed nurse #16, indicated the resident's catheter came out while the bulb was inflated and the bag was full and there was "blood all over the floor, the toilet and himself." She further indicated the resident had complained about burning pain to his penis and that she alerted (name of Nurse Practitioner) "several times about this. The first time another nurse wrote the concern the family member had and for a request for a urinalysis and that request remained in the office for a week without it being addressed. A week later his 'scribe' came to the facility because he [the Nurse Practitioner] couldn't come here and I told her we still had the same issue with [name of resident] and the blood and some pain he was experiencing. The next week I put the concern in the book again and he still didn't address it. The last time I wrote the order for a urinalysis myself, put it in front of him, and told him to sign it. [Name of Resident "B"] didn't show any clinical signs or			

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	07/31/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	symptoms, but his family member indicated that many times he doesn't." A review of the facility job description for Registered Nurse on 07-29-15 at 2:30 p.m., and dated as revised on June 2013 indicated the following: "Position summary: Provides general nursing care to residents in the retirement community and health center by performing the following duties listed below." "Essential Duties and Responsibilities: The following duties are normal for this position. This list is not to be construed as exlcusive or all inclusive. Other duties may be required and assigned. ...Observes patient, records significant conditions and reactions, and notifies supervisor or Physician of patient's condition and reaction to drugs, treatments, and significant incidents." A review of the Facility Policy on 07-30-15 at 1:00 p.m., titled "Notification of Changes," and undated indicated the following: "Policy - The purpose of this policy is to assure the resident, physician and / or family member or legal representative is promptly informed when there is a			

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	07/31/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	change requiring notification." "Compliance Guidelines" 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." "Circumstances requiring notification include: 2b. clinical complications." Further review of this policy contained handwritten notations which the Director of Nurses indicated was her handwriting when she Inserviced the Nursing staff regarding notification. The hand written notations indicated, "In any situation when attending MD [Medical Director] does not respond in a timely manner you can notify DON [Director of Nurses], even can follow up with the Medical Director." This Federal tag relates to Complaint IN00178546. 3.1-5(a)			
F 0315 SS=G Bldg. 00	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive			

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	07/31/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Based on observation, record review and interview the facility failed to ensure a resident who had an indwelling catheter received the necessary care and services to maintain the integrity of the catheter which resulted in the resident being transferred to the local area hospital where it was determined the resident was septic for 1 of 3 residents reviewed for indwelling catheters. (Resident "B"). Findings included: The record for Resident "B" was reviewed on 07-29-15. Diagnosis included, but were not limited to, history of a fractured hip, urinary retention, constipation, sleep apnea, a personal history of falls, hypertension and anemia. The record indicated the resident was admitted with an indwelling Foley catheter. These diagnoses remained current at the time of the record review. A review of the resident's MDS (Minimum Data Set) assessment, dated	F 0315	**F315 No catheter,prevent UTI, restore bladder It is the practiceof this Community to ensure that aresident who enters the Community without an indwelling catheter is not catheterized unless the resident'sclinical condition demonstrates that catheterization is necessary; and aresident who is incontinent of bladder receives appropriate treatment andservices to prevent urinary tract infections and to restore as much normalbladder function as possible What corrective action (s) will be accomplished for those residents found to have been affectedby the deficient practice**: ·Resident B is on an antibiotic for urinary tractinfection. He was started on the antibiotic the day the symptoms were manifested. The resident returned to the Community within72 hours, where he continues to reside. On-going education has been provided to the resident reminding him not to	08/28/2015

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	07/31/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	05-06-15, indicated the resident was cognitively intact. A review of the Resident's current plan of care indicated, the resident "has an Indwelling/Intermittent/Suprapubic catheter use with potential for infection." Interventions to this plan of care included, "Maintain closed drainage system, secure catheter to leg to avoid tension on urinary meatus, change catheter and/or drainage bag(s) per facility protocol or as ordered by PCP [Primary Care Physician] to assure patency, monitor for signs of UTI [urinary tract infection] such as change in color or consistency, a foul odor, or blood in urine, suprapubic, flank or abdominal pain, fever, assess for adequate output, color and odor of urine." During an interview on 07-31-15 at 9:00 a.m., while Resident "B" was observed seated in his wheelchair indicated a nursing staff member indicated it was time to eat. The resident further indicated he told her the bag [in reference to the catheter drainage bag], was full and that she indicated it would be all right. The resident then indicated the nursing staff member pushed him to the dining room anyway. The resident indicated he was aware the bag was full and that it "felt		manipulate the catheter. The Nurse Practitioner has continued to follow the resident. **How other residents having the potential to be affected by the same deficient practicewill be identified and what corrective action(s) will be taken:** ·All residents with indwelling catheters residing in the Community have the potential to be affected by the alleged deficientpractice. Residents exhibiting signs ofa urinary tract abnormality will be referred to the physician for evaluation. **What measures willbe put into place or what systemic changes will be made to ensure that the deficient practice does not recur**: ·Licensed nurses will be re-educated on theprocedure for indwelling catheter use to include appropriate securing ofcatheter and bag, emptying of bag, and use of catheter leg bag to maintaincatheter integrity. Licensed nurses willbe re-educated on the procedure to follow when resident's exhibit signs of a urinary tract abnormality. ·The Director of Nursing or her designee willmonitor the acute change status daily (M-F excluding holidays) for physicianfollow up to unaddressed nursing concerns ·Nurses have been re-educated to call thephysician with the resident's symptoms, duration of	

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	07/31/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	heavy" and thought it was "sliding down his leg." The resident further indicated he was afraid the bag was going to break open while he was in the dining room so he transported himself back to his room room "because I had to use the toilet. The bag was all the way down and this [pointing to the catheter] was out. I pushed the button for help. I couldn't do anything. I was lost. I did have pain right afterwards, but not now." During an interview on 07-29-15 at 8:12 a.m., the concerned family member indicated the resident informed the nursing staff his catheter bag was full and the aide made him go to the dining room anyway. She indicated he was afraid it was going to break open so he went back to his room and the catheter came out and "blood was everywhere so he called for help." She further indicated when she came in t the facility and when she turned the bed covers down, "the sheets were covered in blood." The family member indicated she was aware of what happens with the resident and the catheter and "he gets prone to infection, so after it happened and [name of resident] started to complain of lower abdominal pain, I asked the nurse [licensed nurse #16] to request a doctor's order for a ua [urinalysis]. [Name of resident] doesn't show typical signs of a urinary tract		symptoms, and any otherpertinent information concerning the resident. They will then document this information in the clinical record alongwith any new orders. If no orders areobtained, the clinical record will also reflect that. ·If resident's condition or symptom persist, thelicensed nurse will contact the physician with updates on the resident statusand document such in clinical record. Ifthe physician still does not respond to the nurses concerns the nurses will notifythe Director of Nursing or her designee of this situation for additional followup. **How the correctiveaction (s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place**: ·Licensed nurse will monitor catheter integrityfor residents with indwelling catheter each shift and document monitoring ontreatment record. ·Director of Nursing Services or designee will initiallyinspect each indwelling catheter three times a week for integrity and reviewlicensed nurse documentation for four weeks; then twice a week for four weeks;then weekly for four weeks. ·Findings of the audit will be monitored by theQuality Assurance (QA) meeting until	

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	07/31/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	infection but on that Friday night he had blood in his depends and yellowish something that looked like pus." The family member indicated the request was made four times, before the the Nurse Practitioner ordered it. "By that time it was too late. They had to send [name of resident] to the hospital. When he got to the hospital they told me in the Emergency Room that bag and brief were filled with pus and blood. He has been at risk for kidney failure and previously had a history of sepsis. The hospital determined he had a urinary tract infection and the blood and pus coming from his penis." During an interview on 07-30-15 at 2:30 p.m., licensed nurse #16, indicated the resident's catheter came out while the bulb was inflated and the bag was full and there was "blood all over the floor, the toilet and himself." She further indicated the resident had complained about burning pain to his penis and that she alerted (name of Nurse Practitioner) "several times about this. The first time another nurse wrote the concern the family member had and for a request for a urinalysis and that request remained in the office for a week without it being addressed. A week later his 'scribe' came to the facility because he [the Nurse Practitioner] couldn't come here and I		such time consistent substantialcompliance has been met.	

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	07/31/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	told her we still had the same issue with [name of resident] and the blood and some pain he was experiencing. The next week I put the concern in the book again and he still didn't address it. The last time I wrote the order for a urinalysis myself, put it in front of him, and told him to sign it. [Name of Resident "B"] didn't show any clinical signs or symptoms, but his family member indicated that many times he doesn't." A review of the Clinical record lacked any notation by the Nurse Practitioner related to the concerns the family member had related regarding Resident "B." Further review of the clinical record lacked documentation of the catheter coming out from the resident's bladder with the bulb still inflated or the condition of the resident at the time of the incident including blood on the resident, toilet or the amount of urine in the drainage bag. A review of the hospital record on 07-27-15 at 9:00 a.m., indicated the following: "ER [Emergency Room] Triage note: "Not feeling well, recent uti [urinary tract infection] dx. [diagnosis]. GU [urinary]			

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	07/31/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Intervention: Secured to leg, immediate output yellow in color, with clots and mucous thread odorous." "History of present illness: Pt. [patient] complains of 'feeling tired' bloody drainage from Foley catheter draining blood tinged urine, pt also has thick yellow drainage from the end of his penis. Py [sic] skin is hot and dry and found to have a fever of 101.4 Fahrenheit. ECF [Extended Care Facility] paperwork Foley was anchored on the 5th [July 2015] of the month." "History and Physical - Patient not feeling well for the past 2 weeks. Patient complains of burning with urination, suprapubic tenderness and this morning the urinalysis was sent from the nursing home. However, today the patient developed a fever of 101 and shaking chills. In the ER, urinalysis showed positive for UTI and the Foley has been changed in the emergency room." "Physical Examination: Temperature 101.4 Fahrenheit. Skin: the patient had bleeding from his penis. The urinalysis showed a large amount of occult blood and nitrates were negative. Large amount of leukocyte esterase, WBC [white blood cells] greater than 100, and marked			

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	07/31/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	amount of bacteria." Further review of the hospital laboratory analysis of the urinalysis indicated the resident's urine was "cloudy, with protein of 100 [normal range is negative], with large amounts of blood [normal range is negative] and a large amount of leukocyte esterase [normal range is negative]." "Hospital Transfer - "Principle Diagnosis: UTI [urinary tract infection] with an indwelling catheter." "Additional Diagnoses: SIRS [systemic inflammatory response syndrome - the body's response to an infectious or noninfectious insult], metabolic encephalopathy due to UTI, urinary retention with chronic Foley [catheter], history of CVA [cerebral vascular accident] and BPH [benign prostatic hyperplasia]." "Patient Transfer Report - Bloody drainage from Foley cath. Pt recently treated for an [sic] UTI, patient has an indwelling catheter, draining blood tinged urine, pt. also has thick yellow drainage from the end of his penis. Per ECF paperwork Foley was anchored on the 5th of the month." "Reason for Hospital Stay: The patient complained of fever, chills for a day.			

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	07/31/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Prior to that, the patient also complained of suprapubic tenderness for a week. On the day of admission the patient was also slightly confused." "Hospital Course: 1. SIRS syndrome on admission. The patient had a fever and confusion consistent with SIRS syndrome due to UTI. During the hospital stay with IV [intravenous] antibiotics and IV fluids the patient's fever resolved. 2. Metabolic encephalopathy due to UTI. 3. UTI The patient has a chronic indwelling Foley and came in with signs of UTI. Patient was started on meropemem [an antibiotic] empirically. Urine culture eventually showed greater that 100,000 E. Coli [Escherichia] and final urinalysis showed more than 3 organisms." This Federal tag relates to Complaint IN00178546. 3.1-41(2)			
R 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00178092.	R 0000	Please accept this 2567 Plan of Correction as a Provider's Letter of Credible Allegation. This provider respectfully requests	

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	07/31/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	This visit included the investigation of complaint IN00178546. Complaint IN00178092 Substantiated. State deficiencies related to the allegations are cited at R0096, R0148, R152, F179, R185, R189, R193, R242, R247, R300, R304. Survey dates: July 29, 30 & 31, 2015 Facility Number: 013212 Provider Number: 155817 Aim Number: NA Residential: 67 Total: 67 Sample: 3 Supplemental Sample: 21 These State findings are cited in accordance with 410 IAC 16.2-5.		consideration for paper compliance in lieu of a revisit survey. The creation and submission of this plan of correction does not constitute an admission of any conclusion set forth in the statement of deficiencies of any violations of regulations. This Plan of Correction is offered as our allegation of compliance.	
R 0096 Bldg. 00	410 IAC 16.2-5-1.3(m)(1-2)(A-B)(i-iii) Administration and Management - Deficiency (m) The director of the Alzheimer's and dementia special care unit shall do the following: (1) Oversee the operation of the unit.			

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	07/31/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(2) Ensure that: (A) personnel assigned to the unit receive required in-service training; and (B) care provided to Alzheimer's and dementia care unit residents is consistent with: (i) in-service training; (ii) current Alzheimer's and dementia care practices; and (iii) regulatory standards. Based on observation and interview the Director of the Memory Care Unit, failed to ensure the operations of the Unit in regard to the lack of an operational call system, in which the resident's and family members could summon facility staff for assistance and failed to ensure the processing of soiled linen in a safe and sanitary manner for 1 of 1 laundry rooms observed, and 17 of 24 resident occupied rooms related to the call system. Findings include: During an observation on 07-29-15 at 9:30 a.m., with Licensed nurse #8 in attendance the following was observed in the laundry room of the Memory Care Unit. There were items being washed and dried during this observation. Located on the top of the dryer, was a stack of folded clothes, linens and towels. The hand towel on the top of this stack was heavily soiled with dark brown stains. When	R 0096	**R096-Administration and Management – Deficiency It is the practiceof this Community to ensure the operations of the Memory Care Unit in regard tothe lack of an operational call system, in which the resident's and familymembers could summon facility staff for assistance and failed to ensure theprocessing of soiled linen in a safe and sanitary manner: What correctiveaction (s) will be accomplished for those residents found to have been affectedby the deficient practice**: ·No residents were found to be negativelyaffected. ·The Laundry Room identified by the surveyor is intendedfor use by families and capable residents to do their own laundry. The soiled laundry identified by the surveyorwas immediately removed and cleaned in the community laundry facilities. ·Maintenance technicians made repairs immediatelyto the call light units and receiving pagers that were not functioningproperly.	08/28/2015

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	07/31/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	further interviewed the nurse indicated the hand towel had been heavily soiled due to a resident becoming incontinent of bowel. The nurse indicated these items were ready to be delivered to the resident rooms. Located on the floor to the Laundry room were 2 bags completely filled. The bags were not secured and the Licensed nurse indicated both bags were soiled linen. There were 2 additional bags located in the Laundry room. The Licensed nurse indicated the bags contained "personal" items for the residents who resided on this unit. The corridor adjacent to the Laundry room, contained 3 plastic baskets of soiled clothes and linen, 1 large yellow barrel completely filled and uncovered. The nurse indicated these items were "personal items" for the residents which needed to be washed. The Licensed nurse indicated the items should not be left in the corridor but should have been contained in the Laundry room. During interview, the Licensed nurse indicated the nursing staff is scheduled to wash and dry the residents clothes. During further observation on 07-29-15 at 12:30 p.m., and with Licensed nurse #8		**How otherresidents having the potential to be affected by the same deficient practicewill be identified and what corrective action(s) will be taken:** ·All residents have the potential to be affectedby the alleged deficient practice. The soiled laundry identified by thesurveyor was immediately removed and cleaned in the community laundryfacilities. ·After repairing the call light units that werenot functioning properly, maintenance technicians ensured that all other callunits were functioning correctly. **What measures willbe put into place or what systemic changes will be made to ensure that the deficientpractice does not recur**: ·An additional soiled laundry pick up time wasadded in order to maintain a sanitary environment. The Housekeeping Supervisor or her designee willoversee the laundry and linen collection and cleaning process for all residentsthat do not do their own laundry. ·The Director of Maintenance has added testing ofall residential call light units and receiving pagers to the monthlypreventative maintenance program. **How the correctiveaction (s) will be monitored to ensure the deficient practice will not recur,i.e., what quality**	

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	07/31/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	in attendance the resident call system was observed. The Licensed nurse indicated that once the call system was activated in the resident room, the Certified Nurses Aides received the alert via a pager. During observation of the occupied resident rooms, the following was observed: 1 resident bathroom call light did not alarm 16 bedside call lights did not alarm 2 shower call lights did not alarm 3 resident rooms lacked a call system On 07-29-15 at 12:40 p.m., the call light was activated in an occupied resident room. The resident was lying in bed. The nursing staff did not respond to the alert. During further interview, two Certified Nurses Aides indicated the pager did not alert them, and one Certified Nurses Aide indicated she had her pager on vibrate but "I didn't feel it." During interview on 07-30-15 at 10:00 a.m., the Memory Care Director indicated she was unaware of the problems with the call system or the processing of soiled linen in a safe and sanitary manner and the condition of the Laundry room.		**assurance program will be put into place**: ·The Housekeeping Supervisor or her designee willinspect the laundry area on Memory Support three times weekly for four weeksand then weekly thereafter until substantial compliance has been met. ·The Director of Maintenance or his designee will test 3 residential call light units and receiving pagers weekly for four weeks and then monthly thereafter for 12 months. Malfunctioning units will be immediatelyrepaired or replaced upon identification. ·Findings of these tests will be monitored by theQuality Assurance (QA) meeting until such time consistent substantialcompliance has been met.	

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	07/31/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	This State findings relates to Complaint IN00178092.			
R 0148 Bldg. 00	410 IAC 16.2-5-1.5(e)(1-4) Sanitation and Safety Standards - Deficiency (e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows: (1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility. (2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes. (3) All plumbing shall function properly and comply with state plumbing codes. (4) At least yearly, heating and ventilating systems shall be inspected. Based on observation, interview and record review the facility failed to maintain equipment in good repair, establish and implement a written program for preventative maintenance to ensure the proper functioning for the call system for 1 of 1 memory Care Units observed. Findings include:	R 0148	**R148- Sanitation and Safety Standards -Deficiency** **It is the practiceof this Community to ensure that all residents have the ability to call forassistance as they need it.** **What correctiveaction (s) will be accomplished for those residents found to have been affectedby the deficient practice:** ·Maintenance technicians made	08/28/2015

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	07/31/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	During observation on 07-29-15 at 12:30 p.m., and with Licensed nurse #8 in attendance the resident call system was reviewed. The Licensed nurse indicated that once the call system was activated in the resident room, the Certified Nurses Aides receives the alert via a pager. During observation of the occupied resident rooms, the following was observed: 1 resident bathroom call light did not alarm 16 bedside call lights did not alarm 2 shower call lights did not alarm 3 resident rooms lacked a call system On 07-29-15 at 12:40 p.m., the call light was activated in an occupied resident room. The resident was lying in bed. The nursing staff did not respond to the alert. During further interview, two Certified Nurses Aides indicated the pager did not alert them, and one Certified Nurses Aide indicated she had her pager on vibrate but "I didn't feel it." During an interview on 07-30-15 the Administrator indicated she recently had a conversation with the Maintenance Director. On 07-30-15 at 8:30 a.m. the		repairs immediatelyto the call light units and receiving pagers that were not functioning properly. **How otherresidents having the potential to be affected by the same deficient practicewill be identified and what corrective action(s) will be taken:** ·All residents have the potential to be affectedby the alleged deficient practice. After repairing the call light unitsthat were not functioning properly, maintenance technicians ensured that allother call units were functioning correctly. **What measures willbe put into place or what systemic changes will be made to ensure that thedeficient practice does not recur**: ·The Director of Maintenance has added testing ofall residential call light units and receiving pagers to the monthly preventativemaintenance program. **How the correctiveaction (s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place**: ·The Director of Maintenance or his designee willtest 3 residential call light units and receiving pagers weekly for fourweeks and then monthly thereafter for 12 months. Malfunctioning units will	

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	07/31/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Administrator provided e-mail documentation, dated 07-29-15 between her and the Maintenance Director. The Administrator questioned "Have they been able to go through AL [Assisted Living] and replace the batteries in the call lights for AL ?" The Maintenance Director indicated "Just skilled and Memory. We will get the others on schedule." During further interview the Director of Nurses indicated the facility did not have a policy related to the education or use of pagers by the nursing staff. The Maintenance Director indicated he did not have a system in place to ensure the resident call system was operational in which the residents had a means to summon the nursing staff. This State findings relates to Complaint IN00178092.		be immediatelyrepaired or replaced upon identification. ·Findings of these tests will be monitored by theQuality Assurance (QA) meeting until such time consistent substantialcompliance has been met.	
R 0152 Bldg. 00	410 IAC 16.2-5-1.5(i) Sanitation and Safety Standards - Deficiency (i) The facility shall handle, store, process, and transport clean and soiled linen in a safe and sanitary manner that will prevent the spread of infection. Based on observation and interview the facility failed to ensure the processing of	R 0152	**R152 Sanitation and Safety Standards-Deficiency**	08/28/2015

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	07/31/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	soiled linen in a safe and sanitary manner for 1 of 1 laundry rooms observed. Findings include: During an observation on 07-29-15 at 9:30 a.m., with Licensed nurse #8 in attendance the following was observed in the laundry room of the Memory Care Unit. There were items being washed and dried during this observation. Located on the top of the dryer, was a stack of folded clothes, linens and towels. The hand towel on the top of this stack was a heavily soiled with dark brown stains. When further interviewed the nurse indicated the hand towel had been heavily soiled due to a resident becoming incontinent of bowel. The nurse indicated these items were ready to be delivered to the resident rooms. Located on the floor to the Laundry room were 2 bags completely filled. The bags were not secured and the Licensed nurse indicated both bags contained soiled linen. There were 2 additional bags located in the Laundry room. The Licensed nurse indicated the bags contained "personal" items for the residents who resided on this unit.		It is the practice of this Community to ensure theprocessing of soiled linen is completed in a safe and sanitary manner. **What corrective action (s) will be accomplished forthose residents found to have been affected by the deficient practice:** ·Noresident was found to be affected by this alleged deficient practice. ·The Laundry Room identified by the surveyor isintended for use by families and capable residents to do their ownlaundry. The soiled laundry identifiedby the surveyor was immediately removed and cleaned in the community laundryfacilities. **How other residents having the potential to beaffected by the same deficient practice will be identified and what correctiveaction(s) will be taken:** ·All residents have the potential to be affectedby the alleged deficient practice. The soiled laundry identified by thesurveyor was immediately removed and cleaned in the community laundryfacilities. **What measures will be put into place or what systemicchanges will be made to ensure that the deficient practice does not recur:** ·An additional soiled laundry	

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	07/31/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The corridor adjacent to the Laundry room, contained 3 plastic baskets or soiled clothes and linen, 1 large yellow barrel completely filled and uncovered. The nurse indicated these items were "personal items" for the residents which needed to be washed. The Licensed nurse indicated the items should not be left in the corridor but should have been contained in the Laundry room. During interview, the Licensed nurse indicated the nursing staff is scheduled to wash and dry the residents clothes. During an interview on 07-30-15 at 3:00 p.m. a concerned family member indicated her husband had gone days without clean clothes. "One day I came in and he had someone else's clothes on. I expect my husband to wear what I bring in to him. When I asked about his clothes, the nurse said, 'they're probably in the Laundry room." During interview on 07-30-15 at 10:00 a.m., the Memory Care Director indicated she was unaware of the problems with the processing of soiled linen in a safe and sanitary manner. This State finding relates to Complaint IN00178092.		pick up time wasadded in order to maintain a sanitary environment. The Housekeeping Supervisor or her designee willoversee the laundry and linen collection and cleaning process for all residentsthat do not do their own laundry. **How the corrective action (s) will be monitored toensure the deficient practice will not recur, i.e., what quality assuranceprogram will be put into place:** ·The Housekeeping Supervisor or her designee willinspect the laundry area on Memory Support three times weekly for four weeksand then weekly thereafter until substantial compliance has been met. ·Findings of these inspections will be monitoredby the Quality Assurance (QA) committee throughout the year to ensure thatsubstantial compliance has been met.	

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	07/31/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0179 Bldg. 00	410 IAC 16.2-5-1.6(c) Physical Plant Standards - Deficiency (c) Each facility shall have an adequate air conditioning system, as governed by applicable rules of the fire prevention and building safety commission (675 IAC). The air conditioning system shall be maintained in normal operating condition and utilized as necessary to provide comfortable temperatures in all resident and public areas. Based on observation and interview the facility failed to ensure the heating/cooling ventilation system provided comfortable temperatures in all areas of the Memory Care Unit. This deficient practice effected 1 of 24 rooms observed. (Room #1812). Findings include: During an interview on 07-29-15 at 1:25 p.m., a "Caregiver" for Resident "G" indicated there had been problems with the heating in the winter and the air conditioning in the summer. "It's been like this for quite some time. We put a fan in [name of resident] room just to keep the air moving." During an interview on 07-29-15 at 1:40 p.m., a "Caregiver" for Resident "C" indicated, "it's been so hot in here. They told me that one system regulates the heating and air conditioning for four resident rooms. I don't know how they	R 0179	**R179—PhysicalPlant Standards - Deficiency** **It is the practiceof this Community to provide comfortable temperatures in all areas of theMemory Care unit. The Community disputesthat a room that is temporarily warmer than comfortable does not constitute fora deficiency. A statement from aCaregiver not employed by the Community substantiate that the Community failsto maintain temperatures between 71 and 81 degrees Fahrenheit as defined bystate regulation. Lastly, extensiverepair had been previously completed so that temperatures are consistentlymaintained within the range as defined by the Indiana State Department ofHealth.** **What correctiveaction (s) will be accomplished for those residents found to have been affectedby the deficient practice**: ·The room allegedly identified as 85 degrees waspromptly	08/28/2015

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	07/31/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	set it." During an interview on 07-29-15 at 1:40 p.m., Maintenance staff member #10 indicated "the thermostat only works for 'Heating' and we try to keep the rooms at 74 degrees." During a subsequent interview on 07-29-15 at 1:45 p.m. Maintenance staff member #11 indicated the "residents can't control the temperature in their rooms." With Licensed nurse #8 in attendance 1 resident room was 85 degrees. During an interview on 07-31-15 at 1:30 p.m., a concerned family member indicated there have been all types of problems with the heating and cooling. [Name of resident] room was so cold during the winter we wanted to bring in a space heater and we were told we couldn't. My mother has two windows in her room, and it can get cold in the winter and hot in the summer." During an interview on 07-31-15 at 11:15 a.m., the Maintenance Director verified there had been "problems" with the heating and cooling units. "One unit will regulate the temperatures for four resident rooms. I asked to see what the temperature range those residents want,		cooled to a more comfortable temperature. Several resident rooms connected to the sameHeating/Cooling unit were not identified as having temperature control issuesas were alleged for this room. ·A Heating/Cooling technician came on site toensure proper functioning of the system. **How other residents having the potential to beaffected by the same deficient practice will be identified and what correctiveaction(s) will be taken:** ·All residents have the potential to be affectedby the alleged deficient practice. Noother resident rooms were identified by the surveyor as having room temperaturesthat were above or below standards as set forth by the Indiana State Departmentof Health. ·The community identified the concerns regardingthe warm room temperature and responded accordingly. A Heating/Coolingtechnician came on site to ensure proper functioning of the system. Allresidents have the option to increase their room temperatures with thethermostat in their room. ·Nursing and maintenance staff are available toassist with room temperature adjustment, which is why the technician was calledin upon identifying the warm room.	

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	07/31/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	and then I just 'ballpark' the temperature to try to keep everyone happy." A review of the temperatures on 07-29-15, from the local weather channel indicated at 11:55 a.m. the outside temperature was 85.8 degrees Fahrenheit, at 12:15 p.m. 86.0 degrees Fahrenheit and 12:55 p.m. 86.9 degrees Fahrenheit. This State tag relates to Complaint IN00178092.		**What measures will be put into place or what systemicchanges will be made to ensure that the deficient practice does not recur:** ·The Director of Plant Operations/designeewill complete Room Temperature Audits to alternate complete checks of anentire hall of room temperatures weekly for four weeks, then monthly for threemonths, and then quarterly thereafter for twelve months. **How the corrective action (s) will be monitored toensure the deficient practice will not recur, i.e., what quality assuranceprogram will be put into place:** ·Findings of the Room Temperature Audits will bemonitored by the Quality Assurance (QA) meeting until such time consistentsubstantial compliance has been met.	
R 0185 Bldg. 00	410 IAC 16.2-5-1.6(i)(1-2)(A)(i-iii)(B-E Physical Plant Standards - Noncompliance (i) The facility shall house residents only in areas approved by the director for housing and given a fire clearance by the state fire marshal. The facility shall: (1) Have a floor at or above grade level. A facility whose plans were approved before the effective date of this rule may use rooms below ground level for resident occupancy if the floors are not more than three (3) feet below ground level. (2) Provide each resident the following items upon request at the time of admission:			

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	07/31/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(A) A bed: (i) of appropriate size and height for the resident; (ii) with a clean and comfortable mattress; and (iii) with comfortable bedding appropriate to the temperature of the facility. (B) A bedside cabinet or table with a hard surface and washable top. (C) A cushioned comfortable chair. (D) A bedside lamp. (E) If the resident is bedfast, an adjustable over-the-bed table or other suitable device. (3) Provide cubicle curtains or screens if requested by a resident in a shared room. (4) Provide a method by which each resident may summon a staff person at any time. (5) Equip each resident unit with a door that swings into the room and opens directly into the corridor or common living area. (6) Not house a resident in such a manner as to require passage through the room of another resident. Bedrooms shall not be used as a thoroughfare. (7) Individual closet space. For facilities and additions to facilities for which construction plans are submitted for approval after July 1, 1984, each resident room shall have clothing storage that includes a closet at least two (2) feet wide and two (2) feet deep, equipped with an easily opened door and a closet rod at least eighteen (18) inches long of adjustable height to provide access by residents in wheelchairs.			
	Based on observation and interview the facility failed to ensure the Unit had an operational call system, in which the resident's and family members could summon facility staff for assistance for 18 of 24 resident occupied rooms related to the call system. (Rooms #1701,	R 0185	**R185- Physical Plant Standards-Noncompliance** **It is the practiceof this Community to ensure that all residents have the ability to call forassistance as they need it.** **What correctiveaction (s) will be**	08/28/2015

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	07/31/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	#1703, #1704, #1706, #1708, #1709, #1711, #1801, #1802, #1805, #1806, #1807, #1809, #1810, #1811, #1813, #1815, #1819).) Findings include: During further observation on 07-29-15 at 12:30 p.m., and with Licensed nurse #8 in attendance the resident call system was reviewed. The Licensed nurse indicated that once the call system was activated in the resident room, the Certified Nurses Aides receives the alert via a pager. During observation of the occupied resident rooms, the following was observed: 1 resident bathroom call light did not alarm 16 bedside call lights did not alarm - #1701, #1703, #1704, #1706, #1708, #1709, #1711, #1801, #1802, #1805, #1806, #1807, #1810, #1811, #1813, #1815. 2 shower call lights did not alarm - #1706 and #1711. 3 resident rooms lacked a call system - #1706, #1809 and #1819. On 07-29-15 at 12:40 p.m., the call light		**accomplished for those residents found to have been affectedby the deficient practice**: ·No resident was found to be negatively affectedby the alleged deficient practice. ·Maintenance technicians made repairs immediatelyto the call light units and receiving pagers that were not functioningproperly. **How otherresidents having the potential to be affected by the same deficient practicewill be identified and what corrective action(s) will be taken:** ·All residents have the potential to be affectedby the alleged deficient practice. After repairing the call light unitsthat were not functioning properly, maintenance technicians ensured that allother call units were functioning correctly. **What measures willbe put into place or what systemic changes will be made to ensure that thedeficient practice does not recur**: ·The Director of Maintenance has added testing ofall residential call light units and receiving pagers to the monthlypreventative maintenance program. **How the correctiveaction (s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put**	

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	07/31/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	was activated in an occupied resident room. The resident was lying in bed. The nursing staff did not respond to the alert. During further interview, two Certified Nurses Aides indicated the pager did not alert them, and one Certified Nurses Aide indicated she had her pager on vibrate but "I didn't feel it." During an observation on 07-29-15 at 12:50 p.m., the door to Resident "H" room was locked. The Licensed nurse unlocked the door and entered the resident room. The resident was lying in bed. The Licensed Nurse attempted to activate the call system at the bedside. The call system was not operational and the resident unable to alert the staff for assistance. During interview on 07-30-15 at 10:00 a.m., the Memory Care Director indicated she was unaware of the problems with the call system. This State findings relates to Complaint IN00178092.		**into place**: ·The Director of Maintenance or his designee willtest 3 residential call light units and receiving pagers weekly for fourweeks and then monthly thereafter for 12 months. Malfunctioning units will be immediatelyrepaired or replaced. ·Findings of these tests will be monitored by theQuality Assurance (QA) meeting until such time consistent substantialcompliance has been met.	
R 0189	410 IAC 16.2-5-1.6(m) Physical Plant Standards - Noncompliance			

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	07/31/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Bldg. 00	(m) Ice shall be readily available to residents at all times in the facility. Based on observation and interview the facility failed to ensure ice was available to the resident's who resided on the Memory Care Unit at all times for 3 sampled and 21 supplemental sampled residents. (Resident's "B", "C", "D", "E", "G", "H", "I", "J", "K", "L", "M", "N", "O", "P", "Q", "R","S", "T", "U", "V", "W", "X", "Y" and "Z") Findings include: During the Initial Tour of the facility on 07-29-15 at 10:00 a.m., water pitchers, nor ice appeared to be available at all times to the residents who resided on this unit. During an interview on 07-31-15 at 10:00 a.m., Licensed nurse #14 indicated, "They're [in reference to the residents] aren't allowed to have water or ice in their rooms." During this interview a kitchenette was observed in the main dining area. There were no water pitchers or ice available to the resident's. When further interviewed the Licensed nurse indicated, "They get water and juice at their meals and sometimes during Activities."	R 0189	**R189 Physical Plant Standards - Deficiency** **It is the practiceof this Community to ensure that ice is readily available to residents at alltimes in the facility. The community respectfully disputes this allegation, asice is readily available from the ice machine in the satellite kitchen onMemory Care to residents, families and visitors upon request. The residents are allowed to have water and/or ice at any time or location unless contrary to physicians' orders. There was no evidence provided tosubstantiate that residents lacked ice or had requested it and had been denied.** **What correctiveaction (s) will be accomplished for those residents found to have been affectedby the deficient practice**: ·Ice water was made more readily available to allresidents by placing a decanter in a central location for all residents, staffor family members to use. Additional iceremains readily available upon request. **How otherresidents having the potential to be affected by the same deficient practicewill be identified and what corrective action(s) will be taken:** ·All residents have the potential to be affectedby the alleged	08/28/2015

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	07/31/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A request was made for the hydration program for the Memory Care unit. At the time of the Exit conference on 07-31-15 at 3:00 p.m., the facility Administrative Staff indicated they did have any thing further for review related to the hydration needs of the resident's. This State findings relates to Complaint IN00178092.		deficient practice. Ice water was made available to allresidents by placing a decanter in a central location for all residents, staffor family members to use. **What measures willbe put into place or what systemic changes will be made to ensure that thedeficient practice does not recur**: ·The Director of Dining Services has scheduledstaff to replace the ice water decanter with fresh water each morning and asneeded. **How the correctiveaction (s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place**: ·The Administrator or her designee will randomlyverify the availability and accessibility of ice water three times weekly forfour weeks and then weekly thereafter for three months or until such timeconsistent substantial compliance has been met. ·Findings of these tests will be monitored by theQuality Assurance (QA) meeting until such time consistent substantialcompliance has been met.	
R 0193 Bldg. 00	410 IAC 16.2-5-1.6(q)(1-2) Physical Plant Standards - Deficiency (q) The facility shall have laundry services			

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	07/31/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	either in-house or with a commercial laundry by contract as follows: (1) If a facility operates its own laundry, the laundry shall be designed and operated to promote a flow of laundry from the soiled utility area toward the clean utility area to prevent contamination. (2) Written procedures for handling, storage, transportation, and processing of linens shall be posted in the laundry and shall be implemented.			
	Based on observation and interview the facility failed to ensure processing of soiled linen in a safe and sanitary manner for 1 of 1 laundry rooms observed. Findings include: During an observation on 07-29-15 at 9:30 a.m., with Licensed nurse #8 in attendance the following was observed in the laundry room of the Memory Care Unit. There were items being washed and dried during this observation. Located on the top of the dryer, was a stack of folded clothes, linens and towels. The hand towel on the top of this stack was a heavily soiled with dark brown stains. When further interviewed the nurse indicated the hand towel had been heavily soiled due to a resident becoming incontinent of bowel. The nurse indicated these items were ready to be delivered to the resident rooms.	R 0193	**R193 Physical Plant Standards - Deficiency** **It is the practiceof this Community to ensure the processing of soiled linen is completed in asafe and sanitary manner.** **What corrective action (s) will be accomplished forthose residents found to have been affected by the deficient practice:** ·Noresident was found to be negatively affected by this alleged deficientpractice. ·The Laundry Room identified by the surveyor isintended for use by families and capable residents to do their ownlaundry. The soiled laundry identifiedby the surveyor was immediately removed and cleaned in the community laundryfacilities. **How other residents having the potential to beaffected by the same deficient practice will be identified and what correctiveaction(s) will be taken:** ·All residents have the potential	08/28/2015

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	07/31/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Located on the floor to the Laundry room were 2 bags completely filled. The bags were not secured and the Licensed nurse indicated both bags were soiled linen. There were 2 additional bags located in the Laundry room. The Licensed nurse indicated the bags contained "personal" items for the residents who resided on this unit. The corridor adjacent to the Laundry room, contained 3 plastic baskets or soiled clothes and linen, 1 large yellow barrel completely filled and uncovered. The nurse indicated these items were "personal items" for the residents which needed to be washed. The Licensed nurse indicated the items should not be left in the corridor but should have been contained in the Laundry room. During interview, the Licensed nurse indicated the nursing staff is scheduled to wash and dry the residents clothes. During interview on 07-30-15 at 10:00 a.m., the Memory Care Director indicated she was unaware of the problems with the processing of soiled linen in a safe and sanitary manner. This State findings relates to Complaint IN00178092.		to be affectedby the alleged deficient practice. The soiled laundry identified by thesurveyor was immediately removed and cleaned in the community laundryfacilities. **What measures will be put into place or what systemicchanges will be made to ensure that the deficient practice does not recur:** ·An additional soiled laundry pick up time wasadded in order to maintain a sanitary environment. The Housekeeping Supervisor or her designee willoversee the laundry and linen collection and cleaning process for all residentsthat do not do their own laundry. **How the corrective action (s) will be monitored toensure the deficient practice will not recur, i.e., what quality assuranceprogram will be put into place:** ·The Housekeeping Supervisor or her designee willinspect the laundry area on Memory Support three times weekly for four weeksand then weekly thereafter until substantial compliance has been met. ·Findings of these inspections will be monitoredby the Quality Assurance (QA) committee throughout the year to ensure thatsubstantial compliance has been met.	

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	07/31/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0242 Bldg. 00	410 IAC 16.2-5-4(e)(2) Health Services - Offense (2) The resident shall be observed for effects of medications. Documentation of any undesirable effects shall be contained in the clinical record. The physician shall be notified immediately if undesirable effects occur, and such notification shall be documented in the clinical record. Based on interview and and record review the facility failed to ensure a resident received the ordered dose and was observed for adverse side effects of a nonsteroidal anti inflammatory medication which resulted in the resident being transported to the local area hospital with a gastrointestinal bleed and required a transfusion. This deficient practice affected 1 of 3 sampled residents. (Resident "C"). Findings include: The record for Resident "C" was reviewed on 07-30-15 at 2:00 p.m. Diagnoses included, but were not limited to, Alzheimer's disease, senile dementia, constipation and psychosis. These diagnoses remained current at the time of the record review. A review of the resident's current Service Plan, dated 04-15-15 indicated the	R 0242	**R242 HealthServices-Offense It is the practiceof this Community to ensure a resident receives the ordered dose and is observedfor adverse side effects of any nonsteroidal anti-inflammatory medication. What correctiveaction (s) will be accomplished for those residents found to have been affectedby the deficient practice**: ·Resident C no longer resides at this facility. ·The resident had received physician's orders foribuprofen and these orders were followed. When the resident changed physicianservices, the new physician agreed with the current order for ibuprofen. ·Upon identification of the potentially adverseeffect of this medication, the ibuprofen was discontinued and no longeradministered. **How otherresidents having the potential to be affected by the**	08/28/2015

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	07/31/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	resident had "Pain. Services Provided: Medication as ordered by physician, and observe for medication effectiveness." A review of the physician orders for June 2015 indicated "Ibuprofen (an nonsteroidal) medication 400 mg (milligrams) PO (by mouth) every 4 hours while awake. DX. (diagnosis) back pain." A review of the Medication Record for "06-2015" indicated the medication was "scheduled for 2:00 a.m., 6:00 a.m., 10:00 a.m., 2:00 p.m., 6:00 p.m. and 10:00 p.m." Further review of the Medication Record indicated the resident received the medication every four hours over a 24 hour period on June 1, 2, 3, 4, 5, 6, 7, 8, 10, 11, 12,13,14,15,16,17,18, 19, 20, 21, 22, 23, 24. A review of the Interdisciplinary Notes, dated 06-24-15 at 15:24 [3:24 p.m.], indicated "resident noted exhibiting periods of lethargy, eval. [evaluation] resident noting resident easily aroused, pleasant et [and] cooperative, obtained VS [vital signs] 121/71, pulse 93, respirations 18, request for N.P. [nurse practitioner] to be eval. placed in N.P. folder."		**same deficient practicewill be identified and what corrective action(s) will be taken:** ·All residents have the potential to be affectedby the alleged deficient practice. ·It will continue to be the Community practice tohave the medication administration records reviewed by the pharmacist regularly. Community is enlisting the pharmacistfor additional insight into these medications that have the potential forserious outcomes. **What measures willbe put into place or what systemic changes will be made to ensure that thedeficient practice does not recur**: ·Community residents shall be observed for effectivenessof medications. Any negative sideeffects shall be documented in the clinical record and the physician notifiedimmediately with the clinical record reflecting his notification as well as anynew orders. ·Nurses will be re-educated on accuratetranscription of physician orders, the side effects of nonsteroidalanti-inflammatory medication use and the observations required by them forresidents using this medication. ·The daily nursing report will be reviewed by theAssisted Living Coordinator or her designee each business day to ensure followup on any potentially adverse side effects of nonsteroidal	

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	07/31/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A subsequent notation, dated 06-25-15 at 6:46 a.m., indicated, "At 5:00 CNA [certified nurse's aide] notified this nurse that resident had vomited on floor of room. This nurse in to assess, copious amount of tarry black emesis with thick particles noted. Resident alert et [and] oriented to self et name when called, lethargy and weakness assessed. VS 148/97, Pulse 112 and unable to assess resident oxygen saturations due to bilateral hands cold to touch." During an interview on 07-31-15 at 11:30 a.m., a concerned family member indicated the resident was transported to the hospital and when "she got there they said her blood levels were low and that she was bleeding. They said it was due to receiving all the Ibuprofen. [Resident] required a blood transfusion and the Barrington was told not to give it to her anymore." A review of the Hospital discharge diagnoses included GI (gastrointestinal) bleed and anemia. The result of the hospital laboratory result for Hemoglobin was 7.0 [normal range 11.6 - 15.2] and Hematocrit 22.9 [normal range 34.4 - 45.6%]. During an interview on 07-30-15 at 1:00		anti-inflammatory medication. **How the correctiveaction (s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place**: ·The Assisted Living Coordinator or her designeewill audit all nursing reports for the week to review new orders for nonsteroidalanti-inflammatory medication to ensure a stop date has been provided forre-evaluation by the physician. Theaudit will also include review of the medication administration record to ensureproper transcription for these anti-inflammatory medications. ·These audits will be completed weekly for fourweeks and then monthly thereafter until substantial compliance has been met. Findings of these inspections will bemonitored by the Quality Assurance (QA) committee throughout the year to ensurethat substantial compliance has been met.	

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	07/31/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	p.m., the Director of Nurses indicated she was aware there was a "problem" with the Ibuprofen but was "unaware" the resident had been given the medication "every 4 hours around the clock instead of just waking hours. They didn't tell that part of it." During further interview with another concerned family member on 07-31-15 at 11:30 a.m., indicated, "Originally the Ibuprofen had been ordered by Hospice, but [resident] got better, in May [2015] and they took her off of Hospice. When that happened, The Barrington should have re-reviewed the medications and it should have been their duty to see if she was getting too much or if it had been given like it was ordered. In June [2015] she started having periods when she was lethargic and sleeping a lot. They took her vital signs and they said she was OK. She started vomiting blood and we had her sent to the Emergency Room. The Emergency Room Doctor told us she could 'code' at any time and she needed a transfusion. He said it [in reference to the bleeding] had been going on for weeks and she had probably been bleeding for awhile. They gave her too much." A review of the facility policy on 07-31-15 at 12:30 p.m., titled			

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	07/31/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	"Preparation and General Guidelines," dated January 2007, indicated the following: "B. Administration - 3. If a dose seems excessive considering the resident's age and condition, or a medication order seems to be unrelated to the resident's current diagnoses or conditions, the nurse calls the provider pharmacy for clarification prior to the administration of the medication or if necessary contacts the prescriber for clarification." This State finding relates to Complaint IN00178092.			
R 0247 Bldg. 00	410 IAC 16.2-5-4(e)(7) Health Services - Deficiency (7) Any error in medication administration shall be noted in the resident ' s record. The physician shall be notified of any error in medication administration when there are any actual or potential detrimental effects to the resident. Based on interview and and record review the facility failed to ensure a resident was observed for adverse side effects of a nonsteroidal anti-inflammatory medication which resulted in the resident being transported to the local area hospital with a gastrointestinal bleed and required a transfusion. In addition the facility failed to ensure a resident received a physician ordered breathing treatment and received	R 0247	**R247 HealthServices-deficiency** **It is the practiceof this Community to observe residents for adverse side effects of anonsteroidal anti-inflammatory medication and ensure residents receive ordersand prescribed.** **What correctiveaction (s) will be accomplished for those residents found to have been affectedby the deficient practice**: ·Resident C no longer resides	08/28/2015

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	07/31/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	an antipsychotic medication which resulted in the resident with behaviors. This deficient practice affected 3 of 3 sampled residents. (Residents "B", "C" and "D"). Findings include: 1. The record for Resident "C" was reviewed on 07-30-15 at 2:00 p.m. Diagnoses included, but were not limited to, Alzheimer's disease, senile dementia, constipation and psychosis. These diagnoses remained current at the time of the record review. A review of the physician orders for June 2015 indicated Ibuprofen (an nonsteroidal) medication 400 mg (milligrams) PO (by mouth) every 4 hours while awake. DX. (diagnosis) back pain. A review of the resident's current Service Plan, dated 04-15-15 indicated the resident had "Pain. Services Provided: Medication as ordered by physician, and observe for medication effectiveness." A review of the Medication Record for "06-2015" indicated the medication was "scheduled for 2:00 a.m., 6:00 a.m., 10:00 a.m., 2:00 p.m., 6:00 p.m. and 10:00 p.m."		at the Community. ·Residents B and D have had their orders reviewedto ensure that any transcription errors have been identified and resolved. Availability of all medications was alsoreviewed to ensure proper administration. **How otherresidents having the potential to be affected by the same deficient practicewill be identified and what corrective action(s) will be taken:** ·All residents have the potential to be affectedby the alleged deficient practice. Noother residents were identified as being affected by the alleged deficientpractice involving the use of a nonsteroidal anti-inflammatory medication. ·All new written orders will be verified by checkingeach new order against the medication administration record by the Assisted LivingCoordinator or her designee. **What measures willbe put into place or what systemic changes will be made to ensure that thedeficient practice does not recur**: ·Any unavailable medication will be noted on the24-hour report sheet so that nursing staff can ensure availability within 24hours. Any delay in receiving medicationmust be called to the family and physician's attention and noted in theclinical record.	

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	07/31/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Further review of the Medication Record indicated the resident received the medication every four hours over a 24 hour period on June 1, 2, 3, 4, 5, 6, 7, 8, 10, 11, 12,13,14,15,16,17,18, 19, 20, 21, 22, 23, 24. A review of the Interdisciplinary Notes, dated 06-24-15 at 15:24 [3:24 p.m.], indicated "resident noted exhibiting periods of lethargy, eval. [evaluation] resident noting resident easily aroused, pleasant et [and] cooperative, obtained VS [vital signs] 121/71, pulse 93, respirations 18, request for N.P. [nurse practitioner] to be eval. placed in N.P. folder." A subsequent notation, dated 06-25-15 at 6:46 a.m., indicated, "At 5:00 CNA [certified nurses aide] notified this nurse that resident had vomited on floor of room. This nurse in to assess, copious amount of tarry black emesis with thick particles noted. Resident alert et oriented to self et [and] name when called, lethargy and weakness assessed. VS 148/97, Pulse 112 and unable to assess resident oxygen saturations due to bilateral hands cold to touch." During an interview on 07-31-15 at 11:30 a.m., a concerned family member		·Staff will be re-educated regarding the medicationordering process and procedures for timely follow-up in the case ofunavailability. Failure to follow theguidelines as expected may lead to disciplinary action as indicated. **How the correctiveaction (s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place**: ·The Assisted Living Coordinator or her designeewill audit all nursing reports for the week to review new orders for nonsteroidalanti-inflammatory medication to ensure a stop date has been provided forre-evaluation by the physician. Theaudit will also include review of the medication administration record to ensureproper transcription for these anti-inflammatory medications. The audit will also review any medicationsindicated as unavailable and promptly resolve the availability issue asindicated. ·These audits will be completed weekly for fourweeks and then monthly thereafter until substantial compliance has been met. Findings of these inspections will bemonitored by the Quality Assurance (QA) committee throughout the year to ensurethat substantial compliance has been met.	

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	07/31/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	indicated the resident was transported to the hospital and when "she got there they said her blood levels were low and that she was bleeding. They said it was due to receiving all the Ibuprofen. [Resident] required a blood transfusion and the Barrington was told not to give it to her anymore." A review of the Hospital discharge diagnoses included GI (gastrointestinal) bleed and anemia. The result of the hospital laboratory result for Hemoglobin was 7.0 [normal range 11.6 - 15.2] and Hematocrit 22.9 [normal range 34.4 - 45.6%]. During an interview on 07-30-15 at 1:00 p.m., the Director of Nurses indicated she was aware there was a "problem" with the Ibuprofen but was "unaware" the resident had been given the medication "every 4 hours around the clock. They didn't tell that part of it." During further interview with another concerned family member on 07-31-15 at 11:30 a.m., indicated, "Originally the Ibuprofen had been ordered by Hospice, but [resident] got better, in May [2015] and they took her off of Hospice. When that happened, The Barrington should have re-reviewed the medications and it should have been their duty to see if she			

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	07/31/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	was getting too much or if it had been given like it was ordered. In June [2015] she started having periods when she was lethargic and sleeping a lot. They took her vital signs and they said she was OK. She started vomiting blood and we had her sent to the Emergency Room. The Emergency Room Doctor told us she could 'code' at any time and she needed a transfusion. He said it [in reference to the bleeding] had been going on for weeks and she had probably been bleeding for awhile. They gave her too much." The clinical record lacked documentation of an assessment to the resident's response to this medication, continued indication for usage or verification by the physician of the prescribed dosage. 2. The record for Resident "B" was reviewed on 07-29-15 at 2:30 p.m. Diagnoses included, but were not limited to, Senile dementia, dysphagia and hypertension. The resident also had a pacemaker. The resident had physician orders, dated 07-14-15 at 3:11 p.m., for Albuterol nebulizer treatment 2.5 mg (milligrams) give treatment every four hours for wheezing. The scheduled administration times included 1:00 a.m., 5:00 a.m., 5:00			

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	07/31/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	p.m., and 9:00 p.m., not the physician order for every four hours. A review of the Interdisciplinary Note, dated 07-13-15 at 9:51 p.m., indicated, "...[family member] visited and stated resident seems to be wheezing. Assessment done noted wheezing on bilateral upper lobes, lung sound diminished to bilateral lower lobes, no sob [shortness of breath]. PRN [as needed] neb. [nebulizer] treatment done." A subsequent Interdisciplinary Note, dated 07-14-15 indicated Res. (Resident) has a new order for "Albuterol [a medication to aid in breathing] solution 2.5 ml every 4 hours for sob [Shortness of Breath]." A review of the Medication Record for "07/2015," the resident received three treatments from the time the physician order was received through 07-15-15 at 4:23 p.m. These dates included 07-14-15 in the "morning" and "miday," and on 07-15-15 at "night." A review of the Interdisciplinary Notes indicated "[Family member] asked did res. [resident] receive Neb. [nebulizer] tx. [treatment]. Nurse replied yes at 6:00 a.m. and the next one is due at 3:00 p.m. [Family member] replied, 'no, she is			

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	07/31/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	suppose to have it every 4 hours until the Dr. [Doctor] arrives. Nurse apologized and offered to do tx. [Family member] said, since it was not given at 10:00 a.m. or 2:00 p.m. she would rather just wait and let the Dr. check her out instead of giving it to her." The notation further indicated the medication administration record was reviewed and the 10:00 a.m. and 2:00 p.m. administration was not documented as given. The record lacked documentation of the discrepancy to the administration times or the order for the breathing treatment every four hours. In addition the record lacked information the physician was immediately notified of the family member concern and omission of the breathing treatment. 3. The record for Resident "D" was reviewed on 07-30-15 at 3:00 p.m. Diagnoses included, but were not limited to, dementia, anxiety, agitation, hypertension and constipation. These diagnoses remained current at the time of the record review. The resident had physician orders, dated 05-01-15 for Seroquel (an antipsychotic) 12.5 mg (milligrams) 1 tab. (tablet) PO (by mouth) two times a day. The scheduled times were 9:00 a.m. and 5:00			

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	07/31/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	p.m. A review of the resident's Service Plan, dated 04-14-15 indicated the resident had behaviors. "Services provided" included "Monitor for early warning signs of problem behavior." During a confidential interview on 07-30-15 at 12:00 p.m., revealed the resident had been displaying "behaviors and the resident's family member didn't know why all of a sudden she began to display behaviors when she hadn't been in the recent past. Then the family found out she had been without her medication for a number of days." A review of the Medication Record for July 2015, indicated the resident had not received 8 doses of the medication on 07-26-15, 07-27-15, 07-28-15 and 07-29-15. A review of the Interdisciplinary Notes indicated on 07-25-15 - a notation started but not completed, 07-26-15 a notation started but not completed. The notation on 07-26-15 indicated "Resident with increase behaviors, wanting to smoke and exit seeking and punching and kicking at staff. Tried to redirect times 3, 1:1 walking with her in the hallways and taking her outside without success."			

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	07/31/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The record lacked documentation the resident had not received the medication as ordered by the physician. This State finding relates to Complaint IN00178092.			
R 0300 Bldg. 00	410 IAC 16.2-5-6(c)(4) Pharmaceutical Services - Deficiency (4) Over-the-counter medications, prescription drugs, and biologicals used in the facility must be labeled in accordance with currently accepted professional principles and include the appropriate accessory and cautionary instructions and the expiration date. Based on observation and record review the facility failed to ensure prescription and over the counter medications were labeled in accordance with accepted professional principles for 2 of 4 supplemental sampled residents reviewed and observed during the medication administration pass with Licensed nurse #14. (Residents "G" and "I"). Findings include: 1. Resident "G" had physician orders, dated 03-07-15, for Low Dose Aspirin 81 mg [milligrams] take one table by mouth daily. During the medication pass observation	R 0300	**R300 PharmaceuticalServices** **It is the practiceof this Community to ensure prescription and over the counter medications arelabeled in accordance with accepted professional principles.** **What correctiveaction (s) will be accomplished for those residents found to have been affectedby the deficient practice**: ·The medications for Residents G and I have beenchecked for the presence of correct labels per IAC guidelines, and any medicationslacking correct labeling have been corrected. **How otherresidents having the potential to be affected by the same deficient practicewill be identified and what corrective**	08/28/2015

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	07/31/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	on 07-30-15 at 8:00 a.m., Licensed nurse removed a bottle from the medication cart. The nurse indicated the bottle contained the resident's Aspirin. The container lacked the resident's name. The resident also had Calcium Plus D (a supplement) as ordered by the physician on 03-07-15. Although the label indicated/instructed the nurse to dispense 2 tablets daily, the nurse dispensed 1 tablet. 2. Resident "I" had physician orders dated 04-03-15 for Lasix [a diuretic] 80 mg by mouth every morning. The Licensed nurse removed the medication bottle from the medication cart. The label on the medication bottle indicated to give one tablet - 40 mg in the morning and one tablet in the evening. The container lacked a direction change label to reflect the current order for 80 mg every morning. A review of the facility policy on 07-31-15 at 12:30 p.m., and titled "Preparation and General Guidelines - Medication Administration - General Guidelines," and dated January 2007, indicated the following: "Policy - Medications are administered as prescribed in accordance with good		**action(s) will be taken:** ·All residents have the potential to be affectedby the alleged deficient practice. Allresident medications have been checked for the presence of correct labels perIAC guidelines. Any meds lacking correctlabeling have been corrected. ·With each new admit or new medication orderreceived, nurses will validate they are correctly labeled or label them at thattime. **What measures willbe put into place or what systemic changes will be made to ensure that thedeficient practice does not recur**: ·Any medications that are brought in will bedocumented on the 24-hour report sheet and the nurse will verify that themediation is labelled correctly. Thefollowing nurse will be responsible for validating the label is correct on themedications. **How the correctiveaction (s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place**: ·The Assisted Living Coordinator or her designeewill audit each medication cart to ensure that all medications are properly labeledin accordance with currently accepted professional principles. The audit willalso review any medications	

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	07/31/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	nursing principles and practices and only by persons legally authorized to do so." "Procedures - 3. Prior to administration the medication and dosage schedule on the resident's medication administration record (MAR) is compared with the medication label three times. If the label and MAR are different and the container is not flagged indicating a change in directions or if there is any other reason to question the dosage or directions, the physician's orders are checked for the correct dosage schedule." An additional policy, titled "Medication Policy for Assisted Living and Memory Care," undated, indicated "In order to comply with the Indiana Administrative Code, the following criteria will be considered. Over the counter medications, prescription's drugs and biologicals used in the facility will be labeled in accordance with the currently acceptable professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable." "Labeling of prescription drugs shall include the following: 1. Resident's full name, 2. Physician name, 3. Prescription number, 4. Name of strength of the drug, 5. Directions for use, 6. Date		indicated as unavailable and promptly resolve the availabilityissue as indicated. ·These audits will be completed weekly for fourweeks and then monthly thereafter until substantial compliance has been met. Findings of these inspections will bemonitored by the Quality Assurance (QA) committee throughout the year to ensurethat substantial compliance has been met.	

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	07/31/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	of issue and expiration date (when applicable)." "Any medication with an unclear dosage must have a physician clarification before administering them. Any recent dose change will have the appropriate adhesive label attached to the bottle or care to indicated this to staff administering these meds. [medications]." This State finding is related to Complaint IN00178092.			
R 0304 Bldg. 00	410 IAC 16.2-5-6(e) Pharmaceutical Services - Deficiency (e) Medicine or treatment cabinets or rooms shall be appropriately locked at all times except when authorized personnel are present. All Schedule II drugs administered by the facility shall be kept in individual containers under double lock and stored in a substantially constructed box, cabinet, or mobile drug storage unit. Based on observation, record review and interview, the facility failed to ensure the security of medications for 2 of 2 medication carts. Findings include: During an observation on 07-31-15 at 8:00 a.m., the Medication Administration Pass was observed with Licensed nurse #14.	R 0304	**R304Pharmaceutical Services** **It is the practiceof this Community to ensure that medications are secured properly on themedication carts.** **What correctiveaction (s) will be accomplished for those residents found to have been affectedby the deficient practice**: ·No residents were identified as having been adverselyaffected by the alleged deficient practice.	08/28/2015

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	07/31/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The nurse prepared the medications for Resident "J." The nurse placed the medications Namenda (a medication used in the treatment of Alzheimers disease)14 mg (milligrams), Nifedipine (an antihypertensive medication) 30 mg, Calcium Carb. with vitamin D (a supplement) 600/200 and Therm - M (a supplement) in a plastic cup. The nurse left the area with the medications left on top of the medication cart and went into the nurses station. A confused resident was seated in a wheelchair adjacent to the medication cart. While the medication cart was left unattended the resident touched the straws and cups on the medication cart. The nurse returned to the medication cart and dispensed the medications to the resident. The nurse returned to the medication cart and prepared the medications for Resident "K." The medications included Sertraline 50 mg (an antidepressant), Aricept 23 mg (a medication use din the treatment of dementia), and Aspirin 81 mg. The nurse indicated she needed to wash her hands and left the area with the medication cart left unlocked. The nurse was out of sight of the medication cart. Then nurse returned to the medication		**How otherresidents having the potential to be affected by the same deficient practicewill be identified and what corrective action(s) will be taken:** ·All residents have the potential to be affectedby the alleged deficient practice. The community Pharmacy completed amedication pass audit for the nurses on Assisted Living Memory Support in orderto ensure the medication cart was being properly accessed and secured perprotocol. ·AL Coordinator/designee will do medication passaudits with nurses/QMA's to ensure proper procedures are being followed. **What measures willbe put into place or what systemic changes will be made to ensure that thedeficient practice does not recur**: ·Nursing staff will be re-educated on the"preparation and General Guidelines" for safe medication administration. ·Assisted Living Coordinator or her designee willcomplete medication pass audits of nurses/QMA's. Medication administration deficienciesobserved may result in disciplinary action for failure to follow theguidelines. **How the correctiveaction (s) will be monitored to ensure the deficient practice will not recur,i.e., what quality**	

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	07/31/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	cart and dispensed the medications to the resident. A review of the facility policy on 07-31-15 at 12:15 p.m., titled "Preparation and General Guidelines," and dated January 2007, indicated the following: "B - Administration - ...During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse or aide. No medications are kept on top of the cart. The cart must be clearly visible to the personnel administering medications, and and all outward sides must be inaccessible to residents or others passing by." This State finding is related to Complaint IN00178092.		**assurance program will be put into place**: ·Assisted Living Coordinator or her designee willcomplete medication pass audits of nurses/QMA's. The Assisted Living Coordinator or her designeewill observe two medication passes for four weeks, then weekly for one month,then monthly thereafter until substantial compliance has been met. ·Findings of these medication pass observationswill be monitored by the Quality Assurance (QA) committee throughout the yearto ensure that substantial compliance has been met.	