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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155636 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>01/13/2015 |
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| NAME OF PROVIDER OR SUPPLIER<br><br>HARRISON TERRACE | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1924 WELLESLEY BLVD<br>INDIANAPOLIS, IN 46219 |
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| F000000 | <p>This visit was for the Investigation of Complaint IN00162340.</p> <p>Complaint IN00162340- Substantiated. A deficiency related to the allegations is cited at F323.</p> <p>Survey date: January 12 and 13, 2015</p> <p>Facility number 000241<br/>Provider number 155636<br/>AIM number 100291310</p> <p>Survey team:<br/>Chuck Stevenson RN</p> <p>Census bed type:<br/>SNF/NF: 106<br/>Total: 106</p> <p>Census payor type:<br/>Medicare: 12<br/>Medicaid: 85<br/>Other: 9<br/>Total: 106</p> <p>Sample: 3</p> <p>This deficiency also reflects State findings cited in accordance with 410 IAC 16.2.3-1.</p> | F000000 |  |  |
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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.

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| F000323<br>SS=D                                      | <p>Quality review completed on January 15, 2015 by Cheryl Fielden, RN.</p> <p>483.25(h)<br/>FREE OF ACCIDENT<br/>HAZARDS/SUPERVISION/DEVICES<br/>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based record review and interview, the facility failed to ensure a resident with dementia and who was an assessed elopement risk was provided adequate supervision to prevent elopement while out of the facility at a doctor's appointment (Resident # B). 1 resident of 3 reviewed for supervision to ensure safety.</p> <p>Findings include:</p> <p>The record of Resident # B was reviewed on 1/12/15 at 11:00 A.M. Diagnoses included, but were not limited to, dementia, a history of alcohol abuse, chronic urinary tract infections, hypertension, and chronic obstructive pulmonary disease.</p> <p>A quarterly Minimum Data Set (MDS) assessment dated 11/06/14 indicated Resident # B was cognitively impaired,</p> | F000323   | <p><b>Planof Correction for Harrison Terrace 2015 Complaint</b></p> <p>The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.</p> <p>This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey review on or after January 28th 2015</p> <p><b>F323 FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</b></p> <p>It is the practice of this provider to ensure that all alleged violations involving Free of accident Hazards/supervision/devices are in accordance with State and</p> | 01/28/2015           |   |

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|                    | <p>required extensive staff assistance with transfers and all activities of daily living, could ambulate with supervision, and was incontinent of bowel and bladder.</p> <p>A care plan dated 5/21/14 indicated "Problem: Resident requires a secured unit due to diagnosis of dementia."</p> <p>A care plan dated 5/21/14 indicated "Problem: Resident is at risk for elopement per the elopement risk (sic)."</p> <p>An Elopement Risk Assessment dated 5/21/14 indicated Resident # B was "At risk for elopement."</p> <p>A nurse's note dated 1/06/2015 at 1:45 P.M., indicated "(name of ambulance service) here to pick up resident to transport to appointment with (name of physician) Urology. Resident will be going by himself to this appointment. Resident pleasant and voiced understanding of where he was going. Resident readily went with EMT (emergency medical technician)."</p> <p>An Interdisciplinary Team note dated 1/06/2015 at 6:00 P.M., and noted to be a late entry on 1/07/2015 at 6:59 A.M., indicated: "Resident returned to the facility via Harrison Terrace MCF (Memory Care Facilitator). Resident went</p> |               | <p>Federal law.</p> <p><b>1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?</b></p> <ul style="list-style-type: none"> <li>Resident B's care plan was updated to indicate the resident must have supervision when going to all outside appointments. Resident B's upcoming appointments have been reviewed and supervision has been scheduled to attend these appointments with the resident if applicable.</li> <li>The CECor designee has in-serviced the facility staff on ensuring all residents who go to an outside appointments must have supervision with them on or before 1/28/14.</li> </ul> <p><b>2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken</b></p> <ul style="list-style-type: none"> <li>All residents who are sent to an outside appointment from the facility have the potential to be affected by the same alleged deficient practice.</li> <li>The CECor designee has in-serviced the facility staff on ensuring all residents who go to an outside appointments must have supervision with them on or before 1/28/14.</li> </ul> <p><b>3: What measures will be put into place or what systemic changes will</b></p> |                      |

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|  | <p>for his appointment at (name of medical practice). (Name of ambulance service) transported resident to the appointment via w/c (wheel chair). Resident arrived early for appointment and Ambulance attendants left resident without (name of medical practice) staff being aware. Resident was last visualized at 2:20 P.M. At 3:00 P.M., when resident was being called back for his appointment, he was not in the waiting room. (Name of medical practice) noted an empty w/c and resident no where around. HT (Harrison Terrace) was immediately notified. Several HT staff immediately went out to search the area near (name of medical practice): surrounding businesses, restaurants, and offices. At 4pm, the ED (Executive Director) was notified by police that resident was at (name of acute care hospital). Apparently, a public bystander noticed the resident wandering around and that he looked confused and notified first responders who sent an ambulance to pick up the resident. The ambulance arrived at (name of acute care hospital) at 3:45 pm. HT staff arrived at (name of acute care hospital) at 4:15pm and stayed with resident until he was medically cleared. Resident had been fully dressed in long sleeved shirt, jeans, tie shoes, winter coat and stocking cap. Resident had no injuries, no evidence of prolonged exposure to the cold and no</p> |   | <p><b>be made to ensure that the deficient practice does not recur.</b></p> <ul style="list-style-type: none"> <li>When a resident is scheduled for an appointment the nurse in charge of the resident will ensure the resident has scheduled supervision for the appointment. The nurse will review the transportation schedule and ensure an escort is assigned. Prior to sending the resident the nurse will ensure that the supervision is present with the resident. The nurse will sign on the transfer documentation that the escort is present prior to allowing the resident to leave for the appointment.</li> <li>The facility nursing staff will review the appointment schedule daily and ensure residents going out on an appointment that day have scheduled supervision by identifying the assigned escort on the schedule.</li> <li>DNS or designee will review the daily transportation/appointment schedule each morning ensuring all residents have scheduled supervision for their appointment. The assigned supervision will be documented on the appointment schedule.</li> </ul> <p><b>4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place</b></p> <ul style="list-style-type: none"> <li>An elopement CQI audit tool will be completed for six months</li> </ul> |  |  |   |  |

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|  | <p>evidence of any fall. Head CT was clear, all blood work was OK, resident was (symbol for "positive") for UTI (urinary tract infection) and given Rx (prescription) for ATB (antibiotic). Chronic UTIs was the reason resident was going out to (name of medical practice) for appt. (appointment). Resident was released to HT MCF and transported back to the facility. Resident ambulated into the facility and greeted this writer warmly. Resident was in a pleasant mood. Care plan updated. Present during discussion: ED, MCF (symbol for "and") DNS (Director of Nursing Services)."</p> <p>An "Employee Communication Form" dated 1/06/15 and signed by RN #1, the ED, and DNS indicated "On 1/6/15 (symbol for "at") 1:45pm charge nurse documented that resident was transported to doctor appointment, and going by himself to this appointment. Resident Dx (diagnoses) of Dementia, Senile (symbol for "with") depression listed on his current patient face sheet...This resident should have been escorted to this appointment to ensure resident safety needs were being met." The form indicates RN #1 was terminated for "Resident Safety-Gross carelessness or negligence of duties."</p> |   | <p>with audits being completed once weekly for one month and monthly for 5 months by the DNS or designee.</p> <ul style="list-style-type: none"> <li>·The elopement CQI audit tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed.</li> <li>·Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee.</li> <li>·Date of Compliance 1/28/2015.</li> </ul> |  |  |   |  |

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|  | <p>During an interview on 1/12/15 at 3:00 P.M., with the Executive Director (ED) and Director of Nursing Services (DNS) present, the A.D. indicated it was facility policy for residents to never leave the facility for appointments without an escort and that all staff are aware of this requirement. The facility has a reserve of on call staff to accompany residents to appointments, and staff have access to this information. The DNS indicated that all outside appointments are entered in the facility's computerized record system and that a report of all appointments is generated each day. The DNS indicated that in the morning on 1/06/14 she asked RN #1, Resident B's charge nurse, if an escort had been arranged for his doctor's appointment that day, and that the nurse had assured her that it had been arranged.</p> <p>CNA #2, the aide who was assigned to Resident # B on 1/06/15, was interviewed on 1/13/15 at 9:00 A.M. She indicated that on 1/06/15 she advised RN #1 against sending Resident # B to his appointment without an escort, as it was unsafe and against facility policy, but that the nurse indicated Resident # B "would be fine" and sent him without an escort. CNA #2 also indicated that since RN #1 was the charge nurse that she had the authority to make that decision.</p> |   |   |  |  |   |  |

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|  | <p>A facility policy titled "Elopement (Risk and Missing Resident)" dated 10/13 indicated: "Policy: It is the policy of the facility that staff who have residents under their care are responsible for knowing the location of those residents, and in the case of a missing resident, ensuring appropriate action is taken."</p> <p>3.1-19(c)<br/>3.1-45(a)(1)</p> |   |   |                      |   |