

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 04/04/2013
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NAME OF PROVIDER OR SUPPLIER HARRISON TERRACE	STREET ADDRESS, CITY, STATE, ZIP CODE 1924 WELLESLEY BLVD INDIANAPOLIS, IN 46219
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F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00125436.</p> <p>This visit was in conjunction with Investigation of Complaint IN00126771.</p> <p>Complaint IN00125436 - Substantiated. Federal/State deficiency related to the allegation is cited at F253.</p> <p>Survey Dates: March 26, 27, 28, and April 1, 2, 3, 4, 2013</p> <p>Facility number: 000241 Provider number: 155636 AIM number: 100291310</p> <p>Survey Team: Courtney Mujic, RN- TC Beth Walsh, RN Karina Gates, Medical Surveyor (March 26, 27, 28, 2013)</p> <p>Census Bed Type: SNF/NF: 101 Total: 101</p> <p>Census Payor Type: Medicare: 8</p>	F000000	The facility respectfully requests desk review for paper compliance.	
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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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	<p>Medicaid: 76 Other: 17 Total: 101</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 4/11/13 by Suzanne Williams, RN</p>			

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F000241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, record review, and interview, the facility failed to ensure a resident's dignity was maintained in following up with a resident's verbal request for 1 of 1 resident randomly observed for dignity. (Resident #77)</p> <p>Findings include:</p> <p>Resident #77's clinical record was reviewed on 4/2/2013 at 11 a.m. Diagnoses included, but were not limited to, dementia.</p> <p>An observation of Resident #77 in the dining room on 3/27/2013 at 11:10 am indicated she asked if she could be brought to a table, "I pay all this money and then they just bring me out here and leave me in the middle of the room." The resident was sitting in her wheelchair in the middle of the entrance to the dining room. At 11:10 am CNA #2 indicated, "Oh, we'll get her to a table when she's done with activities, when it's time to eat. Right now she's doing the activity." She did</p>	F000241	<p>1. When resident #77 requests to be placed at a table, the request will be honored.</p> <p>Resident will be interviewed for possible stress and psychosocial well-being. Staff will honor resident's requests promptly.</p> <p>Resident was interviewed and no signs of psycho-social distress were verbalized.</p> <p>2. All residents have the potential to be affected by the alleged deficient practice. Staff was in serviced by Staff Development Coordinator by May 3, on responding and honoring each resident's requests and needs to ensure residents' needs are met and any psychosocial distress is noted and prevented. Customer Care rounds will be conducted daily to inquire of residents if requests are honored promptly. If concerns are noted, the concern will be corrected immediately by responsible staff.</p> <p>3. All staff was inserviced on resident rights by the Staff Development Coordinator by May 3, upon hire and quarterly thereafter. Customer Care rounds will be</p>	05/03/2013

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	<p>not take the resident to a table. The resident was not participating in the activity. CNA #2 remained in the dining room cleaning up tables in preparation for the lunch meal which started at 11:30 a.m.</p> <p>A care plan indicated, "Start date 8/8/2011. Problem: Resident is not the height of dining room table and requests to stay in w/c (wheelchair) at times. Goal: Will demonstrate the ability to consume meals without difficulty due to table height. Approach: Encourage to sit in dining room chair. Assist with meals as needed."</p> <p>An interview with the Director of Nursing (D.O.N.) on 4/3/2013 at 1:25 p.m. indicated, "It was probably an inappropriate response." She indicated she would check into whether or not the CNA thought she wanted to be taken out of her wheelchair and placed into a regular chair, which would then require supervision. She thinks the CNA probably shouldn't have told her she couldn't sit at a table, it wasn't too long before the meal would've started, about 20 minutes. There is no rule about how long residents can sit at a table before the meal begins, except that some residents might not want to</p>		<p>conducted daily to inquire of residents if requests are honored promptly. In addition, any requests made by a resident will be followed through on a timely manner.</p> <p>4. To ensure compliance, the DNS/Designee is responsible for the completion of the Privacy Dignity CQI tool weekly times 4 weeks, bi-monthly times 2 months and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.</p>	

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	<p>wait long for a meal to start and then won't eat because they'll want to leave before it even begins.</p> <p>An interview with the D.O.N. on 4/3/2013 at 1:58 p.m. indicated she went and asked about this resident and she was told that because she is so short, she needs to be supervised closely while she's sitting in a regular chair, so 20 minutes before a meal really is too long for her to be sitting there.</p> <p>3.1-3(t)</p>			

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F000253 SS=B	<p>483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Based on observation and interview, the facility failed to ensure a bathroom floor was cleaned for 1 room and water faucets were secured on the sinks in 2 rooms, of 7 rooms observed during the environmental tour, potentially affecting 6 residents. (Room #'s; 31, 67, 68)</p> <p>Findings include:</p> <p>1. During observation on 3/28/2013 at 10:55 a.m. in room 31, the bathroom floor along the full length of the wall edge behind the toilet and cove base had visible dark colored dust and hair.</p> <p>On 4/4/2013 at 1:27 p.m. during the environmental tour, room 31's bathroom floor along the full length of the wall edge behind the toilet and cove base had visible dark colored debris and hair.</p> <p>An interview on 4/4/2013 at 1:27 p.m. with the Housekeeping Supervisor indicated she was unaware of the concern and the floor and cove base would be cleaned immediately.</p>	F000253	<p>1. Room 67 and 68 water faucets were tightened. Bathroom floor in 31 was cleaned immediately.</p> <p>2. All residents have the potential to be affected by this alleged practice. All resident rooms and bathrooms will be checked by the Housekeeping supervisor for cleanliness and integrity of plumbing Monday through Friday. Weekend nurse supervisor will spot check on weekends for the same.</p> <p>3. Housekeeping staff and maintenance staff were inserviced by the Executive Director/Designee by May 3 on cleaning, checking resident rooms. All resident rooms and bathrooms will be checked daily by the Housekeeping supervisor for cleanliness and integrity of plumbing Monday through Friday. Weekend nurse supervisor will spot check on weekends for the same. The Housekeeping Assessment Report will be completed once a week by each Department Head on room rounds.</p> <p>4. To ensure compliance, the Executive Director/Designee is responsible for the completion of</p>	05/03/2013	

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	<p>2. During an observation on 3/27/2013 at 1:35 p.m., the water faucet on the sink in room 67 was very loose.</p> <p>On 3/27/2013 at 1:32 p.m. indicated the water faucet on the sink in room 68 was observed to be very loose.</p> <p>During an observation on 4/4/2013 at 1:30 p.m. during the environmental tour, the water faucet on the sink in room 67 was very loose.</p> <p>During an observation on 4/4/2013 at 1:30 p.m. during the environmental tour, the water faucet on the sink in room 68 was very loose.</p> <p>An interview on 4/4/13 at 1:30 p.m. with the Maintenance Director indicated he was unaware the water faucets on the sinks in rooms 67 and 68 were loose. He indicated he would fix them immediately.</p> <p>This federal tag relates to Complaint IN00125436.</p> <p>3.1-19(f)</p>		<p>the Housekeeping/Maintenance CQI tool weekly times 4 weeks, bi-monthly times 2 months, and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.</p>	

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F000279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on interview and record review, the facility failed to develop care plans, in a timely manner, for significant weight loss, use of anti-psychotic medication, and for a depression diagnosis for 3 of 38 residents reviewed for care plans. (Residents #26, #115, and #34)</p> <p>Findings include:</p> <p>1. Resident #26's clinical record was reviewed on 4/1/2013 at 1:42 p.m. Diagnoses included, but were not limited to, depression.</p>	F000279	<p>1. For resident #26,a care plan for depression was developed. Resident #34 now has a care plan for antipsychotic medication use which includes observation for adverse side effects. Resident #115 no longer resides in the facility.</p> <p>2. Residents who have the diagnosis of depression, who have triggered the care area of nutritional status on the MDS, and residents who use antipsychotic medication have the potential to be effected. Care plans for these residents have been reviewed by the IDT team.</p>	05/03/2013	

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	<p>An MD order, dated 10/30/2012, indicated, "Citalopram 20mg tablet, take 1 tablet by mouth once daily, diagnosis: depression."</p> <p>A quarterly review MDS (Minimum Data Set) assessment, dated 12/23/2012, indicated Resident #26 had a diagnosis of depression. A "Resident Mood Interview" was conducted and indicated, "A. Little interest or pleasure in doing things 1. Symptom presence 1 = yes. 2. Symptom frequency 2 = 7-11 days (half or more of the days) B. Feeling down, depressed or hopeless 1. Symptom presence 1 = yes 2. Symptom frequency 1 = 7-11 days (half or more of the days) Total severity score 03."</p> <p>Review of Resident #26's clinical record indicated no care plan related to the resident's diagnosis of depression could be found.</p> <p>2. The clinical record for Resident #115 was reviewed on 4/3/13 at 1:30 p.m. The diagnoses for Resident #115 included, but were not limited to: anemia, anxiety, depression, dementia, and constipation. The resident was discharged from the</p>		<p>Inservicing to the Interdisciplinary team related to development of care plans will be provided by Home Office clinical consultant team by May 3, 2013.</p> <p>3. Inservicing to the Interdisciplinary team related to development of care plans will be provided by Home Office clinical consultant team by May 3, 2013. A care plan checklist form will be implemented to ensure all care area assessments are being addressed by the IDT.</p> <p>4. To ensure compliance, the DNS/Designee is responsible for the completion of the Care Plan CQI tool weekly times 4 weeks, bi-monthly times 2 months, and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.</p>		

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	<p>facility on 2/4/13.</p> <p>A review of the clinical record indicated the following weights: 12/7/12=153.2 12/10/12=158 12/11/12=158 12/17/12=148 12/24/12=145 1/7/13=141 1/9/13=145.</p> <p>The Admission MDS (Minimum Data Set), dated 12/14/12, indicated Nutritional Status was a care area that was triggered to be care planned.</p> <p>A review of a RD (Registered Dietician) progress note, dated 1/2/13 at 11:21 a.m., indicated, "Also note wt (weight) decline of approx (approximately) 17# (pounds) from 12/10 wt of 158# to wt of 141# on 12/31. Wt change is significant within past 30 days...will recommend to start multi-vit/min supplement daily r/t (related to) wound and offer 1/2 sandwich TID (three times daily) snack times for added kcal (calories) and for ease in consumption...."</p> <p>A IDT (interdisciplinary team) progress note, dated 1/9/13 at 2:58 p.m., indicated, "Resident reviewed this day r/t wt decline...Review of</p>				

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	<p>recent wts notes wt on 1/7 at 141# triggering a 8% decline x (times) 30 days with wt this day at 145#-admit wt 153# on 12/7...."</p> <p>The care plans for Resident #115 included, but were not limited to: Refusal to have picture taken for medical records, dated 1/15/13, Ineffective tissue perfusion related to hypertension, history of cva (cerebral vascular accident), dated 12/17/12, Risk for Constipation due to medication regimen, impaired mobility, takes self to toilet, dated 12/17/12, and Resident requires a secured unit related to diagnosis of dementia, dated 12/11/13.</p> <p>A review of a care plan for problem, Resident has experienced significant weight loss of greater than 5% or more in 30 days, indicated the care plan start date was 1/23/13. No other care plan related to weight loss was located within the clinical record.</p> <p>During an interview with the DoN (Director of Nursing), on 4/4/13 at 11:40 a.m., she indicated IDT develops care plans related to weight loss usually within a day or two after the weight loss was noted, but in a worse case scenario it might take up to a week to develop a significant</p>			

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	<p>weight loss care plan.</p> <p>3. The clinical record for Resident #34 was reviewed on 4/2/13 at 11:00 a.m. The diagnoses for Resident #34 included, but were not limited to: delusions, increase aggressiveness, and depression.</p> <p>A review of the March Physician's Orders, indicated Olanzapine (anti-psychotic) 5 mg (milligrams) should be taken 1 time daily for delusions and Olanzapine 10 mg should be taken in the evening for delusions. The above orders had a start date of 8/9/12.</p> <p>The care plans for Resident #34 included, but were not limited to: Resident may become physically aggressive, dated 12/5/12, Resident has history of making frequent withdrawals from her personal funds account, giving away her money to other residents, then claiming it was stolen, dated 11/16/12, Resident may exhibit signs and symptoms of depression, dated 11/5/12, Resident has episodes of delusions, dated 5/13/12, and Resident can be verbally aggressive with others, dated 5/9/12. The use of anti-psychotic medication and observation of adverse side effects was not noted in any of the</p>						

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	<p>care plans in the clinical records, including the behavior care plans listed.</p> <p>During an interview with the DoN (Director of Nursing) on 4/2/13 at 11:35 a.m., she indicated there might not always be a care plan specifically related to use of anti-psychotic medication, but observation of adverse side effects, GDR (gradual dose reduction) attempts, and administration as ordered should be documented on a behavior care plan related to the use of anti-psychotic medication.</p> <p>On 4/3/13 at 2:30 p.m., Unit Manager #3 indicated she thinks Social Services created behavior care plans and she doesn't know much about them, but they do go over the care plans in IDT (inter-disciplinary team) meetings.</p> <p>At 10:40 a.m., on 4/4/13, the Memory Care Facilitator, along with the Social Services Director indicated behavior care plans were created by Social Services, but a care plan related to use of anti-psychotic medication use, will be created by the MDS Coordinator.</p> <p>During an interview with the MDS</p>			

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	<p>coordinator on 4/4/13 at 10:55 a.m., she indicated she did not see any type of care plan or interventions in other care plans related to the use of anti-psychotic medication. She also indicated she would create the care plan at that time and the development of an anti-psychotic medication use care plan was overlooked.</p> <p>In a policy, titled, "(Name of Corporation) Behavior Management Policy and Procedures," no date, and received by the DoN on 4/4/13 at 1:15 p.m., it indicated "All residents who are taking (either routinely or as needed) antipsychotic...medication are required to have a...corresponding care plan in order to assist in assessing the efficacy of both interventions and medication use."</p> <p>3.1-35(a)</p>				

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F000280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on interview and record review, the facility failed to update a resident's care plan for choices for 1 of 3 residents reviewed for choices, of 38 residents reviewed for care plans. (Resident #34)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #34 was reviewed on 4/2/13 at 11:00 a.m. The diagnoses for Resident #34 included, but were not limited to: delusions, increase aggressiveness, and depression. The resident admission date was 8/22/12.</p>	F000280	<p>Corrective action for resident #34 included the care plan being updated to reflect resident's preference of wake up time.</p> <p>2. All residents have the potential to be affected. Customer Care representatives will interview each resident to determine preferred wake up times. Residents' care plans will be reviewed and updated with residents' wake up preferences and altered as needed. Nursing staff will be inserviced on honoring residents' preferred wake up times by the staff development coordinator by May 3, 2013.</p>	05/03/2013	

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	<p>During an interview with Resident #34 on 3/27/13 at 9:40 a.m., she indicated she was woken up at 6 a.m., but preferred to wake up at 7 or 8 a.m.</p> <p>A Quarterly MDS (Minimum Data Set), dated 2/6/12, indicated Resident #34 had a BIMS (Brief Interview of Mental Status) of 12, which was indicative of moderately impaired but interviewable.</p> <p>A review of a care plan about Resident #34's preferences had an approach, "Resident may be encouraged to receive enough sleep: resident prefers to rise around 4 am [sic]...."</p> <p>During an interview with the DoN (Director of Nursing) on 4/2/13 at 3:00 p.m., she indicated residents and POAs (power of attorney) were asked at admission of individual preferences for shower times, wake-up times, and sleep times. There were no residents that were woken up at 4 a.m. Documentation of Resident #34's preferences from admission and there after were asked for at this time and again on 4/3/13 at 10:30 a.m.</p> <p>The DoN indicated on 4/3/13, at 1:15 p.m., care plans were updated quarterly and this care plan should've</p>		<p>3. Nursing staff will be inserviced on honoring residents' preferred wake up times by the staff development coordinator by May 3, 2013. Residents' care plans will be reviewed and updated with residents' wake up preferences and altered as needed by the DNS/Designee.</p> <p>4. To ensure compliance, the DNS/Designee is responsible for the completion of the care plan CQI tool weekly times 4 weeks, bi-monthly times 2 months and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.</p>				

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	<p>been updated to the resident's preference and she was not sure where the 4 a.m. wake up time came from.</p> <p>By final exit of the facility, no documentation was provided about the resident's preference for wake-up time.</p> <p>3.1-35(d)(2)(B)</p>				

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F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on interview and record review, the facility failed to follow physician's orders for daily blood pressures, daily weights, and a mental health evaluation, for 2 of 10 residents reviewed for physician's orders. (Resident #14 and #116)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #14 was reviewed on 4/2/13 at 3:00 p.m. The diagnoses for Resident #14 included, but were not limited to: status post heart transplant and hypertension.</p> <p>A review of the March Physician's Orders indicated an order for daily blood pressure and to record in Matrix and an order for daily weight and to record the results in Matrix. Both orders were initiated on 8/23/12.</p> <p>A review of the clinical record indicated the following weights: 3/6/13=166 lbs (pounds). No other weights were located in the clinical record for the month of March.</p>	F000282	<p>1. The physician orders regarding weight and blood pressure for resident #14 is now being followed. Resident #116 received a mental health evaluation on 2/4/13. In addition, the resident was seen by a psychiatrist on 3/26/13.</p> <p>2. All residents have the potential to be affected by this alleged practice. An audit of all MARs and TARs has been completed by the unit managers to ensure all orders are being followed with appropriate documentation. An audit of all residents not receiving mental health services will be completed to ensure no services are missing and all orders followed through.</p> <p>3. Nursing staff will be in serviced on following physician orders by the Staff Development Coordinator by May 3, 2013. Physician orders will be read and reviewed in the daily clinical meeting attended by the IDT. A copy of any order related to mental health services will be given to the Behavior Specialist for follow up. Managers will audit the MARs and TARs three days per week to ensure all orders are being addressed.</p>	05/03/2013	

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	<p>A review of the clinical record indicated the following blood pressures:</p> <p>3/2/13=139/81 3/3/13=139/68 3/5/13=105/60 3/19/13=110/68 3/21/13=143/85 3/22/13=118/72 3/23/13=117/74 3/24/13=120/79 3/25/13=130/82 3/26/13=130/82 3/27/13=109/64 3/28/13=118/64 3/29/13=110/71.</p> <p>During an interview, on 4/2/13 at 11:35 a.m., the DoN (Director of Nursing) indicated staff was expected to follow physician's orders as written.</p> <p>A review of a Progress Note, dated 4/3/13 at 12:56 p.m., indicated "Noted res (resident) has order for daily wt (weight) and B/P (blood pressure). Res did not have daily wt completed or B/P in March. Wt done monthly..."</p> <p>On 4/3/13 at 1:15 p.m., the DoN indicated daily blood pressures and daily weights were not done as ordered, but she was able to find some blood pressures from a</p>		<p>4. To ensure compliance, the DNS/Designee is responsible for the completion of the Medical Record CQI tool weekly times 4 weeks, bi-monthly times 2 months and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.</p>				

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	<p>follow-up from a fall and she documented those blood pressures above. She also indicated the MD (Medical Doctor) was just notified the daily blood pressures and weights were not done as ordered. The DoN also indicated the dates listed on the MAR, under the order, was the start date of the order.</p> <p>2. The clinical record for Resident #116 was reviewed on 4/2/13 at 2:00 p.m. The diagnosis for Resident #116 included, but was not limited to: Alzheimer's disease.</p> <p>A review of a Physician's Order, dated 1/4/13, indicated a Psychological/Mental Health evaluation and treatment by [Name of Company] was to be done. The order was initiated by the MD.</p> <p>Progress Notes dated 12/31/12, 1/29/13, and 1/31/12 indicated IDT met to discuss new and worsening behaviors that occurred on 12/29/12, 1/27/13, and 1/30/13.</p> <p>On the (Name of Corporation) Behavior Symptom Monthly Summary Form for January 2013, it indicated Resident #116 had two days of verbal aggression.</p>			

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	<p>In a policy, titled (Name of Corporation) Behavior Management Policy and Procedures, no date and received by the DoN on 4/4/13 at 1:15 p.m., it indicated "...7. All other behaviors that are not new or worsening will be reviewed via the monthly summary."</p> <p>A Progress Note, dated 2/4/13 at 4:24 p.m., indicated Resident #116 was seen by (Name of Company) for an initial mental health evaluation.</p> <p>On 4/4/13, 10:40 a.m., the Memory Care Facilitator (MCF) indicated, during an interview when an order was written for (Name of Company) to do a mental health evaluation, the company usually sees the Resident that same week or the following week at the latest. She also indicated the Resident should've been seen sooner than a month after the order was written, especially since the order was initiated by the MD (Medical Doctor).</p> <p>3.1-35(g)(2)</p>				

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F000323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 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 on observation, interview, and record review, the facility failed to ensure safety in the beauty parlor related to oxygen being used near a hair dryer, for 1 resident in a random observation. (Resident #27)</p> <p>Findings include:</p> <p>On 4/4/2013 at 3:04 p.m., one resident (Resident #27) was observed in the beauty parlor sitting under a hair dryer. There was also a visitor in the same room sitting in a chair approximately three feet away from the resident. The visitor had on a nasal cannula which was connected to a portable oxygen tank.</p> <p>An Interview with the Executive Director (E.D.), on 4/4/2013 at 3:07 p.m. indicated he would speak with the visitor immediately.</p> <p>During an interview with the E.D., on 4/4/2013 at 3:12 p.m., he indicated he ordered a sign for the beauty shop, related to non-use of oxygen in the</p>	F000323	<ol style="list-style-type: none"> 1. Resident #27 was not effected by the alleged deficient practice. Family has been educated to not allow oxygen usage in the beauty shop. 2. All residents using the beauty shop have the potential to be effected. A sign stating "no oxygen" was placed on the door to the beauty shop and inside the beauty shop so all other potential users will understand the requirements. 3. The beauty shop will be monitored during each use for adherence to this policy by management staff to ensure no one using oxygen is in the beauty shop. Staff development coordinator in serviced all staff on oxygen usage in the beauty shop. 4. To ensure compliance, the ED/Designee is responsible for the completion of the Environment Safety CQI tool weekly times 4 weeks, bi-monthly times 2 months and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI 	05/03/2013	

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	<p>beauty shop, last week and the sign should be in tomorrow or early next week. He also indicated the facility had a temporary sign that they just made and the sign was laying, on the table, in the Marketing office. The E.D. indicated he ordered the sign because hairdryers, electric razors, etc. can cause a potential spark. He also indicated the caregiver in the beauty shop indicated she knew she was not supposed to wear oxygen in the beauty shop.</p> <p>An interview on 4/4/2013, at 3:20 p.m., with the visitor of Resident #27 indicated she had been coming to the facility for quite awhile and had been doing Resident #27's hair every couple of weeks. She also indicated she had been in the beauty shop that day for about an hour to an hour and a half.</p> <p>A document provided by the Executive Director at the exit conference on 4/4/2013 at 4:45 p.m. indicated, "April 4, 2013. At approximately 3:00 p.m. the team leader surveyor approached me about a person in the beauty shop on oxygen doing a resident's hair. I went to the beauty shop and I observed. When this writer went to the beauty shop, the caregiver was sitting in the chair closest to the door and the oxygen was on the side of the chair</p>		committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.				

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	<p>closest to the door. This writer then removed the oxygen from the beauty shop. Resident's family was notified of this incident and family expressed understanding of the concern. Family was told the caregiver was spoken to regarding the use of oxygen."</p> <p>A copy of a handwritten statement provided by the Executive Director at the exit conference on 4/4/2013 at 4:45 p.m. indicated, "When I (name of Maintenance Director) approached the lady who was sitting by the door that we have a policy, she cut me off and said, 'I know I can't have oxygen in this room.'"</p> <p>A policy provided by the Executive Director on 4/4/2013 at 4:32 p.m. indicated, "Oxygen use in the beauty shop" original date: 1/10. Policy: It is the policy of (name of company) to promote the health and safety of the residents using the beauty shop services and all other residents. Procedure: 1. All dryers, equipments, electric cords, etc., will be checked by the maintenance department/designee monthly to ensure good operating condition. 3. If a resident is unable to be without oxygen therapy while in the beauty shop, the following will apply: The oxygen tank will be kept as far away</p>						

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	<p>from the dryer unit as the tubing will allow without creating a hazard for individuals walking in the area. Non-aerosol hairspray will be used on resident's hair using oxygen. Residents oxygen therapy will not be left unattended while in the beauty shop. Curling irons and hair dryers will only be used on the low setting. 4. A fire extinguisher will be located in an area close to the beauty shop."</p> <p>3.1-45(a)(1)</p>			

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F000371 SS=F	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview, and record review, the facility staff failed to wear a hairnet while in the kitchen, ensure food was labeled open dates, and ensure the kitchen floor was clean during random observations. This had the potential to affect 101 of 101 residents who eat from the kitchen.</p> <p>Findings include:</p> <p>1. During a random observation, on 3/26/13 at 11:32 a.m., Human Resources #1 walked into the kitchen, without a hairnet/hair restraint on, near food that was being loaded onto the dining cart.</p> <p>During an interview with the Dietary Manager, on 3/26/13 at 11:35 a.m., she indicated staff walks into the kitchen, all the time, without a hairnet on.</p> <p>A review of a policy, titled "Dietary Personal Hygiene," dated 02/07,</p>	F000371	<p>1. The employee in question was counseled on use of hair covering in the dietary area. Items deemed to be not dated were discarded. Proper floor chemicals were obtained and are being utilized.</p> <p>2. No residents were found to be affected by this alleged deficient practice. All staff will wear hair nets when entering the kitchen. All food will be labeled when opened. The kitchen floor was thoroughly cleaned.</p> <p>3. The Staff Development Coordinator will in-service all staff on use of hair coverings while in the kitchen area. Registered Dietician will in-service dietary staff on labeling and dating, and cleaning the floor. Proper chemical usage for floor mopping after each meal will also be initiated and monitored by the Dietary Manager. Dietary Manager/ designee will monitor labeling and dating of food to ensure proper discard. Dietary Manger/Designee will monitor for appropriate hair covering of anyone entering the kitchen at all times.</p>	05/03/2013	

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	<p>received from the Dietary Manager, at 11:51 a.m. on 3/26/13, indicated staff were to "wear a clean hat and /or other hair restraint."</p> <p>A sign was near the kitchen door indicated, "If you do not have a hair restraint on your head do not come in!!"</p> <p>On 4/4/13 at 12:10 p.m., the Dietary Manager indicated the above sign went up, last week, after people were noted to be walking into the kitchen without a hairnet on.</p> <p>2. During a random observation of the kitchen on 3/26/13, an opened container labeled, "salad dressing" with the date 2/20, on the lid, was noted to be in the cooler. Also in the cooler, were an opened container of "Relish" with a date of 2/20 on the lid and a container of "Ranch Dressing" with a date of 9/17, on the lid.</p> <p>In a policy, titled "Labeling and Dating," no date, received from the Dietary Manager, on 3/26/13 at 11:40 a.m., it indicated "All opened and leftover items need to be labeled with the date of opening/date stored and a discard/use-by date." Under the 30 days section within the policy, it indicated, "Label with the date item is</p>		<p>4. To ensure compliance, the Dietary Manager is responsible for the completion of the Kitchen Environmental Review tool weekly times 4 weeks, bi-monthly times 2 months and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.</p>	

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	<p>opened and discard within 30 days to ensure quality.(*). Examples: salad dressing, mayonnaise,...pickles." The (*) indicated, according to the policy, "the date the product must be consumed or discarded may not exceed the manufacturer's use-by date."</p> <p>During an interview with the Dietary Manager, on 3/26/13 at 1:15 p.m., the Dietary Manager indicated she thinks all the above opened containers were used last week and the date on the food indicated the date the food "came in on the truck." She also indicated the food should've had open dates on the container.</p> <p>On 2:15 p.m. on 3/26/13, the Dietary Manager indicated she was unable to determine the manufacturer's expiration/use-by date on the food containers above.</p> <p>At 11:30 a.m., on 4/3/13, the Dietary Manager indicated she was still unable to determine the manufacturer's expiration/use-by date on the above food container because the documentation from the food distribution company was unclear, but the food containers listed above should've had an open date on them.</p>			

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NAME OF PROVIDER OR SUPPLIER HARRISON TERRACE				STREET ADDRESS, CITY, STATE, ZIP CODE 1924 WELLESLEY BLVD INDIANAPOLIS, IN 46219			
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	<p>The DoN (Director of Nursing), indicated on 4/4/13 at 11:37 a.m., no resident in the facility was strictly NPO (nothing by mouth).</p> <p>3. During a random observation, on 3/26/13 at 11:30 a.m., there were dark stains on the floor near the coffee machine, near the prep sink. Debris was also noted, on the floor, near the coffee machine and prep sink. There was also debris noted near the dishwasher, on the floor.</p> <p>During an interview on 3/26/12 at 11:32 a.m., the Dietary Manager indicated the dark stains and food debris were probably from the coffee machine, from breakfast. She also indicated the kitchen floor was just replaced the previous week and they have been cleaning the floor with just hot water, because they did not have the certain floor cleaner needed for the new floor.</p> <p>During a random observation on 4/3/13, at 1:45 p.m., debris was noted, on the floor, near the dishwasher.</p> <p>During a random observation on 4/4/13, at 3:40, debris was noted, on the floor, near the dishwasher and food prep area.</p>						

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	<p>The Dietary Manager, indicated on 4/4/13 at 12:13 p.m., the facility just got the floor cleaner in, the previous day, and just used hot water on the kitchen floor, for cleaning, for about a week.</p> <p>In a policy, titled, "Cleaning Floors, Tables, and Chairs," dated 02/02, received from the Dietary Manager on 4/4/13 at 12:35 p.m., it indicated, "1. Kitchen floors will be swept and cleaned after each meal..."</p> <p>On 4/4/13, at 3:20 p.m., the Administrator indicated he expected kitchen staff to clean/mop the floor after every meal with cleaner. The Administrator also indicated, the cleaner was probably the same cleaner as housekeeping, so there should be no reason for not mopping the kitchen floor without cleaner.</p> <p>At 3:22 p.m., on 4/4/13, the Maintenance Director indicated kitchen staff just received the kitchen floor cleaner the previous day and the cleaner was not the same as the other housekeeping cleaner.</p> <p>3.1-21(i)(3)</p>						

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F000514 SS=A	<p>483.75(I)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on observation, record review, and interview, the facility failed to document a new behavior for a resident and disposition of personal items upon discharge of a resident, for 2 of 38 residents whose records were reviewed. (Residents #A and B)</p> <p>Findings include:</p> <p>1. On 3/27/2013 at 2:50 p.m., Resident #B, a female, was observed asleep in the bed nearest the window in room 45. There was a male resident asleep in the bed nearest the door. CNA #4 went into the room to check who was in the bed nearest the window. She indicated, "no one should be in that bed." There was a removable stop sign on the door and the door was closed.</p>	F000514	<p>1. Resident B has been redirected to her own room and bed. New identifiers on the door have been placed to assist the resident in her room location. Resident A chart has been updated to indicate the resident has received his/her belongings.</p> <p>2. All residents have the potential to be affected. Residents with behaviors are documented in the medical record with appropriate interventions. Audit of Discharged residents inventory sheets were reviewed to ensure the personal property inventory sheet was signed.</p> <p>3. Staff was in serviced by SDC regarding documenting behaviors and completing documentation of the resident inventory sheet upon</p>	05/03/2013			

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	<p>An interview on 4/1/2013 at 1:25 p.m. with QMA #3 indicated when asked if Resident #B wanders, she replied, "not really, usually not."</p> <p>An interview with the Director of Nursing (D.O.N.) on 4/3/2013 at 1:58 p.m. indicated she spoke with the nurse who was on duty when the incident occurred. The D.O.N. indicated he (the nurse) didn't write a note/event about the incident because he thought the resident had already been care planned for this behavior. She indicated that it should have been documented. She said it would now be documented and care planned. This was a new behavior for the resident; it hadn't happened before.</p> <p>A care plan indicated, "Problem start date: 4/3/2013. Behavior 1: Resident will at times wander into other residents' rooms and sleep in their beds. Approach: Intervention 2: Observe for s/s (signs and symptoms) of fatigue and offer to assist to her room when tired."</p> <p>A "Behavior events" note indicated, "Date recorded: 4/3/2013 at 5:23 p.m. Date/time of behavior: 4/1/2013 at 9:45 a.m. Where did the behavior</p>		<p>discharge by May 3, 2013. Social Service Director will monitor the new and worsening behaviors, to ensure the behavior and interventions are documented. Unit Manager will monitor the inventory sheets for proper documentation regarding the residents belongs upon discharge.</p> <p>4. To ensure compliance, the DNS/Designee is responsible for the completion of the Closed Medical Record CQI and Social Services is responsible for the Behavior Management CQI tool weekly times 4 weeks, bi-monthly times 2 months and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.</p>		

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	<p>occur: in another resident's room 45W. Describe the specific type of behavior that occurred: Resident had laid down in another resident bed and fell asleep. Describe what non pharmacological interventions were attempted in response to the behavior: none."</p> <p>A "Resident progress note" indicated, "Date: 4/4/2013 at 9:01 a.m. IDT (interdisciplinary team) review of new and worsening behavior that occurred on 4/1/2013 at 9:45 a.m. Resident was noted to have wandered into another resident's room and fallen asleep in their bed. Resident was easily awakened and redirected to her own room...Behavior has been care planned, will continue to monitor for continued behaviors and effectiveness of interventions."</p> <p>A policy titled, "(name of company) Behavior Management Policy and Procedure," provided by the Director of Nursing on 4/4/2013 at 2:15 p.m. indicated, "Policy: It is the policy of (name of company) to provide behavior interventions and monitoring for residents with problematic or distressing behaviors...Procedure: 1. Care plans should be initiated for any behavioral issues that affects, or has the potential to affect, the resident or</p>				

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	<p>other residents. 4. When a behavior occurs, the staff communicates to the nurse what behavior occurred. The nurse records or signs off on the behavior on the monitoring form including what interventions were attempted during the episode and whether or not they were effective."</p> <p>2. Resident #A's clinical record was reviewed on 4/4/2013 at 9 a.m. Resident's diagnoses included but were not limited to; dementia, glaucoma, and debility.</p> <p>A nursing progress note indicated Resident #A went out to the ER (emergency room) on 10/25/2012. Further review of the nursing progress notes indicated the resident did not return to the nursing facility.</p> <p>An "articles recorded upon admission" (personal property inventory sheet) with Resident #A's name indicated it was not signed in order to acknowledge the items were returned to the resident upon discharge from the facility.</p> <p>Interview with the D.O.N. on 4/4/2013 at 9:58 a.m. indicated the "articles recorded upon admission" sheet should be signed upon discharge of the resident, and the nursing staff is</p>				

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	<p>responsible for completing this task. At 10:03 a.m. she indicated she does not know what happened with this; she could not verify through any notes in the resident's clinical record that the items had been picked up by the family or not. She indicated she's not sure what exactly happened.</p> <p>3.1-50(a)(1)</p>				