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	05/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CARMEL HEALTH & LIVING COMMUNITY	118 MEDICAL DR CARMEL, IN 46032

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00259311, IN00259361, IN00259551, IN00259823 and IN00261151. Complaint IN00259311-Substantiated. No deficiencies related to the allegations were cited. Complaint IN00259361-Substantiated. No deficiencies related to the allegations were cited. Complaint IN00259551-Substantiated. No deficiencies related to the allegations were cited. Complaint IN00259823-Substantiated. Federal/State deficiencies related to the allegations are cited at F600 and F602. Complaint IN00261151-Unsubstantiated. Unsubstantiated due to lack of evidence. Survey dates: April 30 and May 2 and 3, 2018 Facility number: 000095 Provider number: 155181 AIM number: 100290490 Census bed type: SNF: 7 SNF/NF: 124 Total: 131 Census payor type: Medicare: 4 Medicaid: 103 Other: 24 Total: 131	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.	

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 determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	This deficiency reflects state findings cited in accordance with 410 IAC 16.2-3.1. Quality Review was completed on May 7, 2018.			
F 0600 SS=D Bldg. 00	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; Based on interview and record review the facility failed to ensure a resident was free from sexual abuse caused by a staff member for 1 of 5 residents reviewed for abuse (Resident E). Finding includes: An "Indiana State Department of Health Survey Report System" report dated 4/13/18, indicated on 4/13/18 at 9:03 p.m., Resident E indicated CNA 1 touched her breast and placed his mouth on her breast. An "Employee Communication Form" dated 4/14/18, contained the following, "Reason for Communication" the box for "Violation of Resident Rights/Abuse" had an X marked on it.	F 0600	I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice. The facility will ensure the resident does not receive care from the identified CNA, as CNA #1 was terminated. II. The facility will identify other	05/11/2018

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	"Employer Statement Regarding Incident/Occurrence" indicated "See attached." "Action Taken with this Discussion:" indicated the box "Termination" had an X marked on it. The rest of the comment sections on the form indicated "See attached." The attached documentation titled "Phone Interview with [Name of CNA 1] 4/14/18 3:45 p.m., indicated "[Name of CNA 1] stated that he had tested with the resident about two or three days. He stated that he had been working on another unit for a while and when he returned to the resident's unit, she said she missed him and wanted his telephone number. [Name of CNA 1] stated he wrote his number down on a piece of paper. [Name of CNA 1] stated the one message (sexually explicit one) was sent to the wrong person. He was asked about the message sent right before that message that said 'If I come, will I get some', and he had no answer. He said he had meant that message to go to his wife. He stated he only texted the one resident. [Name of CNA 1] acknowledge that the son said not to contact her and to not to care for her, but [Name of CNA 1] said he worked with her anyway because he was scheduled. [Name of CNA 1] stated he took the resident to the bathroom but never touched her in the peri area. [Name of CAN 1] stated he would roll her into the bathroom, the resident would grab the bar to stand up, but her legs were shaky so he would get behind her and she would sit on his leg to get her around sit on the toilet and he would pull down her brief. Never, ever touched her in her vaginal area. Never a time when he washed her, wiped her, etc. Never. He is shocked, very shocked about this. Thinks someone is setting him up...[Name of CNA 1] stated he told the resident on Monday that the messages were not meant for her. CNA 1 indicated that he was sorry		residents that may potentially be affected by the deficient practice. All residents who have received care have the ability to have been affected by the deficient practice. A full house audit was conducted with all interviewable residents regarding abuse. Skin and pain assessments and family interviews were completed for all non-interviewable residents. III. The systematic change includes abuse training for associates will be held at a minimum of twice per year. This training will also be provided to all staff during new hire orientation. Associates received education to report early signs of unusual attention shown to a resident or residents by an associate. As part of the education, signs have been posted throughout the community defining the types of abuse, when and to whom it must be reported. IV. Administrator or designee will conduct random interviews for the residents and associates using the CQR audit tool for Abuse daily Monday – Friday x 30 days, weekly x 8 weeks and then monthly for 3 consecutive months	

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	and when asked what he was apologizing for, he said for flirting-I tell her she's beautiful." During an interview on 5/2/18 at 3:58 p.m., with CNA 1, he indicated he and Resident E had became friends and he had not worked on her unit for a while and when he returned, she indicated she missed him and asked for his phone number, which he gave to her and they started talking by texting on 4/7/18. He indicated he knew Resident E was lonely and when he sent text messages to her, he made her smile, so he texted her just to make her feel good. CNA 1 indicated in the past, Resident E had asked him to show her his penis, to kiss her, hold her and touch her and she said she would not tell anyone, if he did not tell anyone. He indicated Resident E told him she had a dream he had touched her. CNA 1 indicated Resident E's family member texted him, he believed on 4/8/18, and asked him to stop texting her and stay away from the resident and he would not take further actions against him regarding the inappropriate texting. On April 12, 2018, CNA 1 was scheduled to work on the unit Resident E lived on and he did not know how to tell the facility management staff he was not able to care for her because he had made an agreement with her (Name of family member) to stay away from her. He knew if he told the facility managers about texting Resident E and he could not care for her anymore, he would be in trouble, so he went ahead and cared for her, so he could tell her he was not allowed to take care of her anymore. He indicated when he explained to Resident E this was his last time he would be caring for her because her son had texted him and did not want him near her anymore or texting her, the resident got mad at him. He indicated he knew he was supposed to take a second person in Resident E's room with him when he provided care, but during		for total of 6 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.	

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	his night shift on 4/12/18, there was not another CNA available to go with him, so he went in by himself. He indicated there was never a time when he gave her peri care or touched her inappropriately and he regretted texting her because he knew he was not supposed to get to friendly with the residents he cared for. He indicated he never touched Resident E in her vaginal area and he regretted texting her because those text messages he sent were not appropriate. He indicated the one sexually explicit message was sent to the wrong person, that message was meant for his wife not Resident E. He did not indicate who the message prior to that one was meant for. During an interview on 5/2/18 at 5:20 p.m., Resident E indicated CNA 1 was fondling her breasts, sucked on her breasts and stuck his finger in her vagina. She indicated the CNA's name was (First Name of CNA 1). She indicated her (Name of family member) indicated he discovered the texts from CNA 1 on her phone and texted CNA 1 and told him he was not to text or come around Resident E again. She indicated CNA 1 had told her he loved her and he fondled and sucked her breasts and touched her vagina "half a dozen" times. She indicated she did not know why she did not report those other times. She indicated she refused to let the nurse do the rape kit on her at the hospital because she has short term memory loss and she could not remember being raped, so she did not see a need to go through all that testing. The record for Resident E was completed on 5/3/18 at 3:30 p.m. Diagnoses included, but were not limited to, epilepsy without status epilepticus, depressive episodes, spastic hemiplegia affecting right dominant side and cerebral infarction.			

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The quarterly MDS (Minimum Data Set) assessment dated 3/13/18, indicated the resident's BIMS (Brief Interview for Mental Status) was 15, which indicated the resident was cognitively intact. Her functional status indicated she required extensive assist with two person assist with bed mobility and transfers. She required extensive assist with one person physical assist dressing, toilet use and personal hygiene. She required total dependence with two personal physical assist with two person assistance.

"Patient Discharge Instructions" from (Name of the Hospital) dated 4/14/18 at 3:42 a.m., indicated she was being discharged from the Emergency Room with diagnoses of encounter for medical screening examination and sexual assault of adult, pintail encounter.

A "Point of Care History" report dated 4/11/18 to 4/12/18, indicated on 4/12/18, CNA 1 did provide care to Resident E as her primary CNA after her son asked him not to text her, provide care to her or go around her.

A current policy titled "Abuse Policy" dated October 2014 and revised 8/2016, provided by the Director of Nursing on 4/20/18 at 2:00 p.m., contained the following, "Policy Statement: It is the policy of [Name of Company] to provide each resident with an environment that is free from verbal, sexual, physical, and mental abuse, corporal punishment and involuntary seclusion... III. Preventing Resident Abuse Policy Statement: Our facility will not condone any form of resident abuse and will continually monitor our facility's policies, procedures, training programs, systems, etc, to assist in preventing resident abuse. Policy Interpretation and Implementation: 1. Preventing

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	resident abuse is a primary concern for this facility. It is our goal to achieve and maintain an abuse free environment... IV. Identifying & Recognizing Signs and Symptoms of Abuse...Policy Interpretation and Implementation: 1. the following are some examples of actual abuse/neglect and signs and symptoms of abuse/neglect that soul be promptly reported. However, this listing is not all-inclusive. Other signs and symptoms or actual abuse/neglect may be apparent. when in doubt, report it. a. Signs of Potential Physical Abuse:.. Rape... VII. Reporting Abuse To: A. Administrator. Policy Statement: It is the responsibility of our employees, facility consultants, attending physicians, family members, visitors etc., to immediately report any incident or suspected incident of neglect or resident abuse, including injuries of an unknown source and theft or misappropriation of resident property to the Administrator or Designee of the Administrator is unavailable... Policy Interpretation and Implementation...6. All personnel, residents, family members, visitors, etc., are encouraged to report incidents of resident abuse or suspected incidents of abuse. Such reports may be made without fear of retaliation from the facility or its staff. 7. To assist on in recognizing incidents of abuse, the following definitions of abuse are provided:.. c. Sexual abuse is defined as, but is not limited to, sexual harassment, sexual coercion, or sexual assault...." This Federal tag relates to Complaint IN00259823. 3.1-27(a)(1)			
F 0602 SS=D Bldg. 00	483.12 Free from Misappropriation/Exploitation §483.12			

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	The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. Based on interview and record review the facility failed to ensure a resident's narcotic medication was kept safe and secure during his admission for 1 of 5 residents being reviewed for misappropriation of property (Resident F). Finding includes: A "Indiana State Department of Health Survey Report System" report dated 4/16/18, indicated on 4/16/18 at 1:30 p.m., during the medication pass a nurse noted Resident F did not have a narcotic medication in the locked narcotic box. LPN 3 notified pharmacy whom told her the resident should have medication left on a card, which was not accounted for at that time. The medication was Modifinil (a medication used to help residents stay away during the day time hours). His medication card and the narcotic count sheet for his Modifinil had eight doses, which were unaccounted for. The resident was known to have missed two doses of this medication. LPN 5 refused to participate in the investigation and her employment was terminated. LPN 6 complied with the investigation, but required additional testing of her urine sample and the results were still pending at the time of this report. An "Employee Communication Form" dated 4/16/18, indicated LPN 5 was terminated due to she failed to follow procedure and/or Instructions. She did not cooperate wit the drug diversion	F 0602	I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice. The facility will ensure that Resident F's medication is kept safe and secure. The facility replaced the missing medication at the facility's expense. LPN 5 and LPN 6 were terminated. II. The facility will identify other residents that may potentially be affected by the deficient practice. All residents who have narcotics have the ability to be affected by the deficient practice. A full house audit was completed verifying the narcotic count for all residents on all carts. Additionally, the pharmacy manifests were reviewed and compared to the	05/11/2018

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	investigation. She refused a urine and blood drug screening. The discussion with LPN 5 was if she did not participate in a timely manner with the drug screenings, she would be terminated. She indicated she did not feel comfortable doing a urine screen and she refused the blood screen. A "Employee Communication Form" dated 4/26/18, indicated LPN 6 was terminated due to a violation of company policy and/or procedure. She had a positive drug test for THC (marijuana). The discussion with LPN 6 was that related to the positive drug test during the investigation the facility would not be retaining her for employment. During an interview on 5/2/18 at 12:45 p.m., LPN 3 indicated she was working on dayshift and she was the nurse who found out Resident F's Modifinil was not in the cart and the narcotic sheet for the medication was also missing when she went to administer his medications. She called the Pharmacy and the Pharmacy staff member indicated Resident F received a 15 day supply on 4/8/18, and RN 4 signed for the medication that day. She indicated she notified RN 4 since she was the nurse who signed for the medication to make sure she did sign for the medication and placed it into the narcotic drawer. The Unit Manager for that unit and the Director of Nursing was notified and they all searched for the medication. The resident missed his dose of medication that day. During an interview on 5/2/18 at 12:51 p.m., RN 4 indicated she did sign in Resident F's Modifinil on 4/8/18, on the evening shift, then she locked it in the narcotic drawer in the medication cart. During an interview on 5/2/18 at 12:55 p.m., the DON indicated four nurses were suspended		narcotic master count sheets. Shift to shift count sheets were also reviewed. III. The systematic change includes abuse training for associates will be held at a minimum of twice per year. This training will also be provided to all staff during new hire orientation. Associates received education to report early signs of unusual attention shown to a resident or residents by an associate. As part of the education, signs have been posted throughout the community defining the types of abuse, when and to whom it must be reported. IV. Administrator or designee will conduct random interviews for the residents and associates using the CQR audit tool for Abuse daily Monday – Friday x 30 days, weekly x 8 weeks and then monthly for 3 consecutive months for total of 6 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.	

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	pending investigation of their urine drug screens and the investigation of the missing Modifinil. She indicated two of them came back and two were terminated. They were unable to substantiate what actually happened to the medication. LPN 5 refused to take a urine drug screen at the clinic or let them draw blood for a drug test and refused to participate in the investigation. LPN 6 was terminated for a positive test. The record for Resident F was completed on 5/3/18 at 4:40 p.m. Diagnoses included, but were not limited to, major depressive disorder, cervicalgia, chronic pain due to trauma, post traumatic seizures, and obstructive sleep apnea. The resident had a care plan dated 10/28/16 revised 3/13/18, which addressed the problem he utilized a wake promoting medication Modafinil (a medication used to treat daytime sleepiness) for the diagnosis of obstructive sleep apnea (OSA). The approaches included, but were not limited to, "10/28/16--Medication as ordered...." The resident had a care plan dated 10/21/15 revised 11/28/17, which addressed the problem he had the diagnosis OSA with a potential for disturbed sleep pattern. The approaches included, but were not limited to, "...revision date 10/25/16, Administer Provigil [Modafinil] as ordered." A current policy titled "Clinical--Policy and Procedure for Scheduled Drugs" dated March 2015, provided by the DON on 5/3/18 at 6:15 p.m., contained the following, "Policy Statement: [Name of Company] has implemented this Policy and Procedure for Scheduled Drugs in the interest of complying with all applicable laws, regulations. Highlights: (1) Always log scheduled drugs		Facility Administrator will be responsible for ensuring compliance.	

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	immediately upon receipt. (2) Confirm the count numbers for scheduled drugs at the beginning and end of your shift... General Overview:..The protocols set forth below are the standards to be followed when the Community receives scheduled drugs and for counting scheduled drugs at the beginning and end of your shift...Purpose: This policy defines the general process for how [Name of Company] Associates are to handle scheduled drugs. This policy provides specific procedures on how to log scheduled drugs at receipt and how scheduled drugs should be counted at the beginning and end of associates shift. Policy: Handling of Scheduled Drugs. 1. Receipt of Scheduled Drugs:..1.1.1 When the scheduled drug is delivered by the pharmacy verify that the drug is on the delivery manifest and the quantity received matches the quantity ordered. 1.1.2 Place the scheduled drug in the appropriate locked narcotic box. 1.1.3 Place the green narcotic sheet in the appropriate narcotic binder...1.1.4 Log the Scheduled Drug on the Narcotic Master Count Sheet... 2. Passing of Scheduled Drugs. 2.1 Immediately after a dose of a scheduled drug is administered, the licensed nurse administering the scheduled drug is to enter all of the following information on the green sheet... 4. Shift to Shift counting of Scheduled Drugs 4.1 At the beginning of an associate's shift they must count and account for all scheduled drugs, including refrigerated drugs with the outgoing associate. 4.2 At the end of associate's shift they must count and account for all scheduled drugs, including refrigerated drugs with the oncoming associate...." This Federal tags relates to IN00259823. 3.1-28(a)			