

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155636	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HARRISON TERRACE	STREET ADDRESS, CITY, STATE, ZIP CODE 1924 WELLESLEY BLVD INDIANAPOLIS, IN 46219
--	--

(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
F000000	<p>This visit was for the Investigation of Complaint #IN00149626.</p> <p>Complaint #IN00149626 - Unsubstantiated due to lack of evidence.</p> <p>Unrelated deficiencies are cited.</p> <p>Survey Date: May 21, 2014.</p> <p>Facility number: 000241 Provider number 155636 AIM number: 100291310</p> <p>Survey Team: Tom Stauss, RN-TC Beth Walsh, RN</p> <p>Census Bed Type: SNF/NF: 99 Total: 99</p> <p>Census Payor Type: Medicare:12 Medicaid:77 Other:10 Total: 99</p> <p>These state findings are cited in accordance with 410 IAC 16.2-3.</p> <p>Quality review completed on May 29,</p>	F000000	<p>The creation and submission of this Plan of Correction doesnot constitute an admission by this provider of any conclusion set forth in thestatement of deficiencies, or of any violation of regulation. This provider respectfully requests that the2567 Plan of Correction be considered the Letter of Credible Allegation andrequests a Desk Review in lieu of a Post Survey Revisit on or after June 6,2014</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: 155636	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HARRISON TERRACE	STREET ADDRESS, CITY, STATE, ZIP CODE 1924 WELLESLEY BLVD INDIANAPOLIS, IN 46219
--	--

(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
--------------------	--	---------------	---	----------------------

F009999	<p>2014 by Cheryl Fielden, RN.</p> <p>Based on interview and record review, the facility failed to ensure 2 reference checks were performed upon hire for 3 employees. (Employees A, B & C)</p> <p>On 5/21/14 at 1:52 p.m., during a review of employee records, two employees (employees A & B) records did not have any reference checks included in the files. Another employee, employee C, had one of two completed reference checks in the employee's record.</p> <p>A facility policy titled "Facility Instructions For Conducting A Reference Check" indicated the following: "...The State of Indiana...require two complete reference checks for each employee prior to their start date..."</p> <p>On 5/21/14 at 2:08 p.m., during an interview with the Payroll Coordinator,</p>	F009999	<p>F9999 ReferenceChecks It is the intent of this provider to ensure reference checks are completed for new hire employees. What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? No residents were identified in the alleged deficient practice. How will you identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken No residents are identified in the alleged deficient practice. All employee files were audited for reference checks. What measures will be put into place or what systemic changes you will make to ensure that the alleged deficient practice does not recur In-service education was provided to all department managers and HR</p>	06/06/2014
---------	--	---------	---	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155636	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/21/2014
NAME OF PROVIDER OR SUPPLIER HARRISON TERRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 1924 WELLESLEY BLVD INDIANAPOLIS, IN 46219		
(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>who identified herself as the facility representative who performs new hire reference checks, indicated she did not complete the required amount of reference checks for employees A, B, and C.</p> <p>On 5/21/14 at 2:14 p.m., the Administrator indicated staff should always follow facility policy when performing reference checks.</p> <p>410 IAC 16.2-5-0.5</p>		<p>representatives by Executive Director / Designee by June 6, 2014 on hiring/ reference process that includes interviews, and review of reference checks byrespective manager and Executive Director. This process also includes an interview withthe Executive Director and review of the Criminal History check. Any new managers will be trained on theprocess during their orientation. Compliance will be measured via the 'Personneland Confidential Employee File Checklist', which will be completed for each newhire personnel file. ED will reviewchecklist to ensure complete. How the correctiveaction(s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place Thecorrective actions will be monitored monthly by the HR representative /Clinical Education Coordinator (CEC) x six (6) months, and quarterly thereafter. The results of these audits will be reviewedby the CQI committee overseen by the ED. If the threshold of 100% is not achieved an action plan will be developedto ensure compliance.</p> <p>Compliance date: June 6, 2014</p>		

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

PRINTED: 06/09/2014

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155636	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/21/2014
NAME OF PROVIDER OR SUPPLIER HARRISON TERRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 1924 WELLESLEY BLVD INDIANAPOLIS, IN 46219		
(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	