STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155181	A. Building B. Wing	09/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carmel Health & Living Community	118 Medical Dr Carmel, IN 46032

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on interview and record review, the facility failed to ensure a resident was free from a significant medication error for 1 of 1 resident reviewed for medication errors. (Resident 7) This deficient practice resulted in Resident 7 being hospitalized for toxic metabolic encephalopathy due to a high dose of medication and her end stage renal disease.Findings include:During an interview, on 9/24/25 at 11:52 a.m., Resident 7 indicated she went to the hospital after receiving medication which caused her to see things that were not there. She did not remember a lot about the occurrence, but her daughter became very concerned and insisted she be sent to the hospital.The clinical record for Resident 7 was reviewed on 9/23/25 at 1:17 p.m. The diagnoses included, but were not limited to, end stage renal disease, dependent on renal dialysis, toxic encephalopathy, zoster without complications, and adverse effect of drug medication.A care plan, dated 9/9/22, indicated Resident 7 received hemodialysis due to end stage renal disease.A nursing progress note, dated 7/4/25 at 11:56 a.m., indicated a telehealth video call was initiated by LPN 11 regarding increased pain and blisters to Resident 7's left buttock for the past week. The telehealth Nurse Practitioner 10 gave a diagnosis of shingles (a varicella-zoster virus) with a treatment plan of valacyclovir (an antiviral medication) 1 gram (gm) three times a day for 7 days.A physician's order, dated 7/4/25, indicated to administer valacyclovir 1 gm three times a day for 7 days.A review of the valacyclovir order entered into the electronic health record indicated there were safety alerts which were acknowledged by LPN 11 on 7/4/25 at 12:31 p.m. The alerts included, but were not limited to, severe alert, drug-to-condition interaction, valacyclovir 1 gm should be used with extreme caution with a chronic kidney disease stage 5 glomerular filtration rate of less than 15, a condition related to end stage renal disease. The override reason was the prescriber was aware of this potential risk and the resident's condition would be monitored.A progress note, dated 7/5/25 at 11:03 p.m., indicated a second telehealth video call was initiated and Resident 7 was reported as very anxious and complained of not being able to sleep. Resident 7 started valacyclovir 1 gm, on 7/4/25, and now seemed very giggly and stated she felt drunk. A physician's order was placed to administer hydroxyzine 25 mg and Benadryl 25 mg one time for insomnia and anxiety.An addendum to the second telehealth video call was made and indicated Resident 7 had experienced an onset of confusion which was not baseline behavior. Resident 7 had already received the one-time dose of hydroxyzine and Benadryl.A nursing progress note, dated 7/6/25 at 6:15 a.m., indicated Resident 7 was observed to be confused and not fully making sense. She indicated she could see colors and stripes on the walls. Telehealth was notified and a new order was given for a urinary analysis with culture and sensitivity and lab work.A nursing progress note, dated 7/6/25 at 9:35 a.m., indicated Resident 7 had been seen last night (7/5/25) by a telehealth video call for hallucinations and confusion. STAT (to be given high priority) labs were ordered and had yet to arrive at the facility to be obtained.A nursing progress note, dated 7/6/25 at 10:36 a.m., indicated Resident 7's daughter arrived at the facility after receiving a phone call from the facility explaining Resident 7 was confused and was experiencing hallucinations with laughing and crying fluctuations. The daughter indicated it was taking too long for labs and requested Resident 7 to be transferred to the hospital.The medication administration record, dated 7/4/25 to 7/6/25, indicated Resident 7 received 5 doses of valacyclovir and refused the dose on 7/6/25 at 6:00 a.m.A hospital (continued on next page)

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

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F 0760 Level of Harm - Actual harm Residents Affected - Few	document, dated 7/6/25 through 7/12/25, indicated Resident 7 arrived in the emergency room for hallucinations and confusion for the past 2 days after being started on a full dose of Valtrex (valacyclovir) in the last 3 to 4 days for Shingles. Resident 7 was admitted into the hospital for toxic metabolic encephalopathy due to the high dose Valtrex considering her end stage renal disease. Resident 7's encephalopathy slowly resolved after a couple of days once the Valtrex was stopped. The lab results obtained, on 7/6/25, while in the hospital included, but were not limited to, creatinine 6.18mg/do (high), GFR 6mL/min (low), and CrCl (creatine clearance rate) 7mL/min (low) resulting in toxic metabolic encephalopathy, a suspected side-effect of Valtrex 1 gm three times a day for the past few days with no dose reduction for end stage renal disease.A Nurse Practitioner note, dated 7/22/25, indicated Resident 7 was recently admitted into the hospital for altered mental status after receiving full dose Valtrex which improved after the medication had been stopped.During an interview, on 9/23/25 at 2:50 p.m., the Assistant Director of Nursing (ADON) indicated the telehealth providers had access to the electronic health record and all facility physician progress notes.During an interview, on 9/23/25 at 3:00 p.m., the Clinical Support Nurse 2 indicated the telehealth service was an on-call service and a new provider would see the resident for each telehealth visit. The telehealth providers had access to all the residents' records and when the telehealth provider gave an order the facility nurse entered the order into the resident's record. The valacyclovir dose for end stage renal disease would need to be reduced based on the resident's creatinine clearance rate. Clinical Support Nurse 2 reviewed Resident 7's labs and indicated her most recent kidney function labs did not include a creatine clearance rate, but it could have been determined by using a calculation formula for dosing.During an interview, on 9/24/25 at 10:36 a.m., Clinical Support Nurse 1 indicated the facility contacted the telehealth service and discussed the adverse drug event and all agreed the valacyclovir should have been stopped at the time of the second telehealth video call. The facility conducted a mock order entry for valacyclovir in Resident 7's electronic health record which resulted in 6 dosage alerts. The nurse which transcribed the order for valacyclovir was interviewed but the nurse was unable to recall if she informed the prescribing provider of the alerts.During an interview, on 9/24/25 at 10:36 a.m., Clinical Support Nurse 2 indicated during the mock order, 6 alerts were identified, and each alert was related to kidney disease and dosage.During an interview, on 9/25/25 at 12:21 p.m., LPN 7 indicated a lot of medication alerts were given for a lot of different medications. If the medication she entered resulted in alerts, she would contact the prescribing provider to inform the provider of the alerts and verify if the medication was to be given.During an interview, on 7/25/26 at 5:21p.m., the telehealth NP 10 indicated she received a telehealth video call from LPN 11, on 7/4/25, where she ordered valacyclovir 1 gm three times a day for 7 days. At the time of the video call, NP 10 could see Resident 7 had a diagnosis of chronic kidney disease, stage 3, but indicated end stage renal disease (ESRD) was not listed and she was not aware of the most recent labs. If she had been made aware of the diagnosis of ESRD and the resident's kidney function labs, she would have prescribed a renal dose of the medication and not a full dose. A person with a GFR below 15 would need a renal dose. The telehealth service could communicate with the facility by text messages and video call. She indicated LPN 11 did not contact her via text message or video call related to the valacyclovir order alerts and was unaware the valacyclovir order presented any alerts.A recent publication of PDR.net (physicians' desk reference) indicated .Valtrex is a deoxynucleotide analogue DNA polymerase inhibitor indicated for.Herpes Zoster.Warnings and precautions.Acute renal failure: May occur in elderly patients (with or without reduced renal function), patients with underlying renal disease who receive higher-than-recommended doses of Valtrex for their level of renal function.Use with caution in elderly patients and reduce dosage in patients with renal impairment.Dosage recommendations for adult patients with reduced renal function.Indication.Herpes zoster.Creatinine Clearance (mL/min).10-29 1 gram every 24 hours.<10 500mg every 24 hours.Patients requiring hemodialysis should receive the recommended dose of Valtrex after hemodialysis.Central nervous system adverse reactions, including agitation, hallucinations, confusion, delirium, seizures, and (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	encephalopathy, have been reported in both adult and pediatric patients with or without reduced renal function and in patients with underlying renal disease who received higher-than-recommended doses of Valtrex for their level of renal function. Elderly patients are more likely to have central nervous system adverse reactions. Valtrex should be discontinued if central nervous system adverse reactions occur.A current facility policy, titled Transcribing Orders, undated and received from the Clinical Support Nurse 2 on 9/24/25 at 1:45 p.m., indicated .Physician orders will be transcribed to dedicated medical records timely, completely and accurately using acceptable standards of practice.Physician Telephone Orders.Must be timely. Orders should be written at the time they are received to avoid confusion later.Must be verified.Noted the prescribing physician's name along with the name and title of the name of the licensed professional who is documenting the order.3.1-48(c)(2)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure narcotic reconciliation was documented as completed, medications were available without interruptions in administration, and to ensure accurate administration documentation and destruction by obtaining two nurse's signatures for 3 of 3 medication carts (500 Unit, 700-1 Unit, 800 Unit) and 2 of 2 residents (Resident 138 and 55) reviewed for pharmacy services.Findings include:1. A facility narcotic reconciliation document, for the 500 Unit, was missing signatures to indicate the narcotic reconciliation was completed on 9/10/25 for the on-coming night shift, on 9/13/25 for the on-coming night shift, on 9/15/25 for the on-coming and off-going evening shift, and on 9/17/25 for the on-coming night shift. During an interview, on 9/23/25 at 8:27 a.m., LPN 6 indicated the nurses were to sign on/off on the narcotic count sheet every shift. 2. A facility narcotic reconciliation document, for the 700-1 Unit, was missing signatures to indicate the narcotic reconciliation was completed on 9/22/25 for the on-coming and off-going evening shift. 3. A facility narcotic reconciliation document, for the 800 Unit, was missing signatures to indicate the narcotic reconciliation was completed on 9/1/25 for the on-coming and off-going evening shift. During an interview, on 9/23/25 at 2:36 p.m., LPN 8 indicated staff were to sign the narcotic count sheet when they took over the cart and when they surrendered the cart. During an interview, on 9/24/25 at 9:52 a.m., Clinical Support Nurse 2 indicated the facility assured the narcotic count was completed using the sign on and off count sheets used at the end of each shift. 4. The clinical record for Resident 138 was reviewed on 9/19/25 at 9:58 a.m. The diagnoses included, but were not limited to, benzodiazepine dependence, congestive heart failure, fluid overload, and age-related debility. A progress note, dated 9/16/25 at 3:55 p.m., indicated Resident 138 was admitted to the facility. A hospital Discharge summary, dated [DATE], indicated to take Valium (a benzodiazepine used for anxiety, seizures, muscle spasm, and alcohol withdrawal) 5 milligrams (mg) one half tablet two times daily. A physician's order, dated 9/17/25 and an end date of 9/17/25, indicated to give Valium 5 mg twice per day. The Medication Administration Record (MAR) indicated the morning dose was not given with a comment of need new script. A physician's order, dated 9/17/25, indicated to give Valium 5 mg one half tablet two times daily. The MAR indicated the evening dose was unavailable. Resident 138 missed 3 doses of Valium after she was admitted to the facility. A nursing progress note, dated 9/17/25 at 11:29 p.m., indicated Resident 138 requested Valium earlier (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	in the shift. The medication should be delivered later tonight. Resident 138 indicated she thought she was experiencing withdrawal symptoms and called 911 herself. During an interview, on 9/22/25 at 12:05 p.m., RN 20 indicated the facility did not have Valium in the dosage Resident 138 was prescribed in the Emergency Drug Kit (EDK). The facility could do a stat (high priority) order to get the medication delivered quicker. She was not sure if there was documentation of a stat order. During an interview, on 9/23/25 at 11:02 a.m., Unit Manager 22 indicated he was unsure about the details of the Valium issue, but the facility could do stat orders for the pharmacy to deliver medication quicker. During an interview, on 9/24/25 at 11:16 a.m., Clinical Support Nurse 2 indicated when the nurse entered the order for Resident 138 on admission, they entered Valium 5 mg 1 tablet twice per day, instead of 5 mg one half tablet twice per day. The order was put in incorrectly and they had to fix it. 5. During an interview, on 9/18/25 at 12:07 p.m., Resident 55 indicated the facility ran out of her pain medication quite often. She had gone several days without a medication pain patch. During an interview, on 9/19/25 at 12:27 p.m., Resident 55's daughter indicated her mother's pain patch had been unavailable on several occasions. Her mother had gone 3 days without the pain patch in August, and she was concerned with her mother having withdrawal symptoms. During an interview, on 9/24/25 at 8:21 a.m., Resident 55 indicated she had chronic pain due to back related issues. She had a pain patch and took a pain pill. If the pain patch fell off before it was due to be changed, a new one would not be placed until the date it was due to be changed. Sometimes, the nurse would cover the pain patch with clear dressing to help the patch stay on, but not every nurse did. The clinical record for Resident 55 was reviewed on 9/19/25 at 2:55 a.m. The diagnoses included, but were not limited to, pain, opioid dependence, and long-term use of drug therapy. A care plan, dated 5/21/24, indicated pharmaceutical needs would be provided by the nursing staff. A care plan, dated 5/21/24, indicated Resident 55 had chronic low back pain with chronic and ongoing opioid dependence. A care plan, dated 5/20/24, indicated pain medications were to be given according to the physician's orders and patient request. A physician's order, dated 6/7/25, indicated to administer a Fentanyl 50 mcg/hr (microgram per hour) schedule II patch every 72 hours with instructions to remove the previous patch prior to applying a new patch, rotate sites, and destroy the patch being removed with another nurse. The controlled drug records indicated the facility did not have a record count for Fentanyl from 7/4/25 to 7/10/25 and from 8/15/25 to 8/20/25. The Medication Administration Record (MAR) indicated Fentanyl was unavailable on 7/7/25 and 8/18/25. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The controlled drug record indicated when the patch was removed, it must be immediately destroyed and witnessed with two nurse signatures. The Fentanyl patch was removed or fell off and lacked documentation of a nurse's signature and/or a second nurse witness signature for the following dates: On 6/10/25, there was no documentation for removal or witness signature. On 6/11/25, it was documented fell off on MAR, there was no documentation of destruction. On 6/13/25, there was no documentation for a witness signature. On 6/16/25, there was no documentation for a witness signature. On 6/19/25, there was no documentation for removal or witness signature. On 6/22/25, there was no documentation for a witness signature. On 6/25/25, there was no documentation for removal or witness signature. On 6/28/25, there was no documentation for a witness signature. On 7/1/25, there was no documentation for a witness signature. On 7/4/25, there was no documentation for removal or witness signature. On 7/13/25, there was no documentation for removal or witness signature. On 7/16/25, there was no documentation for a witness signature. On 7/19/25, there was no documentation for removal or witness signature. On 7/22/25, it was documented fell off, there was no documentation of destruction. On 7/25/25, there was no documentation for removal or witness signature. On 7/28/25, there was no documentation for removal or witness signature. On 7/31/25, there was no documentation for a witness signature. On 8/3/25, there was no documentation for a witness signature. On 8/6/25, there was no documentation for removal or witness signature. On 8/9/25, there was no documentation for removal or witness signature. On 8/12/25, there was no documentation for removal or witness signature. On 8/15/25, there was no documentation for removal or witness signature. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/20/25, there was no documentation for removal or witness signature. On 8/23/25, there was no documentation for removal or witness signature. On 8/26/25, there was no documentation for a witness signature. On 8/30/25, there was no documentation for a witness signature. The MAR, dated July 2025, had inconsistent documentation related to the Fentanyl patch placement and indicated the following: On 7/7/25, from 7 a.m. to 3 p.m., it was documented as unavailable. From 3 p.m. to 11 p.m., it was documented as not in place. From 11 p.m. to 7 a.m., it was documented as on the left shoulder. On 7/8/25, from 7 a.m. to 3 p.m., it was documented as N/A. From 3 p.m. to 11 p.m., it was documented as on the upper back. From 11 p.m. to 7 a.m., it was documented as O. On 7/9/25, all three shifts were documented as N/A The MARs, dated June 2025 and August 2025, also contained inconsistent documentation related to the Fentanyl patch placement. After review of the progress notes, controlled drug records, and the MAR, an actual time frame the Fentanyl was unavailability and the missed administrations for Resident 55 was unable to be determined. During an interview, on 9/23/25 at 11:19 a.m., LPN 12 indicated two nurses would need to sign off on the destruction of the Fentanyl patches. During an interview, on 9/23/25 at 3:58 p.m., the Director of Nursing (DON) reviewed the MAR and indicated the documentation in the MAR was not clear or consistent. During an interview, on 9/23/25 at 3:32 p.m., the Assistant Director of Nursing (ADON) indicated most medications were on auto-refill unless the medication was a narcotic. If the medication needed a new prescription, the pharmacy would contact the facility. Fentanyl patch removal would need a signature from the nurse who removed the patch and a second nurse for destruction of the old patch. A current facility policy, titled Resident Rights, dated 6/6/19 and received from the Clinical Support Nurse 2 on 9/24/25 at 1:31 p.m., indicated .Federal and state law as guarantee certain basic rights to all residents of our community. These rights include the resident's right to.Equal access to quality care.Receive care in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life. A current facility policy, titled Medication Administration: General Policies & Procedures, undated and received from the Clinical Support Nurse 2 on 9/24/25 at 1:45 p.m., indicated .Medications are administered as prescribed in accordance with good nursing principles and practices. A current facility policy, titled Drug Disposal, undated and received from the Clinical Support Nurse 2 on 9/24/25 at 1:31 p.m., indicated .The nurse or nurses witnessing the drug destruction is/are (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	responsible for.the following information.entered on a medication destruct record.date of destruction.method of destruction.signatures of the witnesses. A current facility policy, titled Managing Controlled Substances, undated and received from the Clinical Support Nurse 2 on 9/24/25 at 1:31 p.m., indicated .Drugs with high abuse potential are subject to special handling.disposal and record keeping.Schedule II contains drugs with an extremely high abuse potential.it is to be destroyed in the presence of two.licensed nurses.The disposal must be documented on the proof-of-use record on the line representing that dose. A current facility policy, titled CONTROLLED SUBSTANCE RECONCILIATION, undated and received from the Director of Nursing on 9/23/25 at 2:52 p.m., indicated .Each facility should verify the quantity of controlled substances(s) on hand as well as the number of accompanying count sheets at the end of each nursing shift 3.1-25(a) 3.1-25(e)(3) 3.1-25(s)(6) 3.1-25(s)(7) 3.1-25(s)(8)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview and record review, the facility failed to ensure medications were dated when opened, were stored in the original pharmacy packaging, and a medication administration record matched the pharmacy label for a narcotic pain medication for 3 of 5 medication carts (500 Unit, 300 Unit and 700 Unit), 1 of 3 medication storage refrigerators (300 Unit), and 1 of 1 resident (Resident 55) reviewed for drug labeling and storage.Findings include:1. During an observation, on 9/23/25 at 8:17 a.m., with LPN 5 in attendance, the 500 Unit medication cart was found to have the following: a. One 30 milliliter (ml) bottle of morphine with approximately 15 ml left was found without an open date. b. Two 30 ml bottles of morphine with approximately 16 ml left in both bottles were found without an open date. One bottle had a damaged label. 2. During an observation, on 9/23/25 at 11:23 a.m., with LPN 7 in attendance, the 300 Unit medication cart was found to have the following: a. In the drawer of the cart was a clear plastic pouch with the name and room number of Resident 3 written in black and stapled closed. The pouch contained one oval yellow pill, one oval pink pill, one long oval yellow pill, and one round orange pill. The pills were not in the original pharmacy packaging. During an interview, on 9/23/25 at 11:23 a.m., LPN 7 indicated the medications belonged to a resident who did not take them. It was not from her shift. b. One bottle of morphine with approximately four (4) ml left was found without an open date. During an interview, on 9/23/25 at 11:31 a.m., LPN 7 indicated the medication should have had an open date. 3. In the medication storage room, on the 300 Unit, the refrigerator contained one bottle of tuberculin solution (used for tuberculosis testing) found open and without an open date. During an interview, on 9/23/25 at 11:34 a.m., LPN 7 indicated the bottle should have had an open date. The tuberculin solution was good for 30 days after opening. 4. During an observation, on 9/23/25 at 2:18 p.m., with RN 3 in attendance, the 700 Unit medication cart was found to have the following: a. One tube of neomycin-bacitracin-poly-HC eye ointment. The tube was observed to be well used (crushed) and was missing an open date. b. One bottle of olopatadine eye drops was found open without an open date. During an interview, on 9/23/25 at 2:18 p.m., RN 3 indicated the date had been on the top of the lid of the medication container. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. During an observation and interview, on 9/23/25 at 3:32 p.m., the Assistant Director of Nursing (ADON) indicated when a PRN (as needed) medication was ordered and the resident had routine order for the same medication, the nurses could use the PRN dose from the scheduled medication card. The Assistant Director of Nursing reviewed Resident 55's Oxycodone drug record and the medication administration record (MAR) and indicated the medication label on the drug record did not match the medication order on the MAR. She indicated the instructions related to how many times a day had changed, and the nurse should have put a sticker with the new order on the old card. She was unsure how the nurses were verifying the 5 rights of administration without the correct label. The clinical record for Resident 55 was reviewed on 9/19/25 at 2:55 a.m. The diagnoses included, but were not limited to, pain, opioid dependence, and long-term use of drug therapy. A physician's order for Oxycodone 10mg (milligrams) was changed from two times a day to three times a day on 6/6/25. A physician's order for Oxycodone 10 mg was changed from two times a day as needed to two times a day every 12 hours as needed on 6/10/25. The controlled drug record, dated 6/4/25 to 6/14/25, indicated to administer Oxycodone 10 mg two times a day. The controlled drug record, dated 6/15/25 to 6/25/25, indicated to administer Oxycodone 10 mg two times a day. A current facility policy, titled MEDICATION LABELING, undated and received from the Executive Director on 9/23/25 at 10:34 a.m., indicated .Should the attending physician change a medication order for amount to be administered, the nurse may place a change of order-check chart label on the container indicating there is a change in directions for use. A current facility policy, titled Medication Administration General Policies &Procedures, undated and received from the Clinical Support Nurse 2 on 9/24/25 at 1:45 p.m., indicated .Medications are administered as prescribed in accordance with good nursing principles and practices.The label on each medication container shall be read 3 times and compared against the order on the MAR.The nurse or approved designee is responsible for checking to see that the drug and the dosage schedule on the resident's MAR matches the label on the drug's container. The nurse is to check the physician's order for the correct dosage schedule if.The drug container is marked with a signal-type label indicating a recent change in directions for use. A current facility policy, titled MEDICATION LABELING, undated and received from the Executive Director on 9/23/25 at 10:34 a.m., indicated .Contents are not to be transferred from one container to another .Medication containers having soiled, damaged, incomplete, illegible or confusing labels are returned to the dispensing pharmacy for re-labeling A current facility policy, titled MEDICATION ADMINISTRATION: GENERAL POLICIES & PROCEDURES, undated and received from Corporate Support Nurse 2 on 9/24/25 at 1:45 p.m., indicated .Check expiration date on package/container. When opening a multi-dose container or pen, place the date on the container 3.1-25(g)(1) (continued on next page)

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Carmel Health & Living Community	118 Medical Dr Carmel, IN 46032

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3.1-25(k)(2) 3.1-25(k)(3) 3.1-25(k)(4) 3.1-25(k)(5) 3.1-25(k)(6) 3.1-25(k)(7)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, interview and record review, the facility failed to ensure the interdisciplinary team (IDT) determined self-administration of medications was clinically appropriate and notation of the determinations were documented in the resident's medical record and care plan for 1 of 1 resident reviewed for self-administration of nebulizer treatments. (Resident 113)Findings include:During an observation and interview, on 9/19/25 at 9:54 a.m., Resident 113 was observed to be in her room. She had a nebulizer machine with fluid in the nebulizer medicine cup. Resident 113 indicated the nebulizer was set up for her and she forgot to do it. The clinical record for Resident 113 was reviewed on 9/19/25 at 10:04 a.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), pneumonia, and generalized anxiety disorder.A physician's order, dated 7/8/25, indicated to administer 3 milliliters of albuterol sulfate 2.5mg/3mL (0.083 %) solution via inhalation upon rising between 7:00 a.m. and before bedtime between 6:00 p.m. and 10:00 p.m.The resident did not have an assessment, physician order, or a care plan to self-administer nebulizer treatments at the time of the record review.During an interview, on 9/19/25 at 10:13 a.m., RN 3 indicated Resident 113 had an evening nebulizer treatment. She had not been in the resident's room yet and she was not sure if the resident could self-administer nebulizer treatments. During an interview, on 9/24/25 at 9:52 a.m., the Clinical Support Nurse 2 indicated the resident needed to have an assessment, physician's order to self-administer medications and the self-administration needed to be care planned.A current facility policy, titled BEDSIDE MEDICATIONS AND SELF-ADMINISTRATION OF MEDICATIONS, undated and received from the Administrator on 9/23/25 at 9:05 a.m., indicated .if a resident desires to self-administer an assessment is conducted 3.1-11(a)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on interview and record review, the facility failed to ensure blood pressure medications were held according to the physician's orders for 2 of 3 residents reviewed for quality of care. (Resident 13 and 96)Findings include:1. The clinical record for Resident 13 was reviewed on 9/22/25 at 3:09 p.m. The diagnoses included, but were not limited to, hypotension (low blood pressure), repeated falls, weakness, unsteadiness on feet, hypertensive heart disease without heart failure, and essential primary hypertension. A physician's order, dated 6/3/25, indicated to administer midodrine (a medication used to raise blood pressure) 5 milligrams (mg) every 8 hours with special instructions to hold the medication for a systolic blood pressure greater than 140. A Medication Administration Record (MAR), dated August 2025, indicated the midodrine was administered with systolic blood pressure greater than 140 on the following dates and times:On 8/3/25 at 8:00 a.m., with a systolic blood pressure of 152.On 8/17/25 at 4:00 p.m., with a systolic blood pressure of 142. On 8/27/25 at 4:00 p.m., with a systolic blood pressure of 145. A MAR, dated August 2025, indicated midodrine was held with a systolic blood pressure of less than 140, without documentation the resident had refused, on the following dates and times:On 8/1/25 at 12:00 a.m., with a systolic blood pressure of 124 and at 4:00 p.m., with a systolic blood pressure of 134.On 8/2/25 at 12:00 a.m., with a systolic blood pressure of 134 and at 8:00 a.m., with a systolic blood pressure of 120. On 8/3/25 at 12:00 a.m., with a systolic blood pressure of 129. On 8/6/25, all 3 doses were administered with a systolic blood pressure of 127 and 137 with an administration note which indicated the blood pressure was too high for the medication. On 8/7/25, all 3 doses were administered with a systolic blood pressure of 129 and 136. On 8/8/25 at 12:00 a.m., with a systolic blood pressure of 136.On 8/9/25 at 4:00 p.m., with a systolic blood pressure of 133.On 8/10/25 at 12:00 a.m., with a systolic blood pressure of 139.On 8/11/25 at 12:00 a.m., with a systolic blood pressure of 129 and at 4:00 p.m., with a systolic blood pressure of 124. On 8/12/25 at 12:00 a.m., with a systolic blood pressure of 129. On 8/13/25 at 12:00 a.m., with a systolic blood pressure of 125.On 8/14/25 at 12:00 a.m., with a systolic blood pressure of 139 and at 4:00 p.m., with a systolic blood pressure of 139.On 8/15/25 at 12:00 a.m., with a systolic blood pressure of 119.On 8/19/25 at 12:00 a.m., with a systolic blood pressure of 124 and at 4:00 p.m., with a systolic blood pressure of 139.On 8/20/25 at 12:00 a.m., with a systolic blood pressure of 125.On 8/24/25 at 12:00 a.m., with a systolic blood pressure of 134 and at 4:00 p.m., with a systolic blood pressure of 125. On 8/25/25 at 12:00 a.m., with a systolic blood pressure of 136. On 8/26/25 at 4:00 p.m., with a systolic blood pressure of 128. On 8/27/25 at 12:00 a.m., with a systolic blood pressure of 129.On 8/28/25 at 4:00 p.m., with a systolic blood pressure of 127. On 8/29/25 at 12:00 a.m., with a systolic blood pressure of 131. A Medication Administration Record (MAR), dated September 2025, indicated the midodrine was administered with systolic blood pressure greater than 140 on the following dates and times:On 9/1/25 at 4:00 p.m., with a systolic blood pressure of 146.On 9/3/25 at 4:00 p.m., with a systolic blood pressure of 154. On 9/5/25 at 4:00 p.m., with a systolic blood pressure of 146.On 9/7/25 at 8:00 a.m., with a systolic blood pressure of 144. On 9/8/25 at 8:00 a.m., with a systolic blood pressure of 161.On 9/9/25 at 8:00 a.m., with a systolic blood pressure of 157.On 9/11/25 at 12:00 a.m., with a (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	systolic blood pressure of 144. On 9/12/25 at 8:00 a.m., with a systolic blood pressure of 153. On 9/21/25 at 8:00 a.m., with a systolic blood pressure of 155. A MAR, dated September 2025, indicated midodrine was held with a systolic blood pressure of less than 140, without documentation the resident had refused, on the following dates and times:On 9/2/25 at 12:00 a.m., with a systolic blood pressure of 134 and at 4:00 p.m., with a systolic blood pressure of 137.On 9/3/25 at 12:00 a.m., with a systolic blood pressure of 124. On 9/5/25 at 12:00 a.m., with a systolic blood pressure of 139. On 9/6/25 at 12:00 a.m., with a systolic blood pressure of 130.On 9/7/25 at 12:00 am., with a systolic blood pressure of 124. On 9/8/25 at 12:00 a.m., with a systolic blood pressure of 121.On 9/10/25 at 12:00 a.m., with a systolic blood pressure of 134. On 9/12/25 at 12:00 a.m., with a systolic blood pressure of 123. On 9/16/25 at 12:00 a.m., with a systolic blood pressure of 122 and at 4:00 p.m., with a systolic blood pressure of 136.On 9/20/25 at 12:00 a.m., with a systolic blood pressure of 119.On 9/23/25 at 12:00 a.m., with a systolic blood pressure of 123. During an interview, on 9/25/25 at 9:45 a.m., LPN 9 indicated the midodrine medication should not have been administered when the systolic blood pressure was over 140. The nurse's initials would be in parenthesis if the medication was not given. If the resident refused medication, there would be a comment on the MAR. 2. The clinical record for Resident 96 was reviewed on 9/23/25 at 9:17 a.m. The diagnoses included, but were not limited to, peripheral vascular disease, diastolic congestive heart failure, tachycardia, chronic respiratory failure with hypoxia, stage 2 chronic kidney disease, and essential primary hypertension. A physician's order, dated 9/6/24, indicated to administer clonidine (a medication to lower blood pressure) 0.1 mg as needed for a systolic blood pressure greater than 170 twice a day. A physician's order, dated 9/17/24, indicated to administer clonidine as needed twice a day for a systolic blood pressure greater than 170. A MAR, dated August 2025, indicated clonidine was administered with a systolic blood pressure less than 170 on the following dates:On 8/1/25, in the a.m. and p.m. On 8/2/25, in the a.m. and p.m., On 8/3/25, in the a.m. and p.m., On 8/4/25, in the a.m. On 8/5/25, in the a.m. and p.m. On 8/6/25, in the a.m. On 8/7/25, in the a.m. and p.m. On 8/8/25, in the a.m. On 8/9/25, in the a.m. and p.m. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/10/25, in the a.m. and p.m. On 8/12/25, in the a.m. On 8/13/25, in the a.m. On 8/14/25, in the a.m. On 8/15/25, in the a.m. On 8/16/25, in the a.m. and p.m. On 8/18/25, in the a.m. On 8/19/25, in the a.m. and p.m. On 8/20/25, in the a.m. and p.m. On 8/21/25, in the a.m. On 8/22/25, in the a.m. On 8/23/25, in the a.m. On 8/24/25, in the p.m. On 8/26/25, in the a.m. On 8/27/25, in the a.m. and p.m., On 8/28/25, in the a.m. On 8/29/25, in the a.m. and p.m. On 8/30/25, in the a.m. On 8/31/25, in the a.m. A MAR, dated September 2025, indicated clonidine was administered with a systolic blood pressure less than 170 on the following dates: On 9/1/25, in the a.m. On 9/2/25, in the a.m. On 9/3/25, in the a.m. On 9/4/25, in the a.m. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/5/25, in the a.m. and p.m. On 9/6/25, in the a.m. On 9/7/25, in the a.m. On 9/8/25, in the a.m. On 9/9/25, in the a.m. On 9/10/25, in the a.m. On 9/11/25, in the a.m. On 9/12/25, in the p.m. On 9/13/25, in the a.m. On 9/14/25, in the a.m. and p.m. On 9/17/25, in the a.m. and p.m. On 9/18/25, in the a.m. and p.m. On 9/20/25, in the p.m. On 9/21/25, in the p.m. On 9/24/25, in the a.m. During an interview, on 9/25/25 at 11:00 a.m., the Clinical Support Nurse 2 indicated the clonidine order should have been as needed for a systolic blood pressure greater than 170 and not given if the blood pressure was less than 170. A current facility policy, titled MEDICATION ADMINISTRATION: GERNERAL POLICIES & PROCEDURES, received from the Clinical Support Nurse 2 on 9/24/25 at 1:45 p.m., indicated .All medications are to be administered only as prescribed by a physician. A current facility policy, titled Resident Rights, dated 6/6/19 and received from the Clinical Support Nurse 2 on 9/24/25 at 1:31 p.m., indicated .Federal and state laws guarantee certain basic rights to all residents of our community. These rights include the resident's right to.Equal access to quality care.Receive care in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life. A current facility policy, titled Transcribing Orders, undated and received from the Clinical Support Nurse 2 on 9/24/25 at 1:45 p.m., indicated .Physician orders will be transcribed to dedicated medical records timely, completely and accurately using acceptable standards of practice.Physician Telephone Orders.Must be timely. Orders should be written at the time they are received to avoid confusion later.Must be verified.Noted the prescribing physician's name along with the name and title (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of the name of the licensed professional who is documenting the order. 3.1-37(a)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview and record review, the facility failed to ensure oxygen and nebulizer tubing lines were dated and a physician order was in place for the use of oxygen for 3 of 5 residents reviewed for respiratory care. (Resident 12, 113 and 138)Findings include: 1. During an observation, on 9/18/25 at 10:21 a.m., Resident 12 was receiving oxygen via nasal cannula. The oxygen line did not have a date to show when it was last changed. The resident had a nebulizer machine on a gray plastic dresser. The nebulizer was not in use, and the mask was observed to be stored next to the machine and not in a storage bag. The clinical record for Resident 12 was reviewed on 9/24/25 at 3:23 p.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), cough, and age-related debility. A physician's order, dated 9/15/23, indicated to change and date the oxygen tubing, humified bottle, and the nebulizer tubing every week on Sunday and as needed. During an interview, on 9/18/25 at 10:28 a.m., QMA 4 indicated the oxygen line, and the nebulizer line should have been dated. The nebulizer mask should have been stored in a bag, but she did not know where the storage bag was. 2. During an observation, on 9/19/25 at 10:32 a.m., Resident 113 was receiving oxygen and had a nebulizer machine with fluid in the nebulizer medicine cup. The oxygen line and nebulizer line were not dated. The clinical record for Resident 113 was reviewed on 9/19/25 at 10:04 a.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), pneumonia, and generalized anxiety disorder. A physician's order, dated 12/29/22, indicated to change and date the oxygen tubing, humified bottle, and the nebulizer tubing every week on Sunday and as needed. 3. During an observation, on 9/18/25 at 9:58 a.m., Resident 138 was receiving oxygen at 3 liters per minute. During an observation, on 9/18/25 at 3:09 p.m., Resident 138 was receiving oxygen at 3 liters per minute. The clinical record for Resident 138 was reviewed on 9/19/25 at 9:58 a.m. The diagnoses included, but were not limited to, congestive heart failure, fluid overload, and age-related debility. There was no physician's order for oxygen located in the resident's clinical record. During an interview, on 9/18/25 at 3:17 p.m., Registered Nurse (RN) 20 indicated Resident 138 received oxygen, she did not see an oxygen order, and there should be a physician's order for the use of oxygen. During an interview, on 9/18/25 at 3:20 p.m., RN 21 indicated a resident should have a physician's order for the use of oxygen. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 9/25/25 at 10:43 a.m., the Clinical Support Nurse 1 indicated the facility did not have a policy related to the nebulizer machine and it fell under the respiratory/oxygen policy/procedure. A current facility procedure, titled .OXYGEN ADMINISTRATION SKILLS VALIDATION dated 3/4/24 and received from the Corporate Support Nurse on 9/19/25 at 11:38 a.m., indicated .Wash hands and gather the necessary supplies.Tape – for labeling the date and initials of the preparer.Date and initial tape and attach to tubing.Verify physician's order for the liter flow, method of delivery, and length of administration prior to administering oxygen. 3.1-47(a)(6)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on observation, interview and record review, the facility failed to ensure an active physician's order for hemodialysis and monitoring before and after dialysis was obtained for 1 of 1 resident reviewed for dialysis. (Resident 7)Findings include:During an observation, on 9/19/25 at 9:39 a.m., Resident 7 was not in her room, and a staff member indicated the resident had gone to dialysis.During an observation, on 9/22/25 at 9:10 a.m., Resident 7 was not in her room, and a staff member indicated the resident had gone to dialysis.During an observation and interview, on 9/24/25 at 11:52 a.m., Resident 7 was in her room and had just finished eating her lunch after returning from dialysis. She indicated she had been receiving dialysis for a few years.The clinical record for Resident 7 was reviewed on 9/23/25 at 1:17 p.m. The diagnoses included, but were not limited to, end stage renal disease (ESRD), chronic kidney disease stage 3, and dependence on renal dialysis.A care plan, dated 9/9/22, indicated Resident 7 received hemodialysis due to end stage renal disease.A physician's order, dated 7/12/25, indicated to administer midodrine (a medication to treat low blood pressure) before dialysis every Monday, Wednesday and Friday.An active physician's order for dialysis was not located in the electronic health record.Physician's orders which indicated Resident 7 received dialysis on Monday, Wednesday and Friday, was to have a pre dialysis assessment completed before treatment, and a post dialysis assessment completed after treatment was discontinued on 7/6/25.The electronic health record indicated Resident 7 was discharged to the hospital on 7/6/25 and was readmitted into the facility on 7/12/25.A hospital discharge document, dated 7/12/25, indicated the care needs after discharge for post-acute services was dialysis.During an interview, on 9/23/25 at 3:07 p.m., the Assistant Director of Nursing (ADON) reviewed the physician's orders and indicated Resident 7 did not have an active physician's order for dialysis or adequate monitoring in place.During an interview, on 9/25/25 at 3:39 p.m., the Administrator indicated when a resident returned to the facility from the hospital, the hospital discharge papers were reviewed by the nurse. The nurse then placed the orders into the electronic health record. A readmission meeting was held the following day, and orders were to be reviewed. The orders for dialysis were missed.During an interview, on 9/24/25 at 1:37 p.m., the Clinical Support Nurse 2 indicated the facility did not have a policy for physician order reconciliation. Reconciliation of orders was considered standard nursing practice. The morning after the resident returned to the facility, the nursing managers should have met and reviewed all orders to ensure accuracy.A current facility policy, titled Resident Rights, dated 6/6/19 and received from the Clinical Support Nurse 2 on 9/24/25 at 1:31 p.m., indicated .Federal and state laws guarantee certain basic rights to all residents of our community. These rights include the resident's right to.Equal access to quality care.Receive care in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life.A current facility policy, titled Hemodialysis Policy, dated 6/4/16 and received from the Clinical Support Nurse 2 on 9/24/25 at 1:31 p.m., indicated .ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan and the individual resident's goals and preferences.3.1-37(a)

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. Based on interview and record review, the facility failed to ensure the diagnosis used supported the adequate indications for use of the medication for 2 of 6 residents reviewed for unnecessary medications. (Resident 3 and 11)Findings include:1. The clinical record for Resident 3 was reviewed on 9/22/25 at 11:18 a.m. The diagnoses included, but were not limited to, constipation, anxiety disorder, and pain. A physician's order, dated 8/19/25, indicated to administer sennosides-docusate sodium (a medication used for constipation) tablet twice a day for unsteadiness on feet. A pharmacy Medication regimen review, dated 8/26/25, indicated Resident 3's medications were reviewed by the pharmacist with no recommendations. During an interview, on 9/24/25 at 10:21 a.m., the Director of Nursing (DON) reviewed Resident 3's medication orders and indicated the medication sennosides-docusate sodium did not have the correct supporting diagnosis. During an interview, on 9/24/25 at 10:36 a.m., Clinical Support Nurse 2 indicated the pharmacy reviewed medications, allergies, diagnoses, and interactions. 2. The clinical record for Resident 11 was reviewed on 9/18/25 at 12:46 p.m. The diagnoses included, but were not limited to, encounter for orthopedic aftercare following surgical amputation, cellulitis of the left lower limb, and urinary tract infection. A physician's order, dated 8/1/25, indicated to administer cephalexin 500 milligrams once a day for a urinary tract infection. The order had no end date for the medication. During an interview, on 9/22/25 at 11:31 a.m., Clinical Support Nurse 2 indicated Resident 11 was on the cephalexin for a non-healing foot wound, below the knee amputation, and chronic urinary tract infection. The facility nurse practitioner did not note the chronic urinary tract infection, and he would contact the physician. During an interview, on 9/22/25 at 12:04 p.m., Clinical Support Nurse 2 indicated urinary tract infection (UTI) was an incorrect diagnosis and it should have been prophylaxis for a wound. A current facility policy, titled TRANSCRIBING ORDERS, undated and received from Clinical Support Nurse 2 on 9/24/25 at 1:35 p.m., indicated .Medication orders require .drug .and associated diagnosis A facility document, titled Pharmacy Consultant Agreement, undated and received from Clinical Support Nurse 2 on 9/24/25 at 1:42 a.m., indicated .Pharmacy Consultant Services.General Responsibilities.Ensure the proper labeling of all drugs.and that labeling is based on currently accepted professional standards. 3.1-48(a)(4)