STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155181	A. BUILDING 00 B. WING	08/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARMEL HEALTH & LIVING COMMUNITY	118 MEDICAL DR 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 a Recertification and State Licensure. This visit was in conjunction of the Investigation of Complaint IN00239010. Complaint IN00239010 - Unsubstantiated due to lack of evidence. Survey dates: August 22, 23, 24, 25, 28, 29 and 30, 2017 Facility number: 000095 Provider number: 155181 AIM number: 100290490 Census bed type: SNF / NF: 152 Total: 152 Census payor type: Medicare: 13 Medicaid: 110 Other: 29 Total: 152 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.	F 0000	**This plan of correction is to serve as Carmel Health & Living Community's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Carmel Health & Living Community or its management company that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in this facility. Neither does this submission constitute an agreement or admission of the survey allegations. We respectfully request a desk review in lieu of a post-survey revisit.**	

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155181	A. BUILDING 00 B. WING	08/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARMEL HEALTH & LIVING COMMUNITY	118 MEDICAL DR 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
	Quality Review was completed on September 6, 2017.			
F 0258 SS=D Bldg. 00	483.10(i)(7) MAINTENANCE OF COMFORTABLE SOUND LEVELS (i)(7) For the maintenance of comfortable sound levels. Based on observation, interview and record review the facility failed to maintain comfortable sound levels for 1 of 1 residents observed for comfortable sound levels (Resident 47). Finding Includes: During a staff interview, with Unit Manager 1, on 08/23/2017, at 9:43 a.m., CNA 2 and CNA 3 were observed shouting down a long resident hallway to one another, concerning who should answer a patient call light. Unit Manager 1 interrupted the interview and instructed CNA 2 and CNA 3 not to shout in the facility. At that time, Unit Manager 1 indicated CNA 2 and CNA 3 should not have been shouting down the resident hallway. During an interview on 08/23/2017, at 02:14 p.m., Resident 47 indicated the staff socialized in the hall during care and spoke loudly.	F 0258	**I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** The facility will ensure comfortable sound levels will be maintained in all areas for residents. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All residents have the potential to be affected by the	09/18/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155181	A. BUILDING 00 B. WING	08/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARMEL HEALTH & LIVING COMMUNITY	118 MEDICAL DR 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 current facility policy titled, "Noise Control", received from the Director of Nursing on 08/29/2017, at 11:37 a.m., indicated, "...Resident care should be provided in a manner that promotes calm, organized and comfortable sound levels...Personnel should refrain from making loud noises or talking in a loud voice when communicating with coworkers and during shift changes. Personnel should refrain from shouting from one room or section to another...." 3.1-19(f)		alleged deficient practice. Full house audit will be completed by Caring Hearts Representatives/Designee to ensure comfortable sound levels. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** All staff will be educated on maintaining a comfortable sound level in all areas for residents. The systematic change includes educating all new staff in general orientation and annually thereafter on maintaining an appropriate sound level in all resident areas. Signs will be posted in non-resident areas to remind staff to maintain comfortable noise levels in resident areas. **IV The facility will monitor**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155181	A. BUILDING 00 B. WING	08/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARMEL HEALTH & LIVING COMMUNITY	118 MEDICAL DR 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 corrective action by implementing the following measures. Administrator/Designee will audit systematic changes utilizing an audit tool daily for 4 weeks, weekly for 4 weeks then monthly for 4 months. Results of this audit will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of the reviews will be adjusted as needed. Facility Administrator will be responsible for ensuring compliance.	
F 0329 SS=D Bldg. 00	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used--			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155181	A. BUILDING 00 B. WING	08/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARMEL HEALTH & LIVING COMMUNITY	118 MEDICAL DR 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
	(1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; Based on interview and record review the facility failed to monitor for therapeutic Digoxin levels for 1 of 5 resident reviewed for unnecessary medications. (Resident 132)	F 0329	**I. The corrective actions to be accomplished for those**	09/18/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155181	A. BUILDING 00 B. WING	08/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARMEL HEALTH & LIVING COMMUNITY	118 MEDICAL DR 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
	Findings include: The record for Resident 132 was reviewed on 8/30/17 at 8 a.m. Diagnosis included, but were not limited to, dehydration, hypokalemia, ischemic cardiomyopathy, nonrheumatic mirtal valve insuffciency, nonrheumatic tricuspid valve insufficiency, nonrheumatic aortic valve stenosis and essential hypertension. Current physician orders indicated an order ford digoxin with a start date of 11/2/16. Physician orders did not list any labortory draws previously, currently or in the future for blood monitoring of therapeutic medications levels for digoxin. There were no laboratory results in the record to indicate monitoring of a therapeutic digoxin level. A "Note To Attending Physician/Prescriber", dated 8/17/17, from (company name) indicated "The following lab work is recommended for appropriate monitoring.....1. serum digoxin level next lab day and monthly thereafter.... Physician/Prescriber Response....Agree." During an interview with the DON		**residents found to have been affected by the deficient practice.** Resident #132 received labs related to use of digoxin. Lab values were normal and MD was notified **II. The facility will identify other residents that may potentially be affected by the deficient practice.** Residents receiving Digoxin could be affected by the alleged deficient practice. Residents receiving this medication were reviewed by the Pharmacist and recommendations to the MD were made as necessary. **III. The facility will put into place the following systematic changes to**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155181	A. BUILDING 00 B. WING	08/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARMEL HEALTH & LIVING COMMUNITY	118 MEDICAL DR 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
	(Director of Nursing) on 8/30/17 at 8:20 AM she indicated laboratory draws were completed on Tuesdays and Thursdays. August 22, 24 and 29 were all laboratory draw days. 3.1-48(a)(3)		**ensure that the deficient practice does not recur.** The consulting Pharmacist will review all residents receiving Digoxin and make recommendations to the MD as needed during their monthly review. All licensed nurses will be educated on Digoxin and lab monitoring. **IV The facility will monitor the corrective action by implementing the following measures.** DON or designee will audit residents taking Digoxin for ordered labs five times per week for 4 weeks, then weekly for 4 weeks; then, monthly thereafter totaling 12 months. Pharmacy recommendations regarding Digoxin will be audited monthly by the DON or designee to ensure recommendations are	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155181	A. BUILDING 00 B. WING	08/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARMEL HEALTH & LIVING COMMUNITY	118 MEDICAL DR 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
			followed through as needed with the resident's MD. Results of this audit will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed. Facility Administrator will be responsible for ensuring compliance.	
F 0371 SS=E Bldg. 00	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155181	A. BUILDING 00 B. WING	08/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARMEL HEALTH & LIVING COMMUNITY	118 MEDICAL DR 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
	(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. Based on observation, interview, and record review the facility failed to ensure food was labeled with an open date, expired foods were disposed of, and employee food was not stored in resident nourishment refrigerators. This deficient practice had the potential to affect 150 of 152 residents who receive food from the kitchen. Findings Include: During the tour of the kitchen, on, 8/22/2017 at 10:22 a.m., with the Dietary Manager, the Clinical Dietary Manager and the Director of Dining Services, the following observations were made: 1. The reach in refrigerator was observed to have a 32 ounce carton of liquid eggs without an open date. 2. The dry storage area was observed to have a 12 ounce can of evaporated milk unopened with an expiration date of 03/20/2017.	F 0371	**I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** No residents were found to be affected by the alleged deficient practice. The creamer was disposed of on 8/22/17 The liquid eggs were disposed of on 8/22/17 Employee's belongings were removed from resident food pantry area on 8/22/17 **II. The facility will identify**	09/18/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155181	A. BUILDING 00 B. WING	08/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARMEL HEALTH & LIVING COMMUNITY	118 MEDICAL DR 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
	3. The satellite refrigerator on hall 700 was observed to have a take out container of Chinese food, a water bottle, and 2 oranges all without a name and open date label attached. At that time the Dietary Manager indicated she could not determine if the food was a resident's or belonged to an employee. 4. The satellite refrigerator on the 500 hall was observed to have 2 plastic Pepsi soda bottles, a glass dish with tuna salad, and an open 15 ounce glass jar of cheese dip all without a name and open date label attached. 5. The satellite refrigerator on the Woodland hall was observed to have 6- 4 ounce frozen mighty shakes with an expiration date of 07/2017. At that time the Dietary Manager indicated that all expired food should be discarded. During an interview, on 08/30/2017 at 10:07 a.m., with the Director of Nursing, she indicated it is a standard of practice to not store employee foods in resident refrigerators and to place open dates on open food products. A undated document posted on all satellite refrigerators provided by the Dietary manager, on 08/22/2017 at 1:40		**other residents that may potentially be affected by the deficient practice.** All residents have the potential to be affected by the alleged deficient practice. No residents have experienced any food borne illness symptoms. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** Dietary manager and all kitchen staff were educated regarding proper food storage. All staff were educated regarding food storage in resident food pantries. **IV The facility will monitor the corrective action by implementing the following**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155181	A. BUILDING 00 B. WING	08/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARMEL HEALTH & LIVING COMMUNITY	118 MEDICAL DR 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., indicated "Attention all staff effective immediately, this refrigerator is for the resident use only. Do not put any personal items inside or it will be thrown away." A current policy titled "Food and Non-Food Storage" dated 2013 received from the Dietary Manager, on 8/22/2017 at 1:07 p.m., indicated "...11. For both perishable and non-perishable items, the use-by and expiration dates are checked...." 3.1-21(i)(2) 3.1-21(i)(3)		**measures.** The DM/Designee will perform a food storage audit 3 x weekly x 4 weeks, weekly x 4 weeks, then monthly x 4 months The DON/Designee will perform a food storage audit of the food pantries daily x 4 weeks, weekly x 4 weeks, then monthly x 4 months. . Results of this audit will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed. Facility Administrator will be responsible for ensuring compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155181	A. BUILDING 00 B. WING	08/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARMEL HEALTH & LIVING COMMUNITY	118 MEDICAL DR 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 0431 SS=E Bldg. 00	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. 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 when applicable. (h) Storage of Drugs and Biologicals.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155181	A. BUILDING 00 B. WING	08/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARMEL HEALTH & LIVING COMMUNITY	118 MEDICAL DR 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
	(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.			
	Based on observation, interview and record review, the facility failed to safely store medications in 1 of 6 medication carts, failed to ensure expired medication was discarded appropriately in 3 of 6 medication rooms, failed to ensure a controlled substance was stored under a double lock in 1 of 6 medication rooms and failed to ensure medications had a pharmacy label in 2 of 6 medication rooms observed. Findings Include: 1. During a tour of the unit 800 medication storage room, on 08/22/2017 at 11:20 a.m., with the UM (unit manager) in attendance, the following was observed:	F 0431	**I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** No residents were found to be affected by the alleged deficient practice. A lock was placed on the medication storage refrigerator on 8/22/17 Expired medication and supplies were properly disposed of on the date they	09/18/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155181	A. BUILDING 00 B. WING	08/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARMEL HEALTH & LIVING COMMUNITY	118 MEDICAL DR 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 a cabinet containing diabetic supplies, 13 Boxes of Easy-max blood glucose test strips (used to check blood sugar levels) containing 50 strips per box, with an expiration date of August 2012, and two open Glucagon kits (an injectable emergency medication to treat low blood sugar) with no resident name. In a separate cabinet, one open box of Ducolax (a medication for constipation) tablets without a resident's name and an expiration date of 2014. During an interview at that time, the UM indicated medications to be sent back to pharmacy were placed into a gray tote box on the countertop, expired medications were crushed and disposed of in trash bins or flushed down the toilet, and controlled medications should have been disposed of in a drug buster, but she could not locate one in the medication room. A drawer contained: 9 Gray Vacutainers (a sterile glass tube used to collect blood samples) with an expiration date of 06/2015 25 Red Vacutainers with an expiration date of 12/2015 2 Green Vacutainers with an expiration date of 12/2015 13 blue Vacutainers with an expiration date of 09/2010		were noted. Loose pills noted in medication cart drawers were disposed of on 8/25/17. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All residents had the potential to be affected by the alleged deficient practice. All medication carts and medication storage areas have been audited and any outdated items were disposed of. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155181	A. BUILDING 00 B. WING	08/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARMEL HEALTH & LIVING COMMUNITY	118 MEDICAL DR 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
	22 purple Vacutainers with an expiration date of 09/2009 9 Lavender Vacutainers with an expiration date of 05/2011 12 clave connector multi-dose vials (an adapter used to connect a glass vile of medication to an IV bag) with an expiration date of 06/2017 2 glass vials of normal saline with an expiration date of 04/03/2014 During an interview at that time, the UM indicated the supplies should have been disposed of. The medication refrigerator contained: Two open 30 ml (milliliter) bottles of liquid lorazepam (a schedule IV anti-anxiety medication) without open dates, which were not secured in a locked container. During an interview at that time, the UM indicated all controlled substances should have been stored under double lock. 2. During a tour of the unit 400 medication cart, on 08/25/2017 at 02:28 p.m., with LPN 1 in attendance, the following was observed: One green and blue capsule and one half round white tablet in the ledge above the top drawer. One round black tablet, one oval white and blue tablet and one yellow		The systemic change includes the medication rooms and medication carts will be routinely audited using a quality assurance tool to determine proper storage is in place. All licensed nurses have been educated on appropriately securing narcotic medications in medication room storage. All licensed nurses have been educated on reviewing medication and supplies kept in medication room storage for expiration. **IV The facility will monitor the corrective action by implementing the following measures.** DON or designee will audit medication room storage to ensure narcotics are secured appropriately five times per week for 4 weeks, then weekly for 4 weeks; then, monthly	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155181	A. BUILDING 00 B. WING	08/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARMEL HEALTH & LIVING COMMUNITY	118 MEDICAL DR 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
	capsule loose in drawer three. One white oval tablet and one half white oval tablet loose in drawer seven. During an interview at that time, LPN 1 indicated no loose pills should have been left in the medication cart. 3. During a tour of the unit 300 medication storage room, on 08/25/2017 at 03:08 p.m., with LPN 2 in attendance, the following was observed: A cabinet with four foil pouches each containing five albuterol vials (a medication used to treat breathing difficulties) out of the original box with no patent name. A drawer with one open 4 cm (centimeter) x 4 cm xeroform (medicated gauze) dressing, and three 100 ml Heparin (a blood thinner) syringes with an expiration date of 06/29/17. During an interview at that time, LPN 2 indicated expired, unlabeled, and open medications should have been disposed of. 4. During a tour of the unit 700 medication storage room, on 08/28/2017 at 10:49 a.m., with LPN 3 in attendance, the following was observed:		thereafter totaling 12 months. DON or designee will perform a medication storage audit five times per week for 4 weeks, then weekly for 4 weeks; then, monthly thereafter totaling 12 months. DON or designee will perform a supply storage audit weekly x 12 weeks, then monthly thereafter totaling 12 months. Results of this audit will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed. Facility Administrator will be responsible for ensuring compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155181	A. BUILDING 00 B. WING	08/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARMEL HEALTH & LIVING COMMUNITY	118 MEDICAL DR 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
	Stored in a cabinet with various supplies were one 887 ml open bottle of Prostat (a protein supplement) with an expiration date of 08/17, one 473 ml bottle of milk of magnesia (a laxative), two boxes containing 30 vials each of albuterol and two open 200 count bottles of chewable calcium antacid tablets marked with the names of discharged residents. During an interview at that time, LPN 3 indicated medications for residents no longer at the facility should have been disposed of. An undated facility policy titled, "Drug Storage", received from the director of nursing on 08/25/17 at 1:30 p.m., indicated, " ...policy... All expired, damaged and or contaminated medications are removed from resident care areas and stored separately from medications available for administration... procedures... 1. Medications are to remain in the containers in which they were dispensed. Only Pharmacy Personnel may transfer medications from one container to another ... 5. Medications labeled for individual residents are stored separately from floor stock medications when not in the medication cart ... 9. Discontinued and expired medications should be removed from medication carts,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155181	A. BUILDING 00 B. WING	08/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARMEL HEALTH & LIVING COMMUNITY	118 MEDICAL DR 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
	refrigerators and cupboards promptly. Return drugs or destroy according to pharmacy and facility policies. Discontinued drug containers shall be marked to indicate that the drug has been discontinued... 10. All class II drugs must be stored under double lock at all times ... class III, IV and V drugs are also stored under double lock as best practice guideline. 3.1-25(j) 3.1-25(n) 3.1-25(o) 3.1-25(r)			