PRINTED: 05/26/2023

	r of health and hu! R medicare & medic						RM APPROVED IB NO. 0938-039
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155181		JILDING	ONSTRUCTION 00	(X3) DATE COMPL 04/25	SURVEY LETED
	PROVIDER OR SUPPLIER			118 ME	ADDRESS, CITY, STATE, ZIP COD EDICAL DR EL, IN 46032		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE
F 0000 Bldg. 00	IN00397137, IN003 IN00398768, IN004 IN00403649, and II Complaint IN00397 related to the allega and F842. Complaint IN00406 related to the allega and F842. Complaint IN00397 related to the allega and F842. Complaint IN00398 the allegations are complaint IN00406	7137-Federal/State deficiencies tions are cited at F755, F759 8770-Federal/State deficiencies tions are cited at F755, F759 6781-Federal/State deficiencies tions are cited at F755, F759 7046-Federal/State deficiencies tions are cited at F755, F759 8768-No deficiencies related to cited. 8758-No deficiencies related to cited. 8758-No deficiencies related to cited. 8758-No deficiencies related to cited.	F 00	000	The plan of correction is to so as Carmel Health & Living's credible allegation of complia Submission of this plan of correction does not constitute admission by Carmel Health livings or its management company that the allegations contained in the survey reportrue and accurate portrayal or provision of nursing care and services in this facility. Nor do this provision constitute an agreement or admission of the survey allegations. The facility respectfully requests desk review for the following citations	e an & t is a f the l other oes	

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

Complaint IN00405831-No deficiencies related to

TITLE (X6) DATE

Alyssa Holliday **HFA** 05/15/2023

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

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: LKIX11 Facility ID: 000095 If continuation sheet Page 1 of 11

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

PRINTED: 05/26/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155191		A. BU	JILDING	ONSTRUCTION 00	(X3) DATE COMPI	LETED	
		155181	B. WI	NG		04/25	/2023
	PROVIDER OR SUPPLIE			118 ME	ADDRESS, CITY, STATE, ZIP COD EDICAL DR EL, IN 46032		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	the allegations are	cited.					
	Survey dates: Apr	il 23, 24 and 25, 2023					
	Facility number: 0	00095					
	Provider number:						
	AIM number: 100						
	Census bed type:						
	SNF: 5						
	SNF/NF: 128 Total: 133						
	10tai: 155						
	Census payor type:						
	Medicare: 12						
	Medicaid: 112						
	Other: 9						
	Total: 133						
	These deficiency	offeete etate findings eitad in					
	accordance with 41	eflects state findings cited in					
	accordance with 41	10 IAC 10.2-3.1.					
	Quality review was	s completed May 3, 2023.					
F 0755	483.45(a)(b)(1)-(3	3)					
SS=D	Pharmacy						
Bldg. 00		s/Pharmacist/Records					
	§483.45 Pharmad						
	I	provide routine and					
		and biologicals to its					
		in them under an agreement					
	_	3.70(g). The facility may					
	I -	I personnel to administer					
	_	permits, but only under the					
	general supervisi	on of a licensed nurse.					
	§483.45(a) Proce	dures. A facility must					
	- ' '	eutical services (including					
		issure the accurate					
	1 -	ng, dispensing, and					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

LKIX11

Facility ID: 000095

If continuation sheet

Page 2 of 11

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	` '			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING 00 COMPLE				
		155181	B. WI	NG		04/25/	/2023	
NAME OF PROVIDER OR SUPPLIER CARMEL HEALTH & LIVING COMMUNITY			118 ME	ADDRESS, CITY, STATE, ZIP COD EDICAL DR EL, IN 46032				
CARMEL (X4) ID PREFIX TAG	summary (EACH DEFICIEN REGULATORY OF administering of a meet the needs of §483.45(b) Service must employ or of licensed pharmace §483.45(b)(1) Proceed as a spects of the proceed in the facility. §483.45(b)(2) Est records of receipt controlled drugs in an accurate record are in order and the controlled drugs is periodically recond Based on observation review, the facility scheduled medication needs of 2 of 5 residential availability. (Residential for the facility is controlled to the facility scheduled medication needs of 2 of 5 residential availability. (Residential for the facility scheduled medication needs of 2 of 5 residential for the facility scheduled medication needs of 2 of 5 residential for the facility. (Residential for the facility scheduled medication needs of 2 of 5 residential for the facility.) Findings include: 1. On 4/25/23 at 11 (Director of Nursin pulling Resident Trindicated at that times the facility indicated at that times the facility of the facility is a suppliar for the facility of the facility is a suppliar for the facility of the facility is a suppliar for the facility of	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION Ill drugs and biologicals) to f each resident. The Consultation. The facility betain the services of a ist who- vides consultation on all vision of pharmacy services ablishes a system of and disposition of all in sufficient detail to enable inciliation; and termines that drug records that an account of all is maintained and ciled. Ton, interview and record failed to ensure residents' ons were available to meet the dents reviewed for medication tents T and U) 115 a.m., LPN 12 with the DON g) in attendance was observed is morning medications. LPN 12 the, the resident's Vitamin B12	F 07	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) F755: The Facility failed to engresidents' scheduled medicative were available to meet the new of 2 of of 5 residents reviewed medication availability. 1. What Corrective Action(will be accomplished for those residents found to have been affected by the deficient practice. i. Residents T.	sure ons eds I for (s) se	(X5) COMPLETION DATE	
	Emergency Kit (E-	n the cart. The DON went to the Kit) to check if Vitamin B12 was I indicated it was not available			U without ill effects. Pharmacy notified and medication ordere Physician notified and gave fu	ed.		
	in the E-Kit, so the scheduled dose of r	resident was not given the nedication.			instructions. 2. The facility will identify			
		R (Electronic Medication			other residents that may potentially be affected by the)		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155181		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 04/25/2023	
	PROVIDER OR SUPPLIER		118 M	ADDRESS, CITY, STATE, ZIP COD EDICAL DR EL, IN 46032	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
TAG	included, but was norder: 6/17/22, Cyanocoba extended-release tal Administer one tabla and 11:00 a.m. 2. On 4/25/23 at 11 in attendance was o morning medication resident's Latanoprosolution was not away went to the E-Kit to ophthalmic solution indicated it was not resident was not give medication. Resident U's EMAF included, but was norder: 2/28/23, Latanoprosolution Administer one drough daily between 7:00 A current policy, tit Clinical Skills Valid by the ED (Executiva a.m., indicated "ME ADMINISTRATIO VALIDATIONM 60 minutes before counless otherwise dimedication was not provide an explanata notesIf a medication cart or resystem. If the Medicontact the pharmace	alamin (Vitamin B-12) blet 1,000 mcg (micrograms). let by mouth between 7:00 a.m., 222 a.m., QMA 11 with the DON bserved pulling Resident U's las. QMA 11 indicated the bost 0.005% ophthalmic lailable in the cart. The DON locheck if Latanoprost lawas available. The DON locheck if Latanoprost lawas available in the E-Kit, so the loven the scheduled dose of R, dated 4/1/23 to 4/30/23, lot limited to, the following lost ophthalmic drops 0.005%. In the provided layer of the desired layer of the la	TAG	i. All residents have the potential to be affected. In-ho audit conducted to ensure all ordered medications are available and what systems changes will be made to ensure that the deficient practice does not recur; i. All Nursing staff be re-educated on verifying accurate supply of residents medications are available as as when to re-order medicatic eliminate medications running prior to arrival of refilled medications. ii. Nursing Management will conduct we audits to ensure an accurate supply of all residents medications. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what qual assurance program will be printo place; i. The DON/design will be responsible for conduct audits daily for 5 days a week Mon-Fri for 4 weeks, biweek! 4 weeks, monthly for 9 month. The results of the audit will be reviewed at the monthly quality reviewed at the monthly quality and the position of the audit will be reviewed at the monthly quality and the position of the audit will be reviewed at the monthly quality and the position of the audit will be reviewed at the monthly quality and the position of the audit will be reviewed at the monthly quality and the position of the audit will be reviewed at the monthly quality and the position of the audit will be reviewed at the monthly quality and the position of the audit will be reviewed at the monthly quality and the position of the audit will be reviewed at the monthly quality and the position of the audit will be reviewed at the monthly quality and the position of the audit will be reviewed at the monthly quality and the position of the audit will be reviewed.	use lable. put ic will well ons to g out ekly to e lity out nee cting k y for ns. e
	,	1 /	1	1 . 5	-y

LKIX11

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMPLETE			ETED	
		155181	B. WING 04/25/2023			2023	
	PROVIDER OR SUPPLIER			118 ME	ADDRESS, CITY, STATE, ZIP COD DICAL DR EL, IN 46032		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	T	ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	``	LSC IDENTIFYING INFORMATION		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		ΓE	DATE
	and physician respo notesMed pass wa This Federal tag rela				assurance meeting until substantial compliance is achieved and maintained. Changes may be established the auditing process, based up the results of the audit. 5. By what date the systemic changes for each deficiency will be completed. i. Completed by 5/12/23	oon	
F 0759 SS=D Bldg. 00	§483.45(f) Medica The facility must e §483.45(f)(1) Med percent or greater. Based on observation review, the facility of error rate less than 5 observed during 31 of 5 residents observadministration. This rate of 9.67%. (Resident of 19.67%)	ication error rates are not 5; on, interview and record failed to keep the medication of when three (3) errors were opportunities for errors for 3 wed during medication resulted in a medication error	F 07	759	F759: The Facility failed to kee the medication err rate less tha 5% when 3 errors were observed during 31 opportunities for error for 3 of 5 residents observed during medication administration and the second to	an red ors on. error vill	05/12/2023

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER				COMPL	
		155181	B. WING			04/25/	2023
NAME OF I	PROVIDER OR SUPPLIER	2			ADDRESS, CITY, STATE, ZIP COD		
					DICAL DR		
CARMEL	. HEALTH & LIVING	5 COMMUNITY		ARME	EL, IN 46032		
(X4) ID		STATEMENT OF DEFICIENCIE		D	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	T	AG	DEFICIENCY)		DATE
		onic Medication Administration					
		ated 4/1/23 to 4/30/23, included,					
		to, the following order:			i. All residents with insu		
	i i	star U-100 Insulin pen 100			orders have the potential to be)	
) (3 ml to each pen). Administer			affected.	_	
		ously once a day between 6:00			3. What measures will be p		
	p.m., to 10:00 p.m.				into place and what systemic	;	
	2 0 4/25/22 + 11	15 am IDN 12 mid d DON			changes will be made to		
		:15 a.m., LPN 12 with the DON			ensure that the deficient		
		g) in attendance was observed s morning medications. LPN 12			practice does not recur;		
		ne, the resident's Vitamin B12			: All Niversia	-	
		the cart. The DON went to the			i. All Nursin	ig	
		Kit) to check if Vitamin B12 was			staff will be re-educated on	£	
		I indicated it was not available			verifying an accurate supply o	l	
		resident was not given the			resident's medications are available as well as when to		
	scheduled dose of n	C				oto	
	scheduled dose of h	nedication.			re-order medications to elimina	ale	
	Desident T's EMAE	R (Electronic Medication			medications running out prior arrival of refilled medications.		
		ord), dated 4/1/23 to 4/30/23,			arrival of refilled medications.		
		ot limited to, the following			ii. All Nurses		
	order:	or innited to, the following			will be re-educated on priming		
		alamin (Vitamin B-12)			insulin pen prior to administeri		
	I	blet 1,000 mcg (micrograms).			Insum pen phor to auministen	ııg.	
		let by mouth between 7:00 a.m.,			iii. Nursing		
	and 11:00 a.m.				Management will conduct wee	klv	
					audits to ensure an accurate		
	3. On 4/25/23 at 11	:22 a.m., QMA 11 with the DON			supply of all resident's		
		bserved pulling Resident U's			medications.		
		ns. QMA 11 indicated the			4. How the corrective		
	_	ost 0.005% ophthalmic			action(s) will be monitored to	,	
	-	ailable in the cart. The DON			ensure the deficient practice		
		check if Latanoprost			will not recur, i.e., what quali		
		n was available. The DON			assurance program will be p	-	
	_	available in the E-Kit, so the			into place;	-	
		ven the scheduled dose of					
	medication.				i. The		
					DON/designee will be respons	sible	
	Resident U's EMAI	R, dated 4/1/23 to 4/30/23,			for conducting audits daily of		
	included, but was not limited to, the following				medication carts to ensure all		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		l í		ONSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155181	A. BU B. W	UILDING ING	00	COMPI 04/25	
Mar er -	DOLUDED OD COMPT			STREET A	ADDRESS, CITY, STATE, ZIP COD		
	PROVIDER OR SUPPLIE				EDICAL DR		
	. HEALTH & LIVING				EL, IN 46032		,
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	,	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION DATE
	order:				ordered medications are avai	lable	
	2/28/23, Latanopro	st ophthalmic drops 0.005%.			for 5 days a week Mon-Fri for	· 4	
		op to both eyes topically once			weeks, biweekly for 4 weeks,		
	daily between 7:00	a.m., and 11:00 a.m.			monthly for 9 months. The re-		
		d 1017 121 27 12			of the audit will be reviewed a	at the	
		tled "Licensed Nurse Med Pass dation," undated and provided			monthly quality assurance		
		ve Director) on 4/25/23 at 10:30			meeting until substantial compliance is achieved and		
	a.m., indicated "MI				maintained. Changes may be		
	ADMINISTRATIO				established to the auditing	•	
		ledication was given within the			process, based upon the resu	ults of	
	60 minutes before	or after the time designated			the audit.		
		rected by the physicianIf					
		t administered as ordered,			ii. The		
	_	tion on e-mar or progress			DON/designee will be respon		
		ion is not found in the			for conducting audits daily of		
		med room, access the CUBEX			insulin administration for 5 da	ıys a	
	-	ication cannot be found, cy/back up pharmacy (after			week Mon-Fri for 4 weeks,	y for	
	-	and the physician for further			biweekly for 4 weeks, monthly 9 months. The results of the a	=	
	*	val. Document your process			will be reviewed at the month		
		onse in your nursing			quality assurance meeting un	-	
		as not interrupted"			substantial compliance is		
	-	-			achieved and maintained.		
	_	lates to Complaints IN00397137,			Changes may be established	to	
	IN00398770, IN00	406781and IN00397046.			the auditing process, based u	ıpon	
	2.1.40(.)(1)				the results of the audit.		
	3.1-48(c)(1)				5 By what data the		
					5. By what date the systemic changes for each		
					deficiency will be completed	d.	
					and the second s		
					i. Complet	ed	
					by 5/12/23		
F 0842	183 20(f)(E) 102	70(i)(1)_(5)					
SS=D	483.20(f)(5), 483.	s - Identifiable Information					
Bldg. 00		sident-identifiable information.					
J. 22	_ ,,,,	not release information that					
	is resident-identifi						

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	T OF HEALTH AND HO R MEDICARE & MEDIO					ORM APPROVED OMB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155181			(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	COM	TE SURVEY IPLETED 25/2023
	PROVIDER OR SUPPLIE		118 ME	address, city, state, zip EDICAL DR EL, IN 46032	COD	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
TAG	(ii) The facility mare resident-identifial accordance with agent agrees not information exceptiself is permitted §483.70(i) Medic §483.70(i) (1) In a professional stanfacility must main each resident that (i) Complete; (ii) Accurately do (iii) Readily accestive) Systematicall §483.70(i)(2) The confidential all intresident's records regardless of the the records, excet (i) To the individual representative will law; (ii) Required by L	ay release information that is ble to an agent only in a contract under which the to use or disclose the pt to the extent the facility to do so. al records. accordance with accepted dards and practices, the stain medical records on at are- cumented; ssible; and by organized be facility must keep formation contained in the ss, form or storage method of ept when release is- placed in the resident there permitted by applicable	TAG			DATE
	operations, as per compliance with (iv) For public her abuse, neglect, of oversight activities proceedings, law organ donation profession or or to coroners, madirectors, and to	ermitted by and in				

FORM CMS-2567(02-99) Previous Versions Obsolete

compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTI	IPLE CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILD	ING <u>00</u>	COMPLETED	
		155181	B. WING		04/25/2023	
NAME OF I	DD OVADED OD GUDDU IEI		ST	TREET ADDRESS, CITY, STATE, ZIP COD		
	PROVIDER OR SUPPLIEF		11	18 MEDICAL DR		
CARMEI	L HEALTH & LIVING	G COMMUNITY	C	ARMEL, IN 46032		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		II	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE COM EL TOT	
TAG	1	R LSC IDENTIFYING INFORMATION	TA	AG DEFICIENCY)	DATE	
	destruction, or un	formation against loss, authorized use.				
	§483.70(i)(4) Med retained for-	lical records must be				
		me required by State law; or				
		n the date of discharge				
	· ,	requirement in State law; or				
		years after a resident				
	reaches legal age	under State law.				
	8483 70(i)(5) The	medical record must				
	contain-	modical record mast				
	(i) Sufficient inforr	nation to identify the				
	resident;	•				
	(ii) A record of the	e resident's assessments;				
		ensive plan of care and				
	services provided					
	1 ' '	any preadmission				
		sident review evaluations and				
		onducted by the State;				
	professional's pro	urse's, and other licensed				
		idiology and other diagnostic				
		is required under §483.50.				
		on, interview and record	F 0842	F842: The facility failed to er	usure 05/12/2023	
		failed to ensure a resident's		a resident's medications wer		
	medications were c	ompletely and accurately		completely and accurately		
		EMAR (Electronic Medication		documented on the EMAR		
		cord) for 1 of 5 residents		(electronic medication		
		ation administration		administration record) for 1 c		
	documentation. (Re	esident T)		residents reviewed for medic		
	Finding includes:			What Corrective Action	•	
				will be accomplished for th		
		2 a.m., QMA 11 with the DON		residents found to have be	en	
		g) in attendance was observed		affected by the deficient		
		s morning medications. QMA		practice.		
		sident's Latanoprost 0.005%				
	L ophthalmic solution	was not available in the cart.		i Resident U with	out I	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 04/25/2023 155181 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 118 MEDICAL DR CARMEL HEALTH & LIVING COMMUNITY CARMEL. IN 46032 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE The DON went to the E-Kit to check if ill effect. Latanoprost ophthalmic solution was available. The facility will identify The DON indicated it was not available in the other residents that may E-Kit, so the resident was not given the scheduled potentially be affected by the dose of medication. practice. Resident U's EMAR (Electronic Medication i. All residents have the Administration Record), dated 4/1/23 to 4/30/23, potential to be affected. included, but was not limited to, the following 3. What measures will be put orders: into place and what systemic 1/06/23, Hydrochlorothiazide tablet 25 mg. changes will be made to Administer one tablet by mouth once daily ensure that the deficient between 7:00 a.m., and 11:00 a.m., for high blood practice does not recur; pressure. 2/28/23, Latanoprost ophthalmic drops 0.005%. i. All qualified nursing Administer one drop to both eyes topically once staff were re-educated on daily between 7:00 a.m., and 11:00 a.m., for documenting at the time of glaucoma. administering medications. How the corrective The documentation box for Hydrochlorothiazide action(s) will be monitored to for the 4/25/23 between 7:00 a.m., and 11:00 a.m., ensure the deficient practice did not have any initials in the box. QMA 11 was will not recur, i.e., what quality observed during a medication pass administering assurance program will be put this medication to Resident U but failed to sign into place; the medication off after administering the medication. The DON/designee will be responsible for conducting The documentation box for Latanoprost audits of EMAR accuracy daily for ophthalmic solution for the date 4/25/23 between 5 days a week Mon-Fri for 4 7:00 a.m., and 11:00 a.m., had QMA 11's initials in weeks, biweekly for 4 weeks, the box. QMA 11 was not observed during the monthly for 9 months. The results medication pass administering this medication due of the audit will be reviewed at the to the medication was not available to be given to monthly quality assurance the resident. meeting until substantial compliance is achieved and A current policy, titled "Licensed Nurse Med Pass maintained. Changes may be Clinical Skills Validation," undated and provided established to the auditing by the ED (Executive Director) on 4/25/23 at 10:30 process, based upon the results of a.m., indicated "MEDICATION the audit. ADMINISTRATION SKILLS 5. By what date the

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

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155181	(X2) MUI A. BUI B. WIN	LDING	ONSTRUCTION 00	(X3) DATE COMPI 04/25	LETED
NAME OF PROVIDER OR SUPPLIER CARMEL HEALTH & LIVING COMMUNITY		•	118 ME	ADDRESS, CITY, STATE, ZIP COD EDICAL DR EL, IN 46032			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
	60 minutes before unless otherwise dimedication was no provide an explana notesIf a medical medication cart or system. If the Medicontact the pharma hours) for reorder a instructions till arrand physician respinotesMed pass with the provided that the pharma and physician respinotesMed pass with the pharma and physician respinotesMedical pass with the pharma and physician respinoresMedical physician respinores with the pharma and physician respinores with the physician respinores with the physician respinores with the	Medication was given within the or after the time designated irected by the physicianIf it administered as ordered, ition on e-mar or progress ition is not found in the med room, access the CUBEX ication cannot be found, acy/back of pharmacy (after and the physician for further ival. Document your process onse in your nursing ras not interrupted" lates to Complaints IN00397137, 1406781 and IN00397046.			systemic changes for each deficiency will be complete i. Completed by 5/12/23		

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: LKIX11 Facility ID: 000095 If continuation sheet Page 11 of 11