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	07/26/2016

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 Survey. This visit included the Investigation of Complaints IN00196125 and IN00200688. Complaint IN00196125-Substantiated. Federal/State deficiencies related to the allegations are cited at F157, F323, F332. Complaint IN00200688-Substantiated. Federal/State deficiencies related to the allegations are cited at F332. Survey dates: July 18, 19, 20, 21, 22, 25 & 26, 2016. Facility number: 000095 Provider number: 155181 AIM: 100290490 Census bed type: SNF: 11 SNF/NF: 137 Total: 148 Census payor type: Medicare: 13 Medicaid: 119 Other: 16	F 0000	Submission of this plan of correction in no way constitutesan admission by Carmel Health and Living or its management company that theallegations contained in the survey report/2567 is a true and accurateportrayal of the provision of nursing care or other services provided in thisfacility. The Plan of Correction isprepared and executed solely because it is required by Federal and StateLaw. The Plan of Correction is submittedin order to respond to the allegation of noncompliance cited during the Annual/ComplaintSurveys on July 18-26, 2016. Pleaseaccept this plan of correction as Carmel Health and Living's credibleallegation of compliance by August 20, 2016. The facility respectfully requests a desk review of the 2567/Plan of correction of alleged deficiencies This statement of deficiencies and plan of correction willbe reviewed at the September Quality Assurance/Assessment Committee meeting.	

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
	155181	A. BUILDING 00 B. WING	07/26/2016

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
	Total: 148 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality Review was completed by 21662 on August 1, 2016.			
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.			

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	07/26/2016

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 facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on interview and record review, the facility failed to notify a family member of a fall for 1 of 3 residents reviewed for notification of change. (Resident B) Finding includes: During an interview on 07/22/2016 at 8:40 a.m., the resident's family member indicated she had filled out numerous admission forms with the admissions coordinator and had provided her cell phone number on these forms. She indicated she always kept her cell phone with her. She indicated she was notified by the private caregiver the morning of 03/01/2016 of the resident's fall. She indicated she was told by the private caregiver the resident had informed him of the fall when he came to visit on the morning of 03/01/2016, and the caregiver immediately phoned her to let her know what happened. During an interview on 07/22/2016 at 11:25 a.m., the DON (Director of Nursing) indicated the staff would have had access to admission paperwork for contact information in the resident's hard	F 0157	Notify of Changes It is the practice of this provider to ensure that theresident's physician and responsible party are promptly notified regarding asignificant change in condition. **What correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice?** ·Resident B does not reside in the facility anylonger. ·All residents with a change in condition havethe potential to be affected by the alleged deficient practice. **How will you identifyother residents having the potential to be affected by the same deficientpractice and what corrective action will be taken?** ·The facility IDT updates responsible partynotification information during care plan meetings as needed. ·Residents with current changes of condition,including residents with falls in the last 30 days were reviewed and confirmedthat the MD and responsible party was notified. ·All resident face sheets will be reviewed toensure an	08/22/2016

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	07/26/2016

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
	chart. She indicated it was the responsibility of the nursing staff to enter the contact information from the admission paperwork for each new resident into the electronic medical record. On 07/22/2016 at 1:43 p.m., the resident's medical record was reviewed. Diagnoses included, but were not limited to, neuromuscular dysfunction of the bladder and corticobasal degeneration. A document located in the electronic chart titled, "APPLICATION FOR LONG TERM CARE SERVICES", dated 02/25/2016, indicated the name, address and phone number of the resident's family member. A document titled "face sheet" located in the electronic chart indicated, "...Relationship/Spouse. Name/[name of family member]. Responsibilities/Emergency Contact. Call order/1. Phone/[phone number of family member] Primary...." An untitled document dated 02/29/2016, indicated an additional family member's phone number was listed as a contact person. A document titled, "Event Report" dated 03/01/2016, indicated, "...NOTES...dated 02/29/2016 at 8:00 p.m., resident found		accurate/current responsible party notification number exists. **What measures will beput into place or what systemic changes you will make to ensure that thedeficient practice does not recur**? • Allchanges of condition events, including fall events, are reviewed daily inclinical meeting by the Interdisciplinary Team (IDT) Monday through Friday andby the Weekend manager on Saturday and Sunday. Any changes in condition, including falls, will be reviewed for immediateintervention and responsible party and physician notification. • Licensednursing staff received education on identifying and reporting changes inresident condition with emphasis on falls with immediate intervention andnotification to responsible parties and physician. **How will thecorrective action(s) be monitored to ensure the deficient practice will notrecur, i.e., what quality assurance program will be put into place?** • An audittool will be used by DON/Admin/designee weekly x 8 weeks, and monthly x 2 weeks to ensure notification is completed. • Anyidentified concerns from audits will be addressed immediately. • Employeesnot adhering to policy will be re-educated up to and including termination.	

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	07/26/2016

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
	by this writer in room at side of bed, when asked was he trying to get out of bed he gave the thumbs up. can, [sic] nurse and this writer put the resident back in bed. [Name of healthcare provider], contacted. No family listed as contacts. DON notified. no injury noted. VS [vital signs] WNL [within normal limits] et [and] recorded on incident report. Will continue to monitor." A current policy titled "Change in a Resident's Condition or Status" dated 2001, revised October 2010, provided by the Administrator on 07/26/2016 at 2:35 p.m., indicated "Policy statement. Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, ect.)...3. Unless otherwise instructed by the resident, the Nurse Supervisor/Charge Nurse will notify the resident's responsible party or family when: a. The resident is involved in any accident or incident that results in an injury including injuries of an unknown source. b. There is a significant change in the resident's physical, mental or psychosocial status...." This Federal tag relates to Complaint		• Theresults of these audits will be discussed at the monthly facility QualityAssurance Committee meeting for a minimum of 6 months and frequency andduration of reviews will be adjusted as needed. Facility Administrator is responsible for ensuring compliance. Compliance Date: August 22, 2016	

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	07/26/2016

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
	IN00196125. 3.1-5(a)(1)			
F 0164 SS=D Bldg. 00	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. Based on observation and interview, the facility failed to ensure privacy was	F 0164	**F164** It is the practice of this provider to	08/22/2016

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	07/26/2016

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
	provided for 1 of 1 resident observed for privacy provided by a staff member (Resident #52). Finding includes: During a resident interview on 7/18/16 at 3:02 p.m., Resident #52 indicated the staff in the facility did not knock on her door or knock and wait for her to tell them to enter her room prior to entering her room. She indicated she did not feel like she had enough privacy in her room. She indicated she did not want anyone seeing her naked as that was embarrassing to her. On 7/18/16 at 4:16 p.m., the Maintenance Director with the Administrator in attendance opened Resident #52's bathroom door without knocking on it prior to opening it. He indicated when asked if he was going to knock on the bathroom door prior to opening the door, he had seen the resident go down the hallway and she was not in the bathroom. When the Maintenance Director opened the bathroom door, Resident #52 was standing at the bathroom sink. He closed the door and indicated he thought the resident was out of her room and down the hallway. Resident #52 came out of the bathroom and indicated to the Maintenance Director she had "just"		ensure that theresident has the right to personal privacy and confidentiality. **What correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice?** ·The Maintenance Supervisor apologized to theresident immediately. The MaintenanceSupervisor was provided one on one education related to personal privacy andknocking prior to entering a closed door in a resident room. **How will you identifyother residents having the potential to be affected by the same deficientpractice and what corrective action will be taken?** • Allresidents who reside in the facility have the potential to be affected by thealleged deficient practice. **What measures will beput into place or what systemic changes you will make to ensure that thedeficient practice does not recur?** ·All facility staff received education on affordingpersonal privacy to residents. ·Facility managers are assigned groups ofresident rooms in which they will interview residents and families everyquarter using the QIS tool to ensure privacy is being maintained. **How will thecorrective action(s) be monitored to ensure the deficient**	

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	07/26/2016

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
	talked about staff coming into her room without knocking on her door. She asked him what he would have done if she would have been sitting on the toilet and indicated he would have seen her "bare bottom". During an interview on 7/19/16 at 8:18 a.m., the Maintenance Director indicated he should always knock on the residents' doors prior to opening them. 3.1-3(o)		**practice will notrecur, i.e., what quality assurance program will be put into place?** ·The QIS interview tool will be utilized weekly x4 and monthly x 2 with interviewable residents and their responsible parties toensure their privacy is maintained. ·Any identified concerns from audits will beaddressed immediately. ·Employees not adhering to policy will bere-educated up to and including termination. ·The results of these audits will be discussed atthe monthly facility Quality Assurance Committee meeting for a minimum of 6months and frequency and duration of reviews will be adjusted as needed. Facility Administrator is responsible for ensuringcompliance. Compliance Date: August 22, 2016	
F 0242 SS=D Bldg. 00	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. Based on observation, interview and record review, the facility failed to ensure a resident's preference was met and	F 0242	**F242** It is the practice of this provider to ensure that theresidents' have the	08/22/2016

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	07/26/2016

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
	showers were given per his choice for 1 of 3 residents reviewed for choices (Resident #33) and failed to ensure smoking rules for the facility were universally followed for all residents residing in the facility who were reviewed for the facility policy prohibiting smoking. This deficient practice had the potential to affect 82 of 148 residents without cognitive impairment residing in the facility. Findings include: 1. During a resident interview on 7/19/16 at 11:13 a.m., Resident #33 indicated he had one of his showers forgotten at least once a month. He indicated his showers were scheduled on Mondays and Thursdays at 7:10 a.m., so he would have hot water for his showers. He indicated he had to wait until 8:30 a.m., and he still did not get his showers at times. He indicated there was a lot of turnover of CNA's and there was a lack of communication between the CNA's about the time his showers were scheduled and that was why he had to sit out in the hallway waiting for his showers or had not gotten them at all. The "CNA Daily Assignment" sheet indicated the resident's shower days were Mondays and Thursdays on dayshift.		right to make choices. **What correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice?** ·Resident #33 was interviewed by Social Servicesand his preferences for this shower were updated. ·The facility has amended the smoking policy. **How will you identifyother residents having the potential to be affected by the same deficientpractice and what corrective action will be taken?** ·All residents who reside in the facility whohave a preference on bathing have the potential to be affected. ·Preferences are gathered at admission, careplans and at any time the resident wishes to change their preference. ·All residents who are opposed to residents whosmoke have the potential to be affected by the facility smoking policy beingamended. ·The policy has been amended to allow currentresidents who smoke to smoke on the facility property in the parking lot ifthey are cognitively able after assessment. No new residents admitted will be allowed to smoke per policy. **What measures will beput into place or what systemic changes you will make to ensure that thedeficient practice does not**	

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	07/26/2016

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 "Shower Sheets" indicated the resident received showers on these dates in June 2016: 6/2/16 6/6/16 6/9/16 6/13/16 6/16/16 6/20/16 6/23/16 The resident did not documentation of showers for 6/27/16 and 6/30/16. The "Shower Sheets" indicated the resident received showers on these dates in July 2016: 7/4/16 7/7/16 7/11/16 7/18/16 7/21/16 7/25/16 The resident did not have documentation of a shower for 7/14/16. During an interview on 7/25/16 at 2:40 p.m., the Director of Nursing indicated she did not have any further shower documentation for this resident. She indicated she was missing documentation for two showers for June 2016 and one		**recur?** ·All staff received education on assistingresidents with making changes to their preferences and reporting to SS, as wellas the IDT updating preferences at each Care Plan meeting. All staff was also notified of the change tothe amended smoking policy. ·The administrator will update the residentcouncil of the amended smoking policy. **How will thecorrective action(s) be monitored to ensure the deficient practice will notrecur, i.e., what quality assurance program will be put into place?** ·An audit tool will be used by DON/Admin/designeeweekly x 8 and monthly x 2 to ensure preferences are being maintained and anyconcerns about facility policies are being identified. ·The QIS interview tool will be utilized weekly x4 and monthly x 2 with interviewable residents and their responsible parties toensure their preferences are being met. ·Any identified concerns from audits will beaddressed immediately. ·Employees not adhering to policy will bere-educated up to and including termination. ·The results of these audits will be discussed atthe monthly facility Quality Assurance Committee meeting for a minimum of 6months and frequency and duration of reviews will be adjusted as needed.	

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	07/26/2016

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
	shower for July 2016. She indicated his shower time was early in the morning and when she got to the facility of a morning on his shower days he was waiting in the hallway for his showers. 2. During an interview on 7/20/16 at 3:15 p.m., Resident #120 indicated the facility was suppose to be a smoke free facility, but employees and residents go across the parking lot under the awning and sit on the bench and smoke. He indicated there was a resident who went on outings and would smoke prior to getting on the bus, after he got off the bus while at the outing and prior to getting on the bus to go back to the facility. He indicated the resident would sit away from the other residents waiting for the bus or on the outing, but they could still smell the smoke. Resident #120 indicated rules were rules and all residents should have to follow the same rules. He indicated he had suggested to the Administrator to either enforce the non-smoking rules for the facility or make it public, so all the residents knew they could smoke if they wanted. During an interview on 7/20/16 at 4:49 p.m., the Administrator indicated she was aware there were residents smoking on the facility property. She indicated these residents have their smoking materials in		Facility Administrator is responsible for ensuringcompliance. Compliance Date: August 22, 2016	

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	07/26/2016

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
	their rooms. She indicated she had bought a new bench for the resident's who smoked, so the residents who rode the bus for outings would have a bench to sit on while waiting for the bus. She indicated all the residents had a smoking assessment and BIMS (Brief Interview for Mental Status) completed, but these were not a part of the residents' record because the facility did not have a policy for smoking on facility property. She indicated the resident who smoked on the outings left two weeks ago, so he no longer resided at the facility. On 7/20/16 at 5:08 p.m., Resident #126 was observed across the parking lot by Entrance door #4 sitting by a bench smoking. A cigarette butt container was observed at the end of the bench at the opposite end of where the resident was sitting. A current policy titled "Policy and Procedure for Tobacco" dated March 2015, provided by the Administrator on 7/20/16 at 4:44 p.m., indicated "Policy Statement: [Name of Company] has implemented this Policy and Procedure for Tobacco in the interest of ensuring its residents heath and safety...General Overview: The following are guidelines for residents who reside at a [Name of Company], who wish to use tobacco or			

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	07/26/2016

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
	tobacco products. The protocols set forth below are the standards to be followed at the Community regarding tobacco...Policy: There is no smoking of tobacco or other substances in any form i.e. cigarettes, cigar, pipe, vaporizers, e-cigarettes, etc., inside or outside of the community...Procedure: 1. Smoking is prohibited anywhere inside or outside at the community...." 3.1-3(u)(1) 3.1-3(v)(1)			
F 0323 SS=E Bldg. 00	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and			

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	07/26/2016

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
	assistance devices to prevent accidents. Based on observation, interview and record review, the facility had a potential for accidents for not having a policy or safety plan for smoking on the facility property for 5 of 5 residents smoking on the facility property (Residents #126, #132, #155, #190 and #244), failed to ensure water temperatures did not exceed 120 F (Fahrenheit) (Rooms #508, #506, #503, #435 and #433), failed to ensure a post fall intervention, the root cause analysis and new interventions were implemented after falls for 1 of 4 residents reviewed for falls (Resident C). Findings include: 1. During an interview on 7/20/16 at 3:15 p.m., Resident #120 indicated the facility was suppose to be a smoke free facility, but employees and residents go across the parking lot under the awning and sit on the bench and smoke. He indicated there was a resident who went on outings and would smoke prior to getting on the bus, after he got off the bus while at the outing and prior to getting on the bus to go back to the facility. He indicated the resident would sit away from the other residents waiting for the bus or on the outing, but they could still smell the smoke.	F 0323	**F323** It is the practice of the provider to ensure that theresident environment remain as free of accident hazards as is possible. **What correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice?** ·The facility amended the smoking policy forcurrent residents who smoke which includes a safety plan for the keeping ofsmoking materials for residents. ·Residents #126, #132, #155, #190, and #244, werenot affected by the water temperatures allegedly exceeding 120 degrees. ·Resident C plan of care has been reviewed by the IDT with plan of care updates. **How will you identifyother residents having the potential to be affected by the same deficientpractice and what corrective action will be taken?** ·All residents who reside at the facility havethe potential to be affected by the alleged deficient practice. ·The facility amended the current smoking policyto allow current smokers to continue to smoke on the facility property. These resident assessments were updated toinclude cognitive assessments, updated plans of care and smokingassessments.	08/22/2016

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	07/26/2016

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
	During an interview on 7/20/16 at 4:49 p.m., the Administrator indicated there were residents at the facility who smoked. She indicated the residents who smoked were Residents #126, #132, #137, #155 and #190. She indicated she was aware these residents were smoking on the facility property. She indicated these residents have their smoking materials in their rooms except Resident #137 and his family took him out to smoke because he was cognitively impaired. She indicated she had bought a new bench for the resident's who smoked, so the residents who rode the bus would have a bench to sit on while waiting for the bus. She indicated all the residents had a smoking assessment and BIMS (Brief Interview for Mental Status) completed, but these were not a part of the residents' record because the facility did not have a smoking policy on facility property. She indicated the resident who smoked on the outings left two weeks ago, so he no longer resided at the facility. On 7/20/16 at 5:08 p.m., Resident #126 was observed across the parking lot by Entrance door #4 sitting by a bench smoking. A cigarette but container was observed at the end of the bench at the opposite end of where the resident was sitting.		The residents have lockedboxes in which they are responsible for the safekeeping of their smoking materials. They have each signed the amended policy. ·Water temperatures tested weekly with notemperatures exceeding 120 degrees. ·All falls were audited over the last 30 days toensure post fall interventions, root cause analysis, immediate interventions,and appropriate notifications to family and physician were completed timely. **What measures will beput into place or what systemic changes you will make to ensure that thedeficient practice does not recur?** ·All fall events will be reviewed by the IDT indaily clinical meeting Monday through Friday and by the weekend supervisor onSaturday and Sunday to ensure post fall interventions are complete includingimmediate interventions, appropriate notification and root cause analysis. ·All staff received education on identifying andreporting maintenance concerns including water being too hot and completingresident grievances related to facility policy. ·Concern/grievance forms are reviewed dailyMonday through Friday by the administrator. **How will thecorrective action(s) be monitored to ensure the deficient practice will notrecur, i.e., what**	

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	07/26/2016

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
	During an interview on 7/20/16 at 5:44 p.m., the Administrator indicated she just found out a little bit ago Resident #244 was also a smoker. She indicated he had not had a smoking assessment completed because she did not know he was smoking. These residents smoking assessments and BIMS were completed on the following dates: a. Resident #126--Smoking Assessment was completed on 7/5/16 and his BIMS was completed on 6/23/16 with a score of 13, which indicated he was cognitively intact. b. Resident #132--Smoking Assessment was completed on 7/21/16 and his BIMS was completed on 7/20/16 with a score of 1, which indicated he was cognitively intact. c. Resident #155--Smoking Assessment was undated and his BIMS was completed on 5/15/16 with a score of 15, which indicated he was cognitively intact. d. Resident #190--Smoking Assessment was completed on 7/5/16 and his BIMS was completed on 5/10/16 with a score of 15, which indicated he was cognitively		**quality assurance program will be put into place?** ·An audit tool will be used by DON/Admin/designeeweekly x 8 and monthly x 2, to ensure change of condition, and residents with fallsare identified daily and documentation including post fall intervention, rootcause analysis and immediate intervention is appropriate. ·The QIS interview tool will be utilized weekly x4 and monthly x 2 with interviewable residents and their responsible parties toensure their grievances have been followed up on. ·Any identified concerns from audits will beaddressed immediately. ·Employees not adhering to policy will bere-educated up to and including termination. ·The results of these audits will be discussed atthe monthly facility Quality Assurance Committee meeting for a minimum of 6months and frequency and duration of reviews will be adjusted as needed. Facility Administrator is responsible for ensuringcompliance. Compliance Date: August 22, 2016	

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	07/26/2016

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
	intact. e. Resident #244--Smoking Assessment was completed on 7/22/16 and his BIMS was completed on 7/20/16 with a score of 13, which indicated he was cognitively intact. 2. On 7/18/16 at 4:05 p.m., the Administrator was informed during the resident room observations on the 400 and 500 units, the bathroom sink hot water temperatures were as high as 129 F. During an interview on 7/18/16 at 4:10 p.m., with the Maintenance Director and the Administrator in attendance, the Maintenance Director indicated he had placed a new mixing valve (a valve connected to the hot water line off the water heater, which maintained and limited mixed hot water to a desired, set temperature, helping to minimize burns from excessive hot water) on the water heater on the 500 unit on 7/14/16. He indicated the water heater on the 500 unit supplied water to the 400 and 500 units. The temperature of the water heater mixing valve at that time was 120 F. During resident bathroom observations with the Maintenance Director and the Administrator in attendance 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	07/26/2016

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
	bathroom sink hot water temperatures were observed at the following temperatures: a. Room #508--On 7/18/16 at 4:16 p.m., the bathroom sink hot water was observed at 125 F. b. Room #506--On 7/18/16 at 4:19 p.m., the bathroom sink hot water was observed at 125 F. c. Room #503--On 7/18/16 at 4:21 p.m., the bathroom sink hot water was observed at 126 F. d. Room #435--On 7/18/16 at 4:26 p.m., the bathroom sink hot water temperature was observed at 123 F. e. Room #433--On 7/18/16 at 4:29 p.m., the bathroom sink hot water temperature was observed at 121 F. 3. During an interview on 7/19/16 at 2:07 p.m., LPN #4 indicated Resident C had two or more falls in the last 30 days. She indicated he had falls on 6/28/16, 7/4/16, and 7/8/16 without injuries. Resident C's record was reviewed on 7/22/16 at 10:41 p.m. Diagnoses included, but were not limited to, repeated falls, generalized muscle weakness, Parkinson's disease, and			

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	07/26/2016

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
	insomnia. The resident had a Care Plan dated 1/14/16 edited on 7/25/16, which addressed the problem the resident was at risk for falls and fall related injuries related to decreased mobility and a history of falls. He refused to use a bed alarm. He would not call for assistance when needed. He ambulated independently in his room. He received benzodiazepines, an antipsychotic, medication for a diagnosis of Parkinson disease, a anti-hypertensive medication and sleep aide medications. Approaches included, but were not limited to, "...1/26/16--Therapy to evaluate for use of walker to promote safety, as he ambulates independently about...." Resident C had falls, which included, but were not limited to, the following dates and times: A "Fall Event" dated 1/26/16 at 11:00 p.m., indicated the resident had an unwitnessed fall and was found in his doorway. He was resting prior to his fall. Interventions in place at the time of the fall was therapy was treating the resident. Immediate interventions put into place at the time of the fall was the resident was offered food and/or drink, the resident was toileted, the pathways were cleared,			

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	07/26/2016

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
	assistive devices and personal care items were placed within reach. A progress note dated 1/26/16 at 11:09 p.m., (Recorded as a late entry on 1/27/16 at 12:20 a.m.) indicated "Resident found sitting on the floor in the doorway, call light was initiated, Resident stated he went to the bathroom and when he was trying to get back into bed he started sliding down so he lowered himself to the floor put his call light on and scrolled himself to the doorway opened the door and was calling for help to get up... Resident encouraged to use call light for assistance with toileting...." An "IDT [Interdisciplinary Team]/Post Fall Assessment" dated 1/27/16 at 12:49 a.m., indicated the resident was found in the doorway of his room on the floor. The cause of the fall was he lost his strength and was weak. The activity, which was occurring during the fall was he was getting into bed. The footwear the resident was wearing was regular socks. The immediate interventions implemented was adaptive equipment and a urinal was offered. The description indicated a Physical Therapy evaluation will be requested to give the resident a walker if applicable. The root cause/potential factors, which contributed to the fall was the resident did not have			

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	07/26/2016

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
	an ambulation device available. A "Fall Event" dated 1/27/16 at 11:40 p.m., indicated the resident had an unwitnessed fall and was found in his doorway. He was sleeping prior to the fall. The immediate intervention to prevent another fall was rest for the resident. A progress note dated 1/28/16 at 2:31 a.m., indicated "Res found sitting on the floor in the doorway, states he was in bed asleep and next thing he knew he was on the floor next to bed and crawled to doorway to alert staff...." An "IDT/Post Fall Assessment" dated 1/28/16 at 10:54 a.m., indicated the resident had a fall on 1/27/16 at 11:40 p.m., and was found in his doorway of his room on the floor. The cause of the fall was he lost his balance. The activity occurring prior to the fall was he was ambulating in his room. The resident was barefooted. The history of falls the last 30 days was he fell yesterday. The pattern of the falls was both falls occurred when he got up from bed after sleeping. The new immediate intervention was bed canes were ordered to provide stability as the resident stood. The root cause/potential factors, which could have contributed to the fall was he			

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	07/26/2016

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
	awakened and tried to get up and lacked stability at that time. A "Fall Event" dated 2/2/16 at 12:43 a.m., indicated the resident had an unwitnessed fall and he was found bedside his bed. He was using the bathroom independently prior to the fall. Immediate interventions, which were implemented to prevent another fall was the resident was toileted and he was placed in bed to rest. A Progress note dated 2/3/16 at 12:43 a.m., indicated "Res noted on floor w [with] back to side of bed... Res states he needs a larger bed although doesn't appear it would aide in less falls, Staff has often entered room to find res lying on left side and buttocks at the edge of the bed Bed canes possible beneficial as intervention w [with] multiple falls." An "IDT/Post Fall Assessment" dated 2/3/16 at 4:59 p.m., indicated the resident was found bedside his bed on the floor. The cause of the floor was he lost his strength and weakness. The activity occurring during the fall was he was getting out of the bed. The history of falls in the past 30 days was this fall was his fourth fall and the pattern of the falls was he usually falls during the nighttime hours. The immediate intervention was a			

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	07/26/2016

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
	bed cane was placed on his bed. The root cause/potential, which could have contributed to the fall was "Resident continues to be non-compliant with calling for assistance when needed. He also refuses to use any type of alarms A floor mat would not be beneficial, as he may trip over the mat. He receives medications that may be a contributing factor to the falls, as these medications may cause increased drowsiness." Additional information indicated "Received an order for Physical Therapy to Eval and Treat as indicated." A "Fall Event" dated 5/29/16 at 5:32 a.m., indicated the resident had an unwitnessed fall and was found on the floor at the side of his bed. Prior to the fall he was sitting on the side of the bed. The immediate interventions to prevent another fall was the resident was toileted and placed in bed to rest. A progress note dated 5/29/16 at 6:37 a.m., indicated "Res found on floor at bedside...Res states he was getting up to go to the bathroom... encouraged to use call light prior to going to bathroom...." A "Fall Event " dated 7/8/16 at 4:40 a.m., indicated the resident was found laying on the floor sitting on his buttocks. He was laying in bed prior to the fall.			

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	07/26/2016

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 resident's record lacked root cause analysis for the cause of this fall and any new interventions, which were initiated to prevent another fall for the 5/29/16 and 7/8/16 falls.

During an interview on 7/25/16 at 2:40 p.m., the Director of Nursing indicated she did not have any further information regarding the root cause analysis or interventions on the resident's falls other than the information she had already provided.

During an interview on 7/26/16 at 3:40 p.m., Physical Therapist #5 indicated there was no Physical Therapy evaluation completed after the resident's fall on 1/26/16. She indicated the first time Physical Therapy evaluated and treated the resident was on 2/17/16, after a hospitalization.

A current policy titled "Policy and Procedure for Tobacco" dated March 2015, provided by the Administrator on 7/20/16 at 4:44 p.m., indicated "Policy Statement: [Name of Company] has implemented this Policy and Procedure for Tobacco in the interest of ensuring its residents heath and safety...General Overview: The following are guidelines for residents who reside at a [Name of

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	07/26/2016

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
	Company], who wish to use tobacco or tobacco products. The protocols set forth below are the standards to be followed at the Community regarding tobacco...Policy: There is no smoking of tobacco or other substances in any form i.e. cigarettes, cigar, pipe, vaporizers, e-cigarettes, etc., inside or outside of the community...Procedure: 1. Smoking is prohibited anywhere inside or outside at the community...." A current policy titled "Clinical-Fall Prevention Policy and Procedure" dated May 2016, provided by the Director of Nursing on 7/25/16 at 11:50 a.m., indicated "Policy Statement:..As such it is [Name of Company] policy to collect as much information as possible for each fall and use this information to prevent a reoccurrence...Procedure:..It is the responsibility of the interdisciplinary tea to document falls prevention, when a fall occurs, and interventions to avoid future falls. General Overview Of Fall Program:.. Step Two: Fall Event Assessment: The fall event assessment will be completed by the charge nurse if a patient experiences a fall. This data will be utilized by the community to thoroughly investigate the root cause for each fall and ensure effective interventions are put into place to prevent additional falls. Step Three: Strategies of			

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	07/26/2016

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
	Prevention: Strategies to prevent falls are unique for each community. Each fall risk factor is unique for every resident. The community will discuss and analyze fall risk factors and utilize existing resources and create new educational plans to reduce falls through their Quality Assessment Performance Improvement (QAPI) and Quality Assurance (QA) process. Step Four: Strategies Of Intervention: Strategies for interventions to prevent falls will be individual for each patient. Each section of the fall risk assessment tool should be considered and staff should receive education pertaining to these risk factors to reduce falls. Step Five: Interdisciplinary Guidelines: If a falls occurs, the interdisciplinary team (IDT) will meet collectively and examine the fall using the following criteria:.. iii. A root cause analysis will be performed utilizing the '5 Whys' [Name of Company] process:..vii. A narrative IDT note will include: a. Root cause explanation with new intervention strategy to prevent reoccurrence...." This Federal tag relates to Complaint IN00196125. 3.1-19(r)(2) 3.1-45(a)(2)			

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	07/26/2016

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 0329 SS=D Bldg. 00	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic 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 specific targeted behaviors for an antipsychotic medication (Resident C) and failed to ensure Gradual Dose Reductions were completed for an anti-anxiety and hypnotic medications (Resident #177).	F 0329	**F329** It is the practice of the provider to ensure that theresident's drug regimen is free from unnecessary drugs. **What correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice?**	08/22/2016

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	07/26/2016

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: 1. Resident C's record was reviewed on 7/22/16 at 10:41 a.m. Diagnoses included, but were not limited to, repeated falls, Parkinson disease, other depressive episodes, psychotic disorder with delusions due to known physiological condition and restlessness and agitation. Resident C's Physician orders dated July 2016, included, but were not limited to, the following orders: 2/3/16--Monitor resident with antipsychotic therapy for targeted behaviors with following: BEHAVIOR CODES: Isolation in Room=I, Obsessive Bx's [behaviors]=O, Agitation=A, Repetitive Questions=R, Lack of Interest=LI Hallucinating=H, Delusions=D, INTERVENTION CODES: Active listening=A, Low calm tone=LT, Slow movements=SM, Maintain eye contact=EC, Maintain open stance=OS, Allow plenty of physical space=PS, Allow to make choices=C, Provide simple activities=SA, BEHAVIORS DID NOT OCCUR: Place NA in all boxes. 3/1/16--Olanzapine (an antipsychotic medication) 5 mg (milligrams) by mouth twice a day. (Discontinue 7/25/16). 7/25/16--Olanzapine 5 mg by gastric tube		·Resident C's care plan was revised to monitorspecific / targeted behaviors. ·Resident #177 temazepam was discontinued on7-25-16. **How will you identifyother residents having the potential to be affected by the same deficientpractice and what corrective action will be taken?** ·All residents who receive an psychotropicmedication have the potential to be affected. ·Social Services will perform an inclusive auditof all residents who receive a psychotropic medication to ensure that pharmacyrecommendations have been reviewed and completed by the physician and careplans are specific to behaviors that need to be monitored. **What measures will beput into place or what systemic changes you will make to ensure that thedeficient practice does not recur?** • All newphysician orders are reviewed daily in clinical meeting by theInterdisciplinary Team (IDT) Monday through Friday and by the Weekend manageron Saturday and Sunday. Any changes in orderswill be reviewed for update of plan of care and additional targeted behaviorsas well as planned GDR in accordance with facility policy. • IDT teamreceived Corporate directed re-education on behavior management policy andprocedure.	

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	07/26/2016

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
	twice a day. The resident had a Care Plan dated 2/3/16, which addressed the problem he had a "Psychotic disorder with delusions due to known physiological condition that requires the use of antipsychotic medication(s). Olanzapine AEB [as evidenced by] changes in mood and behaviors at times, such as obsessive behaviors related to G-tube, inappropriate clothing coverage, agitation/restlessness/ruminating, as well as repetitive call light use, obsessive anxiety and calling out to staff, resident also has Dx's [diagnoses] of: Parkinson's and a Cognitive communicate deficit He will frequently put his call light on several times a shift for someone to come in and sit with him. he does not like coming out of his room for long periods of time. Sometimes he will not even come out for short periods of time. He often will not allow staff to open his blinds and requests for the door to be closed He has a care-giver that comes in frequently and will stay with him for short periods of time daily. After a few minutes he will dismiss caregiver and after he leaves, he will put his call light back on for staff to come in and sit with him." Approaches included, but were not limited to, "...2/3/16--Monitor resident with antipsychotic therapy for targeted		• All staffreceived education on identifying and reporting changes in resident behaviorswith emphasis on targeted behaviors and documentation in EMAR. **How will thecorrective action(s) be monitored to ensure the deficient practice will notrecur, i.e., what quality assurance program will be put into place?** • An audittool will be used by DON/Social Services/designee weekly x 8 and monthly x 2, to ensure targeted behaviors are beingmonitored and new medications are monitored and reduced per physician order. • Anyidentified concerns from audits will be addressed immediately. • Employeesnot adhering to policy will be re-educated up to and including termination. • Theresults of these audits will be discussed at the monthly facility QualityAssurance Committee meeting for a minimum of 6 months and frequency andduration of reviews will be adjusted as needed. Facility Administrator is responsible for ensuringcompliance. Compliance Date: August 22, 2016	

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	07/26/2016

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
	behaviors with following: BEHAVIOR CODES: Isolation in Room=I, Obsessive Bx's=O, Agitation=A, Repetitive Questions=R, Lack of Interest=LI Hallucinating=H, Delusions=D, INTERVENTION CODES: Active listening=A, Low calm tone=LT, Slow movements=SM, Maintain eye contact=EC, Maintain open stance=OS, Allow plenty of physical space=PS, Allow to make choices=C, Provide simple activities=SA, BEHAVIORS DID NOT OCCUR: Place NA in all boxes...." Progress notes were reviewed and no documentation was found regarding hallucinations or delusions the resident had been displaying. The resident's record lacked monitoring of specific targeted behaviors for his Olanzapine. An "IDT (Interdisciplinary Team) Forms--Medication Management" dated 3/3/16, indicated the medication being reviewed was Olanzapine due to the resident's current intermittent confusion, agitation and obsessive anxiety The diagnosis targeted for treatment was Psychotic disorder with delusions. The associated behaviors the medications had been used to manage were agitation and restlessness, changes in his mood and			

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	07/26/2016

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
	behaviors, repetitive call light use and calling out. The frequency the resident had the behaviors was daily at times. During an interview on 7/26/16 at 12:10 p.m., the Social Service Director (SSD) indicated the Resident C's specific targeted behaviors being monitored for his use of Olanzapine was excessive call light use, restlessness isolation in his room per his preference, anxiety and agitation. She indicated he did not have any delusions or hallucinations at this time. She indicated he was being seen by a Psychiatrist and his Nurse Practitioner. During an interview on 7/26/16 at 2:46 p.m., NP #3 indicated the resident was admitted to the facility on Olanzapine. She indicated his Neurologist placed him on the Olanzapine for his Parkinson's disease. She indicated he had Psychosis secondary to the Sinemet (a medication used to treat Parkinson disease) medication he was prescribed. She indicated she did not know how the Psychosis from the Parkinson's disease was displayed by the resident. She indicated the diagnosis for the Olanzapine was Psychosis disorder with delusions secondary to Parkinson's disease. NP #3 indicated the resident's delusion was he was still a lawyer and he needed to get to the courthouse to prepare			

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	07/26/2016

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
	a brief for court. She indicated she got the information for his behaviors from talking to the nurses and looking in the resident's progress notes. During an interview on 7/26/16 at 2:54 p.m., the SSD indicated the resident was on the Olanzapine on admission because of his agitation, intermittent confusion, restlessness and obsession, anxiety and needing staff's assistance with dressing appropriately because he would come to the hallway door without the appropriate clothing on. She indicated there was no specific behavior monitoring for his antipsychotic. She indicated she looked at the nurses progress notes for new behaviors and any new behavior events, which have been started. 2. Resident #177's record review was completed on 07/22/16 at 9:24 a.m. Diagnoses included, but were not limited to, acute and chronic respiratory failure, edema, hemiplegia and hemiparesis, cardiovascular disease, anxiety, and insomnia. The Physician orders, dated 7/16, indicated Resident #177's medications included, but were not limited to, Clonazepam (an antianxiety medication) 0.5 mg (milligrams) twice a day for anxiety, Lasix (a diuretic medication) 40 mg twice a day for edema, and			

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	07/26/2016

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
	Temazepam (a hypnotic medication) 30 mg every evening PRN (as needed) for sleep. The "Consultant Pharmacist's Medication Regimen Review", dated 3/1/16, indicated Resident #177 had not used his PRN Temazepam in more than 60 days and a recommendation to discontinue the medication was made. A "Note to Attending Physician/Prescriber" with a response of "agree or disagree" was not located. The "Consultant Pharmacist's Medication Regimen Review", dated 4/11/16, indicated Resident #177 had no mood or behavioral disturbances documented in some time and a recommendation was made to reduce his Clonazepam from 0.5 mg twice a day to 0.5 mg just once daily at bedtime. A "Note to Attending Physician/Prescriber" dated 4/14/16, indicated the physician agreed to the reduction of the Clonazepam to once a day at bedtime. During an interview, on 7/26/16 at 3:30 p.m., the Director of Nursing indicated the "Note to Attending Physician/Prescriber" from the pharmacy			

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	07/26/2016

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
	are hand delivered to the physicians during their monthly visits to the facility. The recommendation to discontinue the Temazepam was overlooked and the "Note to Attending Physician/Prescriber" was not given to the physician. She indicated the "Note to Attending Physician/Prescriber" was delivered and agreed upon by the physician for the reduction of Clonazepam, but was not followed through by the facility and was never reduced. A current policy titled "Behavior Management Program" dated October 2013, provided by the Administrator on 7/26/16 at 2:38 p.m., indicated ...Every resident is unique and has lived his/her life in an individual and original manner When it comes to resolving resident behaviors [Name of Company] believes that each behavior has a unique reason and has originated from a set of circumstances that must be examined....Psychosis and agitation: Defined as a severe psychiatric abnormality often times involving a break with reality and compromising hallucinations, delusion, thought disorder and markedly bizarre behavior...Antipsychotic Medications...The resident is experiencing one or more of the following distressful behaviors: fear			

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	07/26/2016

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
	continuously yelling, screaming, crying, significant decline in function and withdraw from fundamental care and health needs like eating or hygiene that could result in a negative outcome... Social services will track residents with orders for an antipsychotic medication and develop a medication reduction committee with other members of the healthcare team. This committee will meet at a minimum on a monthly basis. The facility should include the services psychiatrist or psychologist for each meeting... Medication management meeting note(s) can also be found as an observation within the Matrix system...The medication review committee is encouraged to open a medication management observation if the resident's medical record each time a residents are reviewed for potential adjustment...How often is the resident having these behaviors. Document reduction attempt history, whether it was successful and how the resident responded to previous attempts...If the physician declines the opportunity to attempt a dose reduction work with the provider to narratively document the diagnosis, targeted behavior(s) and the condition warrants the use of the medication. The narrative note should also include a statement that a reduction attempt creates a risk/danger to the			

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	07/26/2016

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
	resident or others and this risk outweighs the potential benefits of a reduction attempt." 3.1-48(a)(3) 3.1-48(a)(5)			
F 0332 SS=D Bldg. 00	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. Based on observation, interview and record review, the facility failed to keep the medication error rate at less than 5% for 2 of 5 residents observed during medication pass. 3 errors were observed during 27 opportunities for errors in medication administration. This resulted in a medication error rate of 11.1% (Residents P and R) Findings include: 1. On 7/21/16 at 5:18 p.m., LPN #1 was observed administering a medication to Resident P, which included Lasix (a diuretic medication used to remove extra fluid from the body) 20 mg (milligrams) by mouth daily. Hold if SBP (Systolic Blood Pressure) was less than 100.	F 0332	**F332** It is the practice of this provider to ensure that thefacility is free of medication error rates of five percent or greater. **What correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice?** ·LPN #1 received one on one education regardingthe five rights of medication. ·LPN #2 upon interview with the DON, stated shedid not give the wrong medication at 4:56pm. However will attend the five rights of medication administration in-servicefor licensed personnel. **How will you identifyother residents having the potential to be affected by the same deficientpractice and what**	08/22/2016

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	07/26/2016

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
	Resident P asked LPN #1 as she handed him the plastic cup with the Lasix pill in it if he only had one pill to take and LPN #1 indicated to the resident "Yes". Resident P's Medication Administration Record (MAR) dated July 2016, included, but were not limited to, the following orders: 5/14/15--Klor-Con (a Potassium supplement) M20 ER (Extended Release) 20 mEq (millequivalents) by mouth twice a day upon rising between 7:00 a.m. -11:00 a.m. and before bedtime between 3:00 p.m.-5:00 p.m. 6/28/16--Lasix 20 mg one tablet by mouth daily at 5:00 p.m. Hold if SBP was less than 100. 7/19/16--PreserVision AREDS (vitamins for the eyes) 320-226-200 unit-mg-unit give two capsules by mouth daily in the afternoon 3:00-5:00 p.m. The MAR dated July 2016, indicated the Klor-Con and PreserVision AREDS were documented as being administered on 7/21/16 at 5:13 p.m. During an interview on 7/25/16 at 9:03 a.m., the Director of Nursing (DON) indicated she spoke with LPN #1 regarding Resident P's PreserVision AREDS and Klor-Con medications. The DON indicated LPN #1 indicated she		**corrective action will be taken?** ·All residents receiving medications have thepotential to be affected by the alleged deficient practice. ·Residents who were identified during the surveyprocess physicians and responsible parties were notified of the concern. **What measures will beput into place or what systemic changes you will make to ensure that thedeficient practice does not recur?** • Licensednursing staff were re-educated on the five rights of medication pass. **How will thecorrective action(s) be monitored to ensure the deficient practice will notrecur, i.e., what quality assurance program will be put into place?** • An audittool will be used by SDC/designee daily x 2 weeks/3 x a week x 2 weeks, andweekly x 8 weeks, to ensure medication pass is completed accurately. • Anyidentified concerns from audits will be addressed immediately. • Employeesnot adhering to policy will be re-educated up to and including termination. • Theresults of these audits will be discussed at the monthly facility QualityAssurance Committee meeting for a minimum of 6 months and frequency andduration of reviews will be adjusted as needed. Facility Administrator is responsible for	

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	07/26/2016

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
	went back and gave the resident those medications after the Lasix was given, when she realized she had forgotten them. She indicated LPN #1 acknowledged she had signed off the medications prior to giving them. 2. On 7/21/16 at 4:56 p.m., LPN #2 was observed administering medications to Resident R, which included Carbidopa-Levodopa (a Parkinson medication) 25-100 mg give 5 tablets by mouth four times a day. Pramipexole (a medication used to treat Parkinson's disease and restless leg syndrome) and Selegiline (a medication used to treat Parkinson's disease) 5 mg give one tablet twice a day. At that time, LPN #2 indicated she had three medications to administer to this resident. Resident R's MAR dated July 2016, included, but were not limited to, the following orders: 4-18-16--Selegiline HCL (hydrochloride) 5 mg by mouth twice daily at 9:00 a.m. and 1:00 p.m. Resident R's MAR dated July 2016, indicated Selegiline HCL had been documented as given on 7/21/16 at 9:00 a.m. and 1:00 p.m. A current policy titled "Licensed Nurse		ensuringcompliance.Compliance Date: August 22, 2016	

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	07/26/2016

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
	Med Pass Clinical Skills Validation" undated, provided by the Clinical Specialist on 7/22/16 at 3:19 p.m., indicated "Medication Administration Skills Validation...5. Check medication administration record...7. Remove medication from drawer, read label when taking from drawer and before putting in medication cup or pouring liquids... a. Read order entirely to check for right resident, right medication, right route, right dose, right time, right documentation...9. Read label again before putting back into drawer...." This Federal tag relates to Complaints IN00196125 and IN00200688. 3.1-48(c)(1)			

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	07/26/2016

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 0465 SS=D Bldg. 00	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to ensure a clean, sanitary, and home like environment related to 5 of 40 resident rooms and the therapy room. (Rooms #209, #213, #307, #314, and #323). Findings include: During the environmental tour, on 7/26/16 at 11:45 a.m., with the Maintenance Director in attendance, the following were observed: a. The window sill and floor in the therapy room were covered in small black debris. During an interview at that time, the Maintenance Director indicated the black debris were pieces of mulch and "pill bugs." b. In room #209, pieces of the wood window frame were broken leaving an irregular, not smooth surface, the baseboard trim under the window was pushed in leaving a rippled, warped appearance and the entry door was	F 0465	**F 465** It is the practice of this provider to ensure that thefacility provides a safe, functional, sanitary and comfortable environment forresidents, staff and the public. **What correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice?** ·The window sills in the therapy gym were cleanedof the mulch and debris. ·Room #209 wood window frame broken was repaired,baseboard trim was repaired, entry door repaired. ·Room #213 bathroom door chipped was repainted. ·Room #307 privacy curtain was changed immediately. ·Room #314 telephone jack was repaired, twoceiling tiles were changed, and the base of the toilet was repaired. ·Room #323 entry door gouged, drywall gouged,window frame, bathroom door marred was completely remodeled. **How will you identifyother residents having the potential to be affected by the same**	08/22/2016

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	07/26/2016

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
	chipped, gouged, and marred. c. In room #213, the bathroom door was chipped, gouged and marred. d. In room #307, the privacy curtain for the bed by the window was not long enough to provide complete privacy. When pulled for privacy, the curtain only reached the end of the footboard. The bathroom was visible from this bed. During an interview, at that time, the Maintenance Director indicated the beds privacy curtain was the incorrect size. e. In room #314, the telephone jack was pulled away from the wall exposing the wires, two ceiling tiles in the bathroom were discolored and water stained, and in the bathroom an inch gap was observed between the flooring and the base of the toilet. During an interview, at that time, the Maintenance Director indicated a plate guard should be around the toilet to cover the spacing. f. In room #323, the entry door was gouged and marred, the wall had two drywall gouges approximately 12 inches in length with drywall debris observed on the floor below, pieces of the wood window frame were broken leaving an irregular, not smooth surface, the bathroom walls were marred and gouged,		**deficientpractice and what corrective action will be taken?** ·All residents living in the facility have thepotential to be effected by the alleged deficient practice. ·An audit was completed of the entire facility bythe Environmental Supervisor of the window frames, facility doors and roomdrywall/paint and a priority list was determined with the Administrator to becompleted over the next 30 and 90 days. **What measures will beput into place or what systemic changes you will make to ensure that thedeficient practice does not recur?** ·All staff received re-education on reportingchanges/needs to the maintenance department via maintenance request formsduring the survey process. This practicewas reiterated at the all staff inservice. ·The facility managers will be given an audittool to use on a weekly basis to review facility aesthetics and report to theEnvironmental Services Supervisor. **How will thecorrective action(s) be monitored to ensure the deficient practice will notrecur, i.e., what quality assurance program will be put into place?** ·An audit tool will be used by Environmentalsupervisor/designe e weekly x 12 weeks to ensure facility environment is abovesatisfactory.	

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	07/26/2016

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
	and the bathroom door was marred, gouged, and had several holes at the bottom of the door. During an interview on 7/26/16 at 12:30 p.m., the Maintenance Director, indicated he was not aware of the rooms needing these repairs or the therapy area was in need of cleaning by housekeeping. He indicated the doors should be sanded and restained and room #323 needed to be completely redone. 3.1-19(f)		·Facility managers will be assigned designatedareas of the facility to audit the environment weekly. ·Any identified concerns from audits will beaddressed immediately. ·Employees not adhering to policy will bere-educated up to and including termination. ·The results of these audits will be discussed atthe monthly facility Quality Assurance Committee meeting for a minimum of 6months and frequency and duration of reviews will be adjusted as needed. Facility Administrator is responsible for ensuringcompliance. Compliance Date: August 22, 2016	