

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

PRINTED: 06/01/2021

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 05/19/2021
NAME OF PROVIDER OR SUPPLIER WOODLAND TERRACE OF CARMEL		STREET ADDRESS, CITY, STATE, ZIP CODE 689 PRO MED LANE 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
R 0000 Bldg. 00	<p>This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00352265.</p> <p>Complaint IN00352265 - Unsubstantiated due to lack of evidence.</p> <p>Survey dates: May 18 and 19, 2021</p> <p>Facility number: 013510</p> <p>Residential Census: 80</p> <p>These State Residential Findings are cited in accordance with 410 IAC 16.2-5.</p> <p>Quality review was completed on May 21, 2021.</p>	R 0000		
R 0120 Bldg. 00	<p>410 IAC 16.2-5-1.4(e)(1-3)</p> <p>Personnel - Noncompliance</p> <p>(e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows:</p> <p>(1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for</p>			

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 05/19/2021
NAME OF PROVIDER OR SUPPLIER WOODLAND TERRACE OF CARMEL		STREET ADDRESS, CITY, STATE, ZIP CODE 689 PRO MED LANE CARMEL, IN 46032		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>nonnursing personnel.</p> <p>(2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia.</p> <p>(3) Inservice records shall be maintained and shall indicate the following:</p> <p>(A) The time, date, and location.</p> <p>(B) The name of the instructor.</p> <p>(C) The title of the instructor.</p> <p>(D) The names of the participants.</p> <p>(E) The program content of inservice.</p> <p>The employee will acknowledge attendance by written signature.</p> <p>Based on interview and record review, the facility failed to ensure an employee received an in-service in Resident Rights in the prescribed time frame for 1 of 5 employees reviewed for in-services (CNA 2).</p> <p>Finding includes:</p> <p>The employee record was reviewed on 05/18/2021 at 4:20 p.m.</p> <p>CNA 2's record contained a Certificate of Completion for Protecting Resident Rights in Assisted Living Facilities dated 08/01/2018.</p> <p>During an interview, on 05/19/2021 at 10:15 a.m., the Director of Nursing indicated she was unable to locate further information regarding staff in-services and employees should be in-serviced in Resident Rights every 12 months.</p>	R 0120	<p>ED immediately contacted employee that failed to receive an in-service on Resident Rights within the prescribed time frame. Employee was provided a copy of the Resident Rights and signed a receipt of the copy. ED gave signed receipt of the Resident Rights to IDOH surveyor.</p> <p>ED audited entire staff for documentation of Resident Rights in-service to ensure all current employees have received it within the prescribed time frame.</p> <p>ED providing Resident Rights training to each employee and requiring signed record of the Resident Rights for those employees that have not received Resident Rights in-service in</p>	06/19/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 05/19/2021
NAME OF PROVIDER OR SUPPLIER WOODLAND TERRACE OF CARMEL		STREET ADDRESS, CITY, STATE, ZIP CODE 689 PRO MED LANE 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
R 0217 Bldg. 00	<p>During an interview, on 05/19/2021 at 10:39 a.m., the Executive Director indicated he was unable to provide a policy and the facility followed the state guidelines for providing the required education in-services.</p> <p>410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency</p> <p>(e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows:</p> <p>(1) The services offered to the individual resident shall be appropriate to the:</p> <p>(A) scope; (B) frequency; (C) need; and (D) preference; of the resident.</p> <p>(2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review.</p> <p>(3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request.</p> <p>(4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services.</p> <p>(5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.</p> <p>Based on observation, interview and clinical</p>	R 0217	<p>2021. ED will complete the Resident Rights documentation audit by June 19, 2021.</p>	06/19/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 05/19/2021
NAME OF PROVIDER OR SUPPLIER WOODLAND TERRACE OF CARMEL		STREET ADDRESS, CITY, STATE, ZIP CODE 689 PRO MED LANE CARMEL, IN 46032		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>record review, the facility failed to document the services to be provided by the facility for 1 of 7 residents reviewed (Resident 5) and failed to ensure the service plans were signed and dated for 7 of 7 resident service plans reviewed (Residents 5, 1, 4, 2, 3, 6 and 7).</p> <p>Findings include:</p> <p>1. During an observation, on 05/18/2021 at 11:12 a.m., Resident 5 walked from the threshold of his room doorway to a couch in his apartment, shuffling his feet as he walked. His hair was uncombed, he appeared unshaven with visible hair stubble on his face and his clothing was wrinkled and disheveled. The sheets and blankets on the bed in the apartment were haphazardly pulled back and crumpled. Clothing was laying on the floor of the bathroom.</p> <p>Resident 5's clinical record was reviewed on 05/18/2021 at 4:10 p.m. Diagnosis included, but were not limited to dementia, hypertension (high blood pressure), osteoarthritis, diverticular disease (inflammation of the colon), gout (inflammatory arthritis) and bilateral cataracts (a cloudy area in the lens of the eye).</p> <p>The resident's "Pre-Admission Assessment - V5", dated 03/05/2021, indicated the following:</p> <p>"...Resident chooses to have staff come to apartment and wake in the morning..."</p> <p>"...Resident requires standby assistance with preparation and performance of grooming tasks..."</p> <p>"...Resident requires some assistance to bathe or shower..."</p> <p>"...Resident requires some assistance with clothes selection and/or help with dressing/undressing..."</p>		<p>service plan for resident that facility had failed to document services for. Resident signed and date the updated service plan. HSD or designee will audit all residents to ensure all residents have an updated signed and dated by the resident service plan within the last 6 months.</p> <p>HSD or designee will assess and update any service plans that are not in compliance. Resident will sign and update any service plans that are not in compliance.</p> <p>HSD or designee will continue to conduct a resident assessment and update the resident service plans with a resident signature and date semi-annually on an ongoing basis. HSD or designee will audit resident service plans monthly for 3 months to ensure compliance.</p> <p>HSD or designee will complete the Resident Service plan audit by June 19, 2021.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 05/19/2021
NAME OF PROVIDER OR SUPPLIER WOODLAND TERRACE OF CARMEL		STREET ADDRESS, CITY, STATE, ZIP CODE 689 PRO MED LANE CARMEL, IN 46032		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>"...Resident chooses to have staff check on resident during the night..."</p> <p>"...Resident has a history of falls and requires specification on service plan to manage..."</p> <p>"...Resident requires assistance transferring..."</p> <p>"...Resident requires escorting throughout residence to attend activities of choice and meals three times a daily..."</p> <p>"...Resident requires one or more assuasive/adaptive device for eating, ambulating, or grooming/hygiene..."</p> <p>"...Resident requires medication management 2x/day..."</p> <p>Resident 5's service plan, with an initiation date of 03/17/2021 and a revision date of 05/11/2021, included 2 focus areas, falls and transferring. Needs identified during the Pre-Admission Assessment were not observed to be included in the service plan and the service plan was not signed and dated.</p> <p>2. The clinical record for Resident 1 was reviewed on 05/19/2021 at 10:30 a.m. Diagnosis included, but were not limited to, cerebral palsy and urinary incontinence. The service plan for Resident 1, dated 03/27/2021, was not signed and dated.</p> <p>3. The clinical record for Resident 4 was reviewed on 05/19/2021 at 10:46 a.m. Diagnosis included, but were not limited to, asthma, anxiety disorder and osteoporosis. The service plan for Resident 4, dated 04/26/2021, was not signed and dated.</p> <p>4. The record for Resident 2 was reviewed on 05/18/2021 at 3:00 p.m. Diagnoses included, but were not limited to, hypertension and Diabetes Mellitus. The service plan for Resident 2, dated 07/16/2020, was not signed and dated.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 05/19/2021
NAME OF PROVIDER OR SUPPLIER WOODLAND TERRACE OF CARMEL		STREET ADDRESS, CITY, STATE, ZIP CODE 689 PRO MED LANE CARMEL, IN 46032		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>5. The record for Resident 3 was reviewed on 5/18/2021 at 3:10 p.m. Diagnoses included, but were not limited to, chronic fatigue and hypertension. The service plan for Resident 3, dated 04/05/2021, was not signed and dated.</p> <p>6. The record for Resident 6 was reviewed on 05/18/2021 at 3:12 p.m. Diagnoses included, but were not limited to, lung disease and hypertension. The service plan for Resident 6, dated 04/21/2021, was not signed and dated.</p> <p>7. The record for Resident 7 was reviewed on 05/19/2021 at 10:20 a.m. Diagnoses included, but were not limited to, dementia, stroke and Parkinson's Disease. The service plan for Resident 7, dated 08/25/2020, was not signed and dated.</p> <p>During an interview, on 05/18/2021 at 5:15 p.m., the Director of Nursing indicated all service plans should be reviewed and updated related to the resident's change in condition, signed and dated.</p> <p>A current policy, titled "Resident Service Plan," dated 10/12/2018 and provided by the Executive Director on 05/19/2021 at 10:40 a.m., indicated "...2. The services offered and planned for each resident will be appropriate to the scope, frequency, need and preference of each resident...3. The Service Plan will reflect the functional level of the resident and will contain a brief explanation of the amount and frequency of assistance or interventions to be provided for each of the assessment areas...7. The resident and/or resident's family member/legal representative will sign and date his or her Service Plan...10. Each resident's Service Plan shall be reviewed</p>			

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

PRINTED: 06/01/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 05/19/2021	
NAME OF PROVIDER OR SUPPLIER WOODLAND TERRACE OF CARMEL			STREET ADDRESS, CITY, STATE, ZIP CODE 689 PRO MED LANE 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 revised as indicated by subsequent Resident Assessments...."				