

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155149	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/29/2015
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NAME OF PROVIDER OR SUPPLIER  HARCOURT TERRACE NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260
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F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit included the investigation of Complaint IN00162422.</p> <p>This visit was in conjunction with the Investigation of Complaint IN00163279 completed January 29, 2015.</p> <p>Complaint IN000162422-Substantiated. Federal/State deficiencies related to the allegations are cited at F-282, F-312, and F-323.</p> <p>Survey dates: January 21, 22, 23, 26, 27, 28 and 29, 2015.</p> <p>Facility number: 000070 Provider number: 155149 AIM number: 100266190</p> <p>Survey Team: Sandra Nolder, RN-TC Michelle Carter, RN Michelle Hosteter, RN Gloria Bond, RN (January 26, 27, 28 and 29, 2015) Tammy Alley, RN (January 21, 2015)</p> <p>Census bed type: SNF: 10 SNF/NF: 88</p>	F000000	<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 the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Post Survey Review on or after February 18, 2015.</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.

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F000156 SS=A	<p>Total: 98</p> <p>Census payor type: Medicare: 15 Medicaid: 67 Other: 16 Total: 98</p> <p>Sample: 7</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review was completed by Tammy Alley RN on February 4, 2015.</p> <p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility</p>				

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	<p>or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State</p>			

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	<p>client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>Based on interview and record review, the facility failed to inform residents their skilled nursing services had ended in a timely manner for 1 of 3 residents reviewed for Notice of Medicare Non-Coverage. (Residents #46)</p> <p>Findings include:</p> <p>Resident #46's legal representative was mailed the "Notice of Medicare Non-Coverage" notice that indicated, "The Effective Date Coverage of Your Current Skilled Nursing Services Will End: [date]... Please sign below to</p>	F000156	<p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <p>·Resident #46 No longer resides in this facility</p> <p><b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p> <p>·All residents currently receiving services under their Medicare</p>	02/18/2015

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	<p>indicate you received and understood this notice. I have been notified that coverage of my services will end on the effective date indicated on this notice and that I may appeal this decision by contacting my QIO [Quality Improvement Organization]."</p> <p>A copy of the notice was dated 6/19/14, and lacked a signature and date by the resident's legal representative. The notice and resident's medical record lacked documentation the facility had attempted three times to get the notice signed by the resident's legal representative.</p> <p>Resident #46's record was reviewed on 01/29/2015 12:33 p.m.. Diagnoses included, but were not limited to, edema, osteoporosis, rehabilitation procedures, pain, presenile with delirium dementia, insomnia, chronic airway obstruction, diabetes mellitus.</p> <p>During an interview on 11/29/15 at 11:15 a.m., the SSD (Social Service Director) indicated this resident had been on skilled services for therapy and had been discharged from therapy on 6/17/14. She indicated she had not attempted to reach the legal representative three times to sign the "Notice of Medicare Non-Coverage" notice. She indicated the legal representative came into the facility</p>		<p>benefits at this facility have the potential to be affected</p> <ul style="list-style-type: none"> <li>·Business Office Manager or designee will audit current residents receiving services under their Medicare benefit to identify any resident with the potential for non-coverage of services and notify Social Services accordingly.</li> <li>·Executive Director or designee will in-service Social Services Director and Memory Care Facilitator according to the Checklist/Instructions for issuing a Notice of Medicare Non Coverage (NOMNC)/Determination on Continued Stay including appropriate and timely documentation and notification by February 18, 2015.</li> </ul> <p><b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</b></p> <ul style="list-style-type: none"> <li>·Executive Director or designee will in-service Social Services staff according to the Checklist/Instructions for issuing a Notice of Medicare Non Coverage (NOMNC)/Determination on Continued Stay including appropriate and timely documentation and notification</li> <li>·Interdisciplinary Team will review all residents receiving services under the Medicare</li> </ul>				

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F000246 SS=D	<p>and visited the resident from time to time, so she could have gotten the notice signed at some point. She indicated she had called the legal representative 48 hours before the resident's therapy services ended to inform her the services were ending, then mailed the notice out to her. The SSD indicated she had not followed up with the resident's legal representative on visits to the facility, phone calls or additional mailings in an attempt to get the notice signed.</p> <p>SSD (Social Service Director) indicated that she understood if the resident was discharged prior to the end of his or her 100 Medicare days or ended his or her skilled services, she was to give the resident 48 hours notice before the resident was discharged or the skilled services ended in order to give the resident a chance to appeal. She indicated she was taught this information from an inservice by (name of company).</p> <p>3.1-4(f)(3)</p> <p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p>		<p>benefit weekly in the Medicare Meeting to ensure timely notification of The Notice of Medicare Non Coverage based on projected discharge date and last covered day under Medicare benefit</p> <p><b>How the corrective action(s) 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>· Notice of Medicare Non-Coverage Letters (NOMNC) CQI tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year. Data will be submitted to the CQI committee for follow up.</li> <li>· If 95% a threshold is not achieved, an action plan will be developed to ensure compliance</li> </ul>	

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	<p>Based on observation and interview, the facility failed to have the resident's call lights accessible for 3 out of 3 residents reviewed for accommodation of needs. (Residents #47, #85, and #73).</p> <p>Findings include:</p> <p>1. On 1/22/2015 at 2:40 p.m., Resident #47's call light was observed on the floor by the head of her bed out of her reach.</p> <p>On 1/27/2015 at 3:28 p.m., with CNA #6 in attendance, Resident #47, was observed in bed with the call light on the floor next to the head of the bed.</p> <p>During an interview at that time, CNA #6 indicated the resident's call light must have fallen off the bed.</p> <p>2. On 1/22/2015 at 11:00 a.m., Resident #85 was observed sitting in his highback chair, by the foot of his bed, and his call light was hanging out of his reach.</p> <p>On 1/27/2015 at 3:15 p.m., Resident #85 was observed in his in bed with his call light at the foot of the bed out of his reach.</p> <p>3. On 1/27/2015 at 6 p.m., Resident #73's call light was observed on the floor by the foot of her bed. The resident was</p>	F000246	<p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <ul style="list-style-type: none"> <li>· Resident #47 has call light within reach</li> <li>· Resident #85 has call light within reach</li> <li>· Resident #73 has call light within reach</li> </ul> <p><b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p> <ul style="list-style-type: none"> <li>· All residents have the potential to be affected by the alleged deficient practice.</li> <li>· The Executive Director completed an audit to ensure that all call lights were in place</li> <li>· Staff will be in-serviced on accommodation of resident needs including call lights being accessible by the Director of Nursing Services or designee by February 18th, 2015</li> </ul> <p><b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?.</b></p>	02/18/2015

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F000282 SS=E	yelling out, "I'm hungry."  During an interview at 6:05 p.m., LPN #5 indicated the call light should not be on the floor like that.  3.1-3(v)(1)  483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER		<ul style="list-style-type: none"> <li>Staff will be in-serviced on accommodation of resident needs including call lights being accessible by the Director of Nursing Services or designee by February 18, 2015.</li> <li>Licensed nurses will conduct rounds on all shifts each day using a nurse rounds audit tool to ensure that call lights are accessible to all residents.</li> </ul> <p><b>How the corrective action(s) 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>Resident Care Rounds CQI tool will be completed weekly x 4 weeks, monthly x 6 months, and then quarterly for one year with results reported to the Continuous Quality Improvement Committee overseen by the Executive Director.</li> <li>If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance.</li> </ul>		

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	<p><b>CARE PLAN</b> 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 observations, interviews and record reviews, the facility failed to ensure plans for care, facility policies, and physicians orders were followed, appropriately, for 5 of 39 residents, in a sample of 39, reviewed for care plans. (Residents F, R, B, C, and S)</p> <p>Findings include:</p> <p>1. The clinical record for Resident F was reviewed on 1/26/15. Diagnoses included, but were not limited to, frontal lobe dementia and insomnia.</p> <p>Reportable incident documentation submitted to the Indiana State Department of Health, Long Term Care Division, on 1/27/15 at 10:03 a.m., and nursing progress notes, dated 1/27/15 at 12:42 a.m., indicated Resident F eloped on 1/27/15, shortly after midnight. Using her body weight, Resident F broke through an exit door that led outside. The alarm sounded and Resident F was in the staff's sight the entire episode.</p> <p>Immediate action taken, documentation indicated staff were able to take the resident back into the building and the</p>	F000282	<p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <ul style="list-style-type: none"> <li>· Resident F no longer resides in this facility.</li> <li>· Resident R is receiving wound dressing changes, incontinence care and transfers per physician's order/ plan of care, is assessed, and is kept pain free as possible.</li> <li>· Resident B is checked every 2 hours and receives routine incontinence care per care plan.</li> <li>· Resident C receives as needed pain medication with complaints of pain, scheduled pain medication, scheduled pain medication 30 minutes prior to dressing change, and now has a new order for a local anesthetic to use as needed during dressing changes. Care plan has been updated accordingly</li> <li>· Resident S has urinary output documented in ccs per facility policy.</li> </ul>	02/18/2015

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	<p>resident was put on 1:1 (one on one supervision).</p> <p>IDT (Interdisciplinary Team) notes, dated 1/27/15 at 9:07 a.m., indicated Resident F was receiving 1:1 supervision. A discontinue time was not evidenced during documentation and physician orders reviews.</p> <p>Resident F was observed in her room, laying down in bed, with her eyes closed, during an observation at 12:15 p.m., on 1/28/15. Resident F was the only person in the room.</p> <p>LPN #1 indicated, during an interview at 12:15 p.m., on 1/28/15, Resident F was no longer under 1:1 supervision, so there was no staff member with her, in her room, to provide 1:1 supervision. The 1:1 was only for yesterday, 1/27/15.</p> <p>The Director of Nursing Services (DNS) indicated, during an interview on 1/28/15 at 12:21 p.m., she would have to check the orders, but was pretty sure Resident F should have 1:1 supervision, at that time. The DNS did not know why Resident F was unattended.</p> <p>During an interview with the Executive Director (ED), on 1/28/15 at 12:24 p.m., she indicated Resident F should have 1:1</p>		<ul style="list-style-type: none"> <li>· LPN #4-No longer employed with facility.</li> <li>· CNA#1 and CNA#2 are no longer employed with this facility.</li> </ul> <p><b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p> <ul style="list-style-type: none"> <li>· All residents who receive 1:1 supervision, wound dressing changes, routine incontinent care, hooyer lift transfers, and have suprapubic catheters have the potential to be affected by the alleged deficient practice.</li> <li>· Care Plans for all residents identified have been reviewed and updated if needed by the Interdisciplinary Team according to physician orders and facility policy for all residents who receive 1:1 supervision, wound dressing changes, routine incontinent care, hooyer lift transfers, and have suprapubic catheters.</li> <li>· Staff will be in-serviced by Director of Nursing Services (DNS) or designee by February 18, 2015 on following residents care plans and resident profiles, 1:1 supervision procedure, Skin Management Program, Pain Management Policy, and Bladder Program.</li> </ul>	

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	<p>supervision, at all times, and was unaware Resident F was left unattended.</p> <p>At 12:45 p.m., on 1/28/15, during an observation, CNA #7 arrived to provide 1:1 supervision for Resident F.</p> <p>The ED indicated, during an interview on 1/28/15 at 12:50 p.m., there was a communication error. Apparently, there was an aide in the room with Resident F, earlier and the aide took a break. Therefore, Resident F was left unattended, during the aide's break. The aide did not communicate with staff, appropriately.</p> <p>During an interview on 1/28/15 at 2:50 p.m., CNA #7 indicated she was the aide scheduled for 1:1 supervision with Resident F that day (1/28/15), and was with Resident F at 8:30 a.m. to 11:55 a.m., when she took a lunch break. The MCF (memory care facilitator) was supposed to relieve her (CNA #7) until she returned. CNA #7 indicated 1:1 supervision was to be provided, continuously, and she indicated she did not know why Resident F was left unattended.</p> <p>Resident F was not provided 1:1 supervision, as expected, secondary to an elopement on 1/27/15, from 11:55 a.m. to</p>		<p><b>What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?</b></p> <ul style="list-style-type: none"> <li>Staff will be in-serviced by Director of Nursing Services (DNS)/designee by February 18, 2015 on following residents care plans and resident profiles, 1:1 supervision procedure, Skin Management Program, Pain Management Policy, and Bladder Program.</li> <li>Director of Nursing and/or designee will conduct rounds on all shifts to ensure care plans and physician orders are followed related to 1:1 supervision, wound dressing changes, pain management, routine incontinence care, and catheters are emptied each shift and documented in cc's.</li> <li>The Interdisciplinary Team will review all physicians orders, vital signs report, facility activity report in clinical meeting to ensure that services are provided according to physician orders and plan of care including: urine output of catheters are documented in ccs, resident complaints of pain are addressed, dressing changes are done per physician's order, and resident's are receiving 1:1 supervision</li> </ul>				

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	<p>12:45 p.m., on 1/28/15.</p> <p>2. On 1/27/15 at 2:55 p.m., the record review for Resident R was completed. Diagnoses included, but were not limited to, multiple sclerosis, adult failure to thrive, pressure ulcer and chronic pain.</p> <p>The physician order dated 1/19/15, for Resident R's right gluteal wound indicated: discontinue Dakins to buttocks wound (2) Buttock wound sterile water cleanse, moisten fluffed gauze with Silvasorb gel (a gel that contains a antimicrobial medication to prevent infection to the wound) and loosely pack wound swab periwound (around the wound) with skin prep ( a skin barrier wipe to protect the skin). Cover with ABD ( a type of wound dressing) and Medifix tape. Change daily and as needed if soiled or dislodged. This was the last wound order found in the chart.</p> <p>On 1/28/2015 10:52 a.m., LPN #4 removed the old undated and unmarked dressing. The dressing was a small square of adhesive with a pink color to outside and non adhesive bandage on the other side.</p> <p>On 1/28/15 at 1:00 p.m., the final dressing change was completed. LPN #4 used sterile water to clean the wound. She used Silvasorb soaked gauze, soaked</p>		<p>Monday-Friday and Saturday and Sunday by the Weekend Supervisor.</p> <p><b>How the corrective action(s) 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>Elopement Risk, Skin Management, Pain Management, Mechanical Lift, and Resident Care Rounds CQI tools will be completed weekly x 4 weeks, monthly x 6 months, and then quarterly for one year with results reported to the Continuous Quality Improvement Committee overseen by the Executive Director.</li> <li>If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance.</li> </ul>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155149	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/29/2015
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NAME OF PROVIDER OR SUPPLIER  HARCOURT TERRACE NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260
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	<p>with sterile water and fluffed the gauze and placed it into the wound. She used skin prep around the peri wound and covered the wound with a large white ABD pad, then secured the pad with a large piece of Medifix tape. She indicated at that time these were the current orders. The dressing she placed was different than the one removed earlier in the shift.</p> <p>The care plan dated 7/13/11, indicated the resident was at risk for pain related to chronic pain, knee pain, Gout (inflammatory condition of the joints), H/O (history of) pain related to Multiple Sclerosis. Administer meds as ordered, assist/encourage to reposition frequently, document effectiveness of prn medications, notify MD if pain is unrelieved, worsening or having break thru pain as needed, observe for changes in day to activities, observe for changes in sleep pattern, observe for changes in sleep pattern. Observe for non verbal signs of pain, changes in breathing, vocalizations, mood/behavior changes, eyes change expression, sad/worried face, crying, teeth clenched, changes in posture, offer non pharmacological interventions such as quiet environment, rest, shower, back rub, reposition.</p> <p>On 1/27/15 at 2:00 p.m., CNA #1 and</p>			

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NAME OF PROVIDER OR SUPPLIER  HARCOURT TERRACE NURSING AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260			
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	<p>CNA #2 were observed transferring Resident R with a Hoyer lift from her Broda chair into her bed. The CNA's placed the Hoyer pad underneath the resident, transferred her and positioned her in bed. The resident had facial grimacing and a furrowed brow while the CNA's were transferring her. CNA #2 told the resident they were going to remove her pants and clean her up. CNA #1 and CNA #2 moved the resident to her left side and to the other while removing her pants. The resident yelled out as CNA #1 pulled on the left side of pants and CNA #2 pulled on the right side of the pants and pulled them down underneath of the resident's knees. Then CNA #1 and CNA #2 continued care by pulling off the resident's brief, unfastening it on the left side and pulled the brief down without taking the seam off of the right side. As they turned to reposition her on her right side the resident indicated "that hurts." She was yelling, had facial grimacing and her eyebrows were furrowed.</p> <p>On 1/28/15 at 11:20 a.m., LPN # 4 indicated during interview, the CNA's completing the transfer and care should have reported the complaints of pain to her. LPN # 4 indicated she had not been notified of the resident's complaints of pain.</p>						

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NAME OF PROVIDER OR SUPPLIER  HARCOURT TERRACE NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260
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	<p>A document titled "Pain Management" dated 1/03, with revision dates of 12/03, 1/06, 1/08, 3/10 and 9/2013 was provided by the Assistant Director of Nursing on 1/29/15 at 11:15 a.m. The policy indicated, "...It is the responsibility of the facility to ensure that each resident is assessed for pain, and the efficacy of pain medication, while keep the resident as comfortable and pain free as possible...."</p> <p>3. Resident B's record was reviewed on 1/26/15 at 10:05 a.m. Diagnoses included, but were not limited to, acute cerebrovascular disease (stroke), hemiplegia (paralysis), convulsions, and iron deficiency anemia.</p> <p>An IDT (Interdisciplinary Team) "Bladder Continence Review" dated 1/8/15, indicated the recent bladder assessment without a catheter was concluded on 1/12/15. The review indicated the resident was always incontinent (no episodes of continent voiding). She was not mentally and physically aware of the need to void and able to use a toilet, commode, urinal or bedpan. She was not appropriate for a scheduled toileting program. The review indicated routine incontinent care would be provided for the resident.</p> <p>The resident had a Care Plan dated</p>			

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NAME OF PROVIDER OR SUPPLIER  HARCOURT TERRACE NURSING AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260			
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	<p>7/13/11, which addressed the problem she was incontinent due to cerebrovascular accident and hemiplegia. The approaches included, but were not limited to, "8/14/14--toilet resident prior to activities...7/13/14--Assist with incontinent care as needed. Check every 2 hours for incontinence...."</p> <p>A continuous observation of Resident B occurred on 1/26/15 from 9:50 a.m., to 1:57 p.m.</p> <p>On 1/26/15 at 9:50 a.m., the resident was in her wheelchair in the activity room. She had just finished doing an exercise activity.</p> <p>On 1/26/15 at 10:00 a.m., the resident was transported to the main dining room and sat in front of the TV waiting for the next activity to start.</p> <p>On 1/26/15 at 10:25 a.m., the resident was taken to therapy by a therapist.</p> <p>On 1/26/15 at 11:00 a.m., the resident was brought back to the main dining room by the therapist to join the activity already in progress.</p> <p>On 1/26/15 at 11:26 a.m., the resident remained in the main dining room. The activity was finished. The resident was</p>						

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	<p>sitting in her wheelchair with the TV playing.</p> <p>On 1/26/15 at 11:35 a.m., an activity person transported the resident to the nurse on her hallway and told the resident's nurse she had requested a pain pill.</p> <p>On 1/26/15 at 11:39 a.m., the resident received a pain pill by the nurse who was responsible for her care and she remained sitting in the hallway by the nurses cart. At that time no staff member had asked the resident if she needed to be checked and changed or needed to go to the toilet.</p> <p>On 1/26/15 at 11:47 a.m., the resident was brought to the main dining room by the SSD (Social Service Director).</p> <p>On 1/26/15 at 12:45 p.m., the resident received her lunch tray and was eating.</p> <p>On 1/26/15 at 1:23 p.m., the resident was brought back to her room by a therapist.</p> <p>On 1/26/15 at 1:25 p.m., LPN #4 and CNA #10 transferred the resident to bed with a Hoyer lift.</p> <p>On 1/26/15 at 1:50 p.m., CNA #10 and CNA #12 gave the resident pericare and changed her brief. The resident's brief</p>			

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NAME OF PROVIDER OR SUPPLIER  HARCOURT TERRACE NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260
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	<p>was moderately saturated with a yellow urine, which had a concentrated urine odor.</p> <p>During an interview on 1/26/15 at 2:00 p.m., CNA #10 indicated that she had not worked on Resident B's unit for awhile, but last time she worked over there the resident came and told the CNA's when she had to use the bathroom. She indicated the CNA's used the stand up lift and toileted the resident, but since she broke her leg she had to be placed on the toilet with the hooyer lift. She indicated the resident usually told the staff she had to be toileted, 2-3 times a shift. She indicated it had been over 2 hours, since she had checked or changed the resident the last time.</p> <p>On 1/27/15 5:35 p.m., the DNS (Director of Nursing Services) indicated she would have expected the CNA caring for the resident to have checked and changed or toileted the resident every 2 hours.</p> <p>4. Resident C's record was reviewed on 1/27/15 at 10:51 a.m. Diagnoses included, but were not limited to, great toe amputation, dementia unspecified with behavior disturbance, Alzheimer's disease, flaccid hemiplegia (paralysis on one half of the body), hypertension, chronic ischemic heart disease,</p>			

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NAME OF PROVIDER OR SUPPLIER  HARCOURT TERRACE NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260
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	<p>cerebrovascular disease (stroke), peripheral vascular disease (poor circulation to the lower extremities).</p> <p>The resident had a Care Plan dated 6/25/13, that addressed the problem she was at risk for pain related to decreased mobility due to diagnosis of osteoporosis and wound. The approaches included, but were not limited to, "6/25/13- -Administer meds as ordered...6/25/13- -Document effective of prn [as needed] medications, Notify MD if pain is unrelieved and/or worsening...6/25/13- -Observe for non verbal signs of pain: changes in breathing, vocalizations, mood/behavior changes, eyes change expression, sad/worried face, crying, teeth clenched, changes in posture...."</p> <p>On 1/27/15 at 10:55 a.m., LPN #1 was observed changing Resident C's RLE(Right Lower Extremity) wound dressing. She placed the resident's RLE onto a clean incontinence pad on the bed. At that time, Resident C indicated to LPN #1 her RLE was tender. LPN #1 removed the old dressings. The old dressings were stuck to the edges of the resident's wound. The resident indicated to the nurse at that time when she removed the dressings "Ouch, that hurts." The dressings were dried along the edges of the resident's wound. LPN #1</p>			

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NAME OF PROVIDER OR SUPPLIER  HARCOURT TERRACE NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260
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	<p>indicated to the resident at that time she was being as gentle as she could be and she would be done in a minute. The resident had a furrowed brow and grimaced when she removed the dressings from the resident's RLE.</p> <p>LPN #1 irrigated the wound with normal saline in a syringe. The resident indicated to LPN #1 at that time the wound was tender and LPN #1 indicated at that time to the resident, she was being as gentle as she could be. LPN #1 indicated at that time, she had medicated the resident at 10:00 a.m., with her routine Tramadol. The resident indicated at that time, the pain medicine helped a little bit, but her leg was still hurting.</p> <p>LPN #1 smeared the Santyl around in a circular motion four times, while crossing over the inside of the wound. The resident indicated at that time, the wound bed was hurting and LPN #1 indicated at that time, she was being as gentle as she could be and she was almost finished with the dressing. The resident was observed with furrowed brows and facial grimacing during that time. LPN #1 used a sterile cotton tipped applicator and applied the Hydrogel gauze to Resident C's wound. The resident indicated at that time, her wound bed was hurting. LPN #1 indicated at that time to the resident,</p>			

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NAME OF PROVIDER OR SUPPLIER  HARCOURT TERRACE NURSING AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260			
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	<p>she was being as gentle as she could. The resident was observed with facial grimacing and furrowed brows while LPN #1 was packing the wound with the Hydrogel gauze.</p> <p>The resident indicated at that time, as the LPN #1 was applying the Calazime to the edges of the wound and wrapping the RLE with the Kerlix gauze that her leg was hurting. LPN #1 indicated that she was just about done with the dressing change. The resident was observed with facial grimacing and furrowed brows throughout these two steps of the dressing change. LPN #1 did not stop during the wound dressing change to medicate the resident with any as needed medication. Resident C indicated to LPN #1 while she was cleaning her trash up after the dressing change that her RLE continued to hurt.</p> <p>During an interview on 1/27/15 at 11:29 a.m., LPN #1 indicated the resident had not normally had that much pain when her wound dressing was changed, but the old dressing was dry around the wound edges and it stuck to her wound when she tried to remove it. She indicated she normally would have stopped and medicated the resident having pain during a dressing change, then finished the dressing, but she had pre-medicated</p>						

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NAME OF PROVIDER OR SUPPLIER  HARCOURT TERRACE NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260
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	<p>Resident C, so she thought she would be okay.</p> <p>On 1/27/15 at 11:30 a.m., LPN #1 was observed asking Resident C at the nurses station if she was still having RLE pain and the resident indicated at that time she was having pain. At that time, LPN #1 medicated the resident with her as needed Acetaminophen pain medication.</p> <p>During an interview on 1/28/15 5:45 p.m., the DNS indicated LPN #1 should have stopped doing the dressing change and medicated the resident, waited for the medication to take effect, then resumed with the dressing change.</p> <p>5. Resident S record was reviewed on 1/26/2015 at 11:25 a.m. Diagnoses included, but were not limited to, diabetes, history of frequent urinary tract infections and chronic use of a suprapubic urinary catheter.</p> <p>On 1/26/2015 at 11:35 a.m., the resident's urinary catheter bag was observed hanging down below the bed and being 3/4 full of dark yellow to amber colored urine.</p> <p>The resident's record indicated on 1/26/2015 at 11:57 p.m., the resident's fluids were equal to, "360mL [milliliter]" and the resident's urine was equal to</p>			

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NAME OF PROVIDER OR SUPPLIER  HARCOURT TERRACE NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260
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F000309 SS=G	<p>"large."</p> <p>The resident's care plan indicated the resident required a suprapubic catheter and, "will have catheter care managed appropriately...."</p> <p>The facility's policy and procedure titled, "Bladder Program" and last dated 11/2014 indicated under residents with Foley catheters, "...Urinary output from Foley catheters will be documented in cc's [cubic centimeters]...."</p> <p>During an interview on 1/28/2015 at 1:15 p.m., LPN #5 indicated she did not know the facility's policy and procedure with urinary catheters and urinary output documentation.</p> <p>This Federal tag relates to Complaint IN00162422.</p> <p>3.1-35(g)(1)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p>			

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NAME OF PROVIDER OR SUPPLIER  HARCOURT TERRACE NURSING AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260			
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	<p>Based on observation, interview and record review, the facility failed to ensure a dressing change was completed without potential for infection for 1 of 2 residents observed for a dressing change (Resident C) and failed to ensure effective pain management was provided for 2 of 2 residents reviewed for pain management resulting in Resident C complaining of pain throughout and after a wound dressing change. (Resident C and R)</p> <p>Findings include:</p> <p>1. Resident C's record was reviewed on 1/27/15 at 10:51 a.m. Diagnoses included, but were not limited to, hypertension, chronic ischemic heart disease, and peripheral vascular disease (poor circulation to the lower extremities).</p> <p>The resident's recapitulation (recap) orders dated January 2015, included, but were not limited to, the following: 6/13/13--Acetaminophen (a non-narcotic pain medication) 325 mg (milligrams) Take two tablets (650 mg) by mouth every six hours as needed for moderate pain 12/9/14--Tramadol (a pain medication) 50 mg take one tablet by mouth twice daily as needed. 12/10/14--Keflex (An antibiotic</p>	F000309	<p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b> · Resident C has wound dressing change completed per "Dressing Change" policy without potential for infection. · Resident C has an effective pain management plan in place and it is followed when wound care is provided. · Resident R has been reviewed and has an effective pain management plan in place for when resident transfers per hoyer lift and during incontinence care · LPN #1-has been educated on the "Dressing Change" policy. · CNA#1 and CNA#2 are no longer employed with the facility. <b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b> · All residents that receive wound dressing changes, are transferred per hoyer lift, require assistance with repositioning, and incontinence care have the potential to be affected by the alleged deficient practice. · All residents with wounds will be reviewed by Wound Nurse/Designee to ensure that an effective pain management plan is in place and care plan is updated accordingly. · Nursing staff will be in-serviced by February 18, 2015 by the DNS/designee on the Dressing</p>	02/18/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155149	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/29/2015
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NAME OF PROVIDER OR SUPPLIER  HARCOURT TERRACE NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260
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	<p>medication) 500 mg (milligrams) by mouth three times a day for 10 days for right lower extremity (RLE) wound. 12/12/14--Tramadol 50 mg take one tablet by mouth three times a day. 1/19/15--RLE wound--Cleanse the wound with normal saline (wound cleanser). Apply Santyl (an ointment medication that removes the dead tissue from the wound) to the wound bed. Top the wound with hydrogel (a gel medication applied to the wound to aid in the prevention of the wound drying out) gauze. Apply Calazime (an ointment applied around the wound as a skin protector) to periwound. Cover the wound with an ABD (abdominal) pad and Kerlix (gauze wrapping). Change daily and as needed if soiled or dislodged.</p> <p>1/27/15--Hydrocodone/APAP (a narcotic pain medication) 5/325 mg one tablet by mouth 30 minutes prior to wound treatment daily for pain.</p> <p>An "Infection Control Individual Report" dated 12/10/14 at 10:52 a.m., indicated the resident had redness and swelling to the RLE. She was ordered Keflex 500 mg by mouth for 10 days on 12/10/14.</p> <p>A "Non-Pressure Wound Skin Evaluation Report" dated 1/20/15 at 2:00 p.m., indicated the resident had a full thickness</p>		<p>Change (Incision or Wound) Policy, Pain Management Programs, and appropriate mechanical lift transfers. · The IDT will review Facility Activity Report and progress notes daily and weekend supervisor on Saturday and Sunday to identify residents with complaints of pain when the wound is touched, when the wound is packed, when the dressing is removed, and for general pain during the dressing change to make sure that pain was assessed and addressed during wound dressing changes. The DNS/designee will audit medication administration records for corresponding administration of pain medication. · DNS/designee will review as needed pain medication usage by reviewing the medication administration record and narcotic count record daily to contact physician for evaluation of routine use by February 18, 2015 · All residents will be asked QIS questions regarding pain by Customer Care Representatives weekly. If pain is identified, physician will be notified, care plans updated, and followed as needed. <b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</b> · Licensed Nurses will be in-serviced by February 18, 2015 by the DNS/designee on the Dressing Change Policy, Pain</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155149	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/29/2015
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NAME OF PROVIDER OR SUPPLIER  HARCOURT TERRACE NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260
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	<p>wound to her RLE caused by trauma, which was not present on admission to the facility. The wound origination date was 12/9/14. The wound measured 7.5 cm (centimeters) x 5.5 cm x 0.3 cm. The wound bed color was 100% red granulation (the pink/red, moist tissue, which fills the open wound when it begins to heal). The wound had a small amount of serosanguineous (light red to pink, thin, watery and normal during the inflammatory stage of healing) drainage.</p> <p>A Wound Physician progress note dated 1/19/15, indicated "Chief Complaint: RLE hematoma... HPI (History Physical Information):... Duration: First noted 10/29/14...Integumentary:... Wound #1 Right, Anterior Lower Leg is a Full Thickness Trauma Wound and has received a status of Not Healed. Subsequent wound encounter measurements are 7.5cm length x 5.5cm width x 0.3cm depth...The patient reports a wound pain of level 3. The wound is deteriorating... Wound Orders: Wound #1 right, Anterior Lower Leg... Cleanse wound bed with NS [normal saline]. Pat dry. Apply skin prep or barrier cream to periwound. Santyl to wound bed followed by hydrogel moistened, fluffed gauze, then cover with dry gauze and secure daily and PRN [as needed], soiled-Cover with ABDS &amp; Kerlix.</p>		<p>Management Policy, and Mechanical Lift policy. · The IDT will review Facility Activity Report and progress notes daily and weekend supervisor on Saturday and Sunday to identify residents with complaints of pain when the wound is touched, when the wound is packed, when the dressing is removed, and for general pain during the dressing change to make sure that pain was assessed and addressed during wound dressing changes. The DNS/designee will audit medication administration records for corresponding administration of pain medication. · DNS/designee will review as needed pain medication usage by reviewing the medication administration record and narcotic count record daily to contact physician for evaluation of routine use by February 18, 2015. · All residents will be asked QIS questions regarding pain by Customer Care Representatives weekly. If pain is identified, physician will be notified, and care plans updated as appropriate. · CNAs will be skills validated on mechanical lift transfers by February 18, 2015 by the Clinical Education Coordinator or designee · Licensed nurses will have Dressing Change skills validation completed by February 18, 2015 by the Clinical Education Coordinator or designee. · All residents with wounds will be</p>	

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	<p>Change daily &amp; PRN... Ulcer of lower limbs, except pressure ulcer, Ulcer of calf--Deteriorated with slightly larger dimensions but no slough or odor today. change to Santyl for chemical maintenance [sic] debridement, hydrogel for moist wound healing &amp; to decrease pain when dressing removed...."</p> <p>A Wound Physician progress note dated 1/19/15, indicated "Chief Complaint: RLE hematoma [a blister filled with bloody drainage]... HPI (History Physical Information):... Duration: First noted 10/29/14...Integumentary:... Wound #1 Right, Anterior Lower Leg is a Full Thickness Trauma Wound and has received a status of Not Healed. Subsequent wound encounter measurements are 7.5cm length x 5.5cm width x 0.3cm depth...The patient reports a wound pain of level 3. The wound is deteriorating [getting worse]... Ulcer of lower limbs, except pressure ulcer, Ulcer of calf--Deteriorated with slightly larger dimensions but no slough or odor today...."</p> <p>A Physician progress note dated 1/12/15, indicated "...History of present illness... Resident has wound to RLE-recent I &amp; D [Incision and Drainage]... Review of Systems:... Symptom Management:... Pain Location: RLE... Pain description:</p>		<p>reviewed by Wound Nurse/Designee to ensure that an effective pain management plan is in place and followed. Orders and Care Plans will be updated as needed. <b>How the corrective action(s) 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>· Skin Management Program</li> <li>CQI and Pain Management CQI tool will be completed weekly x 4 weeks, monthly x 6 months, and then quarterly for one year with results reported to the Continuous Quality Improvement Committee overseen by the Executive Director</li> <li>· If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance</li> </ul>	

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NAME OF PROVIDER OR SUPPLIER  HARCOURT TERRACE NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260
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	<p>Intermittent Pain Triggers: Dressing changes Pain Treatments: Medications Pain Duration: Three weeks up to two months... Opioid Use for Pain: No...."</p> <p>Nursing progress notes reviewed for RLE wound dressing changes from 12/9/14 to 1/27/15, and the resident had 35 dressing changes completed. She complained of pain during the dressing changes at the following times these number of times: Whenever the wound area was touched--1 time Packing of the wound--7 times Removal of the dressing--5 times General pain during the dressing change--10 times</p> <p>The resident's MAR's (Medication Administration Records) were reviewed from 12/9/14 to 1/27/15, for pain medication administration. The resident's MAR dated December 2014, indicated the resident received as needed doses of pain medications these number of times: Tramadol 50 mg--5 times Acetaminophen--0 times</p> <p>The resident's MAR dated January 2015, indicated the resident received as needed doses of pain medications these number of times: Tramadol--0 times</p>			

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	<p>Acetaminophen--1 time, which was 1/27/15, after her wound dressing was changed.</p> <p>On 1/27/15 at 10:55 a.m., LPN #1 was observed changing Resident C's RLE wound dressing. She placed her clean supplies on a towel barrier on the resident's bed. She washed her hands. She placed the resident's RLE onto a clean incontinence pad edge of the bed. At that time, Resident C indicated to LPN #1 her RLE was tender. LPN #1 opened her dressing supplies on the clean towel barrier and got her supplies ready for the dressing change. She tore two pieces of tape and placed them on the resident's nightstand, then dated and initialed them. She got her empty trash bag ready on the nightstand and took a pair of scissors out of the plastic bag, which she had used to bring the dressing supplies down to the resident's room. She placed the pair of scissors on the clean towel barrier with the clean supplies without wiping them off. She donned clean gloves at that time.</p> <p>LPN #1 removed the old dressing by cutting it off with the pair of scissors then she laid the scissors back on the clean towel barrier field without cleaning the scissors. The old 4 x4 gauze dressings were lying on top of the wound and the</p>			

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	dressings were stuck to the edges of the resident's wound due to being dried along the edges of the resident's wound. The resident indicated to the nurse at that time when she removed the dressings "Ouch, that hurts." LPN #1 indicated to the resident at that time she was being as gentle as she could be and she would be done in a minute. The resident had a furrowed brow and grimaced when LPN #1 removed the dressings from the resident's RLE. She threw the old dressing in the trash. The old 4 x 4 gauze pads covering the wound had a moderate amount of brownish red drainage on them. She irrigated the wound with normal saline in a syringe without changing her gloves. The resident indicated to LPN #1 at that time the wound was tender and LPN #1 indicated at that time to the resident, she was being as gentle as she could be. LPN #1 indicated at that time, she had medicated the resident at 10:00 a.m., with her routine Tramadol. The resident indicated at that time, the pain medicine helped a little bit, but her leg was still hurting. The wound was approximately the size of an orange. The wound bed was red with white slough along the lateral outside edge of the wound. LPN #1 removed her gloves and washed her hands, then donned clean gloves.			

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	<p>LPN #1 applied Hydrogel onto one 4 x 4 gauze dressing, then laid it back on the open package. LPN #1 squeezed Santyl ointment into the middle of the wound, then used one sterile cotton tipped applicator and smeared it around the entire wound. She started in the middle where the glob of ointment was and continued to smear the Santyl around in a circular motion four times, while crossing over the inside of the wound. The resident indicated at that time, the wound bed was hurting and LPN #1 indicated at that time, she was being as gentle as she could be and she was almost finished with the dressing. The resident was observed with furrowed brows and facial grimacing during that time She pulled the 4 x 4 gauze smeared with Hydrogel gauze apart into a flat circle and used a sterile cotton tipped applicator and applied it to Resident C's wound. The resident indicated at that time, her wound bed was hurting. LPN #1 indicated at that time to the resident, she was being as gentle as she could. The resident was observed with facial grimacing and furrowed brows while LPN #1 was packing the wound with the Hydrogel gauze.</p> <p>LPN #1 applied Calazime ointment around the periwound with a sterile tipped applicator, then covered the</p>			

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	<p>wound with an ABD pad. She wrapped the Kerlix gauze around the ABD pad and secured it with tape. The resident indicated at that time, as the LPN #1 was applying the Calazime to the edges of the wound and wrapping the RLE with the Kerlix gauze that her leg was hurting. LPN #1 indicated that she was just about done with the dressing change. The resident was observed with facial grimacing and furrowed brows throughout these two steps of the dressing change. LPN #1 did not stop during the wound dressing change to medicate the resident with any as needed pain medication. She cleaned up her trash and removed her gloves. Resident C indicated to LPN #1 while she was cleaning her trash up after the dressing change that her RLE continued to hurt. She washed the pair of scissors with soap and water, then washed her hands.</p> <p>During an interview on 1/27/15 at 11:29 a.m., LPN #1 indicated she should have removed her gloves, then irrigated resident C's RLE with normal saline. She indicated she had cleansed her scissors with alcohol before she went into the room. She indicated she should have applied the Santyl by starting in the middle of the wound and worked her way out towards the outside of the wound. She indicated she should not have placed</p>			

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NAME OF PROVIDER OR SUPPLIER  HARCOURT TERRACE NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260
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	<p>the pair of scissors on the clean towel barrier next to her clean supplies after she cut the old dressing off the resident's RLE. LPN #1 indicated the 4 x 4 gauze dressings that she removed from the wound should not have been laid on top of the resident's wound. She indicated the resident had not normally had that much pain when her wound dressing was changed, but the old dressing was dried around the wound edges and it stuck to her wound when she tried to remove it. LPN #1 indicated she normally would have stopped and medicated the resident having pain during a dressing change, then finished the dressing, but she had pre-medicated Resident C, so she thought she would be okay throughout the dressing change.</p> <p>On 1/27/15 at 11:30 a.m., LPN #1 was observed asking Resident C at the nurses station if she was still having RLE pain and the resident indicated at that time she was having pain. At that time, LPN #1 medicated the resident with her as needed Acetaminophen pain medication.</p> <p>During an interview on 1/28/15 at 1:15 p.m., the DNS (Director of Nursing Services) indicated LPN #1 should have removed her gloves and washed her hands after she removed the old dressing on 1/27/15, then cleansed Resident C's</p>			

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NAME OF PROVIDER OR SUPPLIER  HARCOURT TERRACE NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260
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	<p>RLE wound. She indicated LPN #1 should have placed the pair of scissors on a dirty field, not the clean field after cutting the old dressing off her RLE wound. The DNS indicated LPN #1 should have applied the Santyl with a gauze from the inside of the wound to the outside of the wound and the Hydrogel gauze should have been fluffed when she applied it to the resident's RLE wound.</p> <p>During an interview on 1/28/15 at 5:45 p.m., the DNS indicated LPN #1 should have stopped doing the dressing change and medicated the resident, waited for the medication to take effect, then resumed with the dressing change.</p> <p>A current policy titled "Dressing Change (Incision or Wound)" dated 09/2012, provided by the DNS on 1/28/15 at 3:33 p.m., indicated "Procedure Steps:.. 6. Put on gloves. 7. Remove old dressing from residents and put directly in trash receptacle. 8. Remove gloves and discard. 9. Perform hand hygiene. 10. Put on gloves. 11. Initiate wound care according to the physician order:.. a) cleanse away debris or drainage from the wound... 13. Remove gloves and discard. 14. Perform hand hygiene. 15. Put on gloves. 16. Apply new dressing according to the physician orders..."</p> <p>2. On 1/27/15 at 2:55 p.m., the record</p>			

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	<p>review for Resident R was completed. Diagnoses included, but were not limited to, multiple sclerosis, adult failure to thrive, pressure ulcer and chronic pain.</p> <p>The care plan dated 7/13/11, indicated the resident was at risk for pain related to chronic pain, knee pain, Gout (inflammatory condition of the joints), H/O (history of) pain related to Multiple Sclerosis. Administer meds as ordered, assist/encourage to reposition frequently, document effectiveness of prn (as needed) medications, notify MD if pain is unrelieved, worsening or having break thru pain as needed, observe for changes in day to activities, observe for changes in sleep pattern, observe for changes in sleep pattern. Observe for non verbal signs of pain, changes in breathing, vocalizations, mood/behavior changes, eyes change expression, sad/worried face, crying, teeth clenched, changes in posture, offer non pharmacological interventions such as quiet environment, rest, shower, back rub, reposition.</p> <p>On 1/27/15 at 2:00 p.m., CNA #1 and CNA # 2 were observed transferring Resident #47 with a Hoyer lift from her broda chair into her bed. The CNA's placed the Hoyer pad underneath the resident, transferred her and positioned her in bed. The resident had facial</p>			

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NAME OF PROVIDER OR SUPPLIER  HARCOURT TERRACE NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260
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	<p>grimacing and a furrowed brow while the CNA's were transferring her. CNA #2 told the resident they were going to remove her pants and clean her up. CNA #1 and CNA #2 moved the resident to her left side and to the other while removing her pants. The resident yelled out at as CNA #1 pulled on the left side of pants, and CNA #2 pulled on the right side of the pants and pulled them down underneath of the resident's knees. Then CNA #1 and CNA #2 continued care by pulling off the resident's brief, unfastening it on the left side and pulling the brief down without taking the seam off of the right side. As they turned to reposition her on her right side the resident indicated "that hurts." She was yelling, had facial grimacing and her eyebrows were furrowed.</p> <p>On 1/28/15 at 11:20 a.m., LPN # 4 indicated during interview, the CNA's completing the transfer and care should have reported the complaints of pain to her. LPN # 4 indicated she had not been notified of the resident's complaints of pain</p> <p>A document titled "Pain Management" dated 1/03, with revision dates of 12/03, 1/06, 1/08, 3/10 and 9/2013 was provided by the Assistant Director of Nursing on 1/29/15 at 11:15 a.m. The policy</p>			

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NAME OF PROVIDER OR SUPPLIER  HARCOURT TERRACE NURSING AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260			
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F000312 SS=D	<p>indicated, "...It is the responsibility of the facility to ensure that each resident is assessed for pain, and the efficacy of pain medication, while keep the resident as comfortable and pain free as possible...."</p> <p>3.1-37(a)</p> <p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, interview and record review, the facility failed to ensure a resident was provided incontinent care in a timely manner for 1 of 4 residents being reviewed for incontinence care. (Resident B)</p> <p>Findings include:</p> <p>Resident B's record was reviewed on 1/26/15 at 10:05 a.m. Diagnoses included, but were not limited to, acute cerebrovascular accident (Stroke), hemiplegia (paralysis to one half of the body), convulsions, and iron deficiency anemia.</p>	F000312	<p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <p>· Resident B is checked every 2 hours and receives routine incontinence care.</p> <p><b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p> <p>· All residents who receive routine incontinent care have the potential to be affected by the</p>	02/18/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155149	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/29/2015
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NAME OF PROVIDER OR SUPPLIER  HARCOURT TERRACE NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260
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	<p>An IDT (Interdisciplinary Team) "Bladder Continence Review" dated 1/8/15, indicated the recent bladder assessment without a catheter was concluded on 1/12/15. The review indicated the resident was always incontinent (no episodes of continent voiding). She was not mentally and physically aware of the need to void and able to use a toilet, commode, urinal or bedpan. She was not appropriate for a scheduled toileting program. The review indicated routine incontinent care would be provided for the resident.</p> <p>A document titled "Resident Profile" dated 1/26/15, indicated "...7/13/2011- -Check every 2 hours for incontinence...."</p> <p>A continuous observation of Resident B occurred on 1/26/15 from 9:50 a.m. to 1/26/15 at 1:57 p.m.</p> <p>On 1/26/15 at 9:50 a.m., the resident was in her wheelchair in the activity room. She had just finished doing an exercise activity.</p> <p>On 1/26/15 at 10:00 a.m., the resident was transported to the main dining room and sat in front of the TV waiting for the next activity to start.</p>		<p>alleged deficient practice.</p> <ul style="list-style-type: none"> <li>·The DNS or designee will review all resident's most recent IDT Bladder Continence Review to identify those receiving routine incontinence care to ensure that the care plan and resident profile are updated and followed by February 18, 2015.</li> <li>·Staff will be in-serviced by DNS/Designee on The Bladder Program including routine incontinence care every two hours by February 18, 2015.</li> <li>·Licensed nurses will conduct rounds on all shifts using nurse rounds audit tool to ensure that residents receiving routine incontinence are checked every 2 hours.</li> </ul> <p><b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</b></p> <ul style="list-style-type: none"> <li>·The DNS or designee will review all resident's most recent IDT Bladder Continence Review to identify those receiving routine incontinence care to ensure that the care plan and resident profile are updated and followed by February 18, 2015.</li> <li>·Staff will be in-serviced by DNS/Designee on providing incontinence care in a timely manner/ Bladder Program by February 18, 2015.</li> <li>·Licensed nurses will conduct rounds on all shifts using nurse</li> </ul>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155149	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/29/2015
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	<p>On 1/26/15 at 10:25 a.m., the resident was taken to therapy by a therapist.</p> <p>On 1/26/15 at 11:00 a.m., the resident was brought back to the main dining room by the therapist to join the activity already in progress.</p> <p>On 1/26/15 at 11:26 a.m., the resident remains in the main dining room. The activity was finished. The resident was sitting in her wheelchair with the TV playing.</p> <p>On 1/26/15 at 11:35 a.m., an activity person transported the resident to the nurse on her hallway and told the resident's nurse she had requested a pain pill.</p> <p>On 1/26/15 at 11:39 a.m., the resident received a pain pill by the nurse who was responsible for her care and she remained sitting in the hallway by the nurses cart. At that time no staff member had asked the resident if she needed to be checked and changed or needed to go to the toilet.</p> <p>On 1/26/15 at 11:47 a.m., the resident was brought to the main dining room by the SSD (Social Service Director).</p> <p>On 1/26/15 at 12:45 p.m., the resident received her lunch tray and was eating.</p>		<p>rounds audit tool to ensure that residents receiving routine incontinence are checked every 2 hours.</p> <p><b>How the corrective action (s) 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>· Resident Care Rounds CQI tool will be utilized weekly x 4, monthly x 6, and quarterly thereafter for one year. Data will be submitted to the CQI committee for follow up.</li> <li>· If 95% threshold is not achieved, an action plan will be developed.</li> </ul>	

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	<p>On 1/26/15 at 1:23 p.m., the resident was brought back to her room by a therapist.</p> <p>On 1/26/15 at 1:25 p.m., LPN #4 and CNA #10 transferred the resident to bed with a hoyer lift.</p> <p>On 1/26/15 at 1:50 p.m., CNA #10 and CNA #12 gave the resident pericare and changed her brief. The resident's brief was moderately saturated with a yellow urine and had a concentrated urine odor.</p> <p>During an interview on 1/26/15 at 2:00 p.m., CNA #10 indicated that she had not worked on Resident B's unit for awhile, but last time she worked over there the resident came and told the CNA's when she had to use the bathroom. She indicated the CNA's used the stand up lift and toileted the resident, but since she broke her leg she had to be placed on the toilet with the Hoyer lift. She indicated the resident usually told the staff she had to be toileted, 2-3 times a shift. She indicated it had been over 2 hours, since she had checked or changed the resident the last time.</p> <p>On 1/27/15 5:35 p.m., the DNS (Director of Nursing Services) indicated she would have expected the CNA caring for the resident to have checked and changed or</p>			

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F000314 SS=G	<p>toileted the resident every 2 hours.</p> <p>This Federal tag relates to Complaint IN 00162422.</p> <p>3.1-38(a)(2)(C)</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, interview and record review, the facility failed to have interventions in place to prevent possible infection for a wound and to prevent and place interventions to avoid the digression of a wound from moisture associated skin damage to an unstageable pressure wound for 1 of 2 residents reviewed for pressure wounds. (Resident R)</p> <p>Findings include:</p> <p>On 1/27/15 at 2:55 p.m., the record review for Resident R was completed.</p>	F000314	<p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <p>Resident R is laid down in between meals and pressure is offloaded and wound is covered by dressing per physician's orders.</p> <p><b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p>	02/18/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155149	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/29/2015
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	<p>Resident had multiple sclerosis, adult failure to thrive, pressure ulcer, incontinence of bowel and bladder (inability to hold urine or feces) and chronic pain.</p> <p>The events page indicated :</p> <p>8/29/14-the resident had a new area that was not present on admission 1 centimeter (cm) x 1 cm, current treatment Duoderm.</p> <p>10/3/14-The Assistant Director of Nursing (ADON) documentation indicated the resident had a right gluteal moisture associated skin damage area which measured 2.0 cm x 2.5 cm x 0.1 cm.</p> <p>10/7/14-The ADON's documentation indicated the resident had a moisture associated skin damage area which measured 2.5 cm x 3.0 x 0.1 cm. There was a new physician's order to cleanse right gluteal fold with normal saline, pat dry, apply medihoney, cover with optifoam, change daily on the 2-10 shift and as needed.</p> <p>10/21/14-The ADON's documentation indicated the resident had a right gluteal moisture associated skin damage area which measured 1.5 cm x 8.0 x 1 cm.</p>		<p>·All residents with wounds have the potential to be effected by the alleged deficient practice</p> <p>·Nursing staff will be in-serviced on Skin Management Program, Dressing Change (Incision or Wound), and following the plan of care including off loading of pressure and lying down after meals by the DNS/designee by February 18, 2015.</p> <p>·Nurses will be checked off on Dressing Change Skills Validation observed by DNS/Designee by February 18, 2015.</p> <p><b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</b></p> <p>·Nursing staff will be in-serviced on Skin Management Program, Dressing Change (Incision or Wound), and following the plan of care including off loading of pressure and lying down after meals by the DNS/designee by February 18, 2015.</p> <p>·Nurses will be checked off on Dressing Change Skills Validation observed by DNS/Designee by February 18, 2015.</p> <p>·Licensed nurses will conduct rounds on all shifts to ensure that the correct wound treatment is in place per physician's order and wound prevention/healing</p>	

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	<p>Treatment therahoney and optifoam.</p> <p>10/28/14-The ADON's documentation indicated the resident had a right gluteal moisture associated skin damage area which measured 2.8 cm x 2.5 cm x 0.1 cm. Treatment therahoney and optifoam.</p> <p>11/4/14-The ADON's documentation indicated the resident had a right gluteal moisture associated skin damage area which measured 3.5 cm x 1.5 cm x 0.1 cm. Treatment therahoney and optifoam.</p> <p>11/12/14-The ADON's documentation indicated the resident had a right gluteal moisture associated skin damage area which measured 2.5 cm x 2.5 x 0.1 cm. Treatment therahoney and optifoam.</p> <p>11/18/14-The ADON's documentation indicated the resident had a right gluteal moisture associated skin damage area which measured 3.5 cm x 1.8 cm x 0.1 cm. Treatment therahoney and optifoam.</p> <p>11/25/14-The ADON's documentation indicated the resident had an unstageable area which measured 3.5 cm x 4 x 0.1 cm The physician ordered to discontinue current treatment and to cleanse the right gluteal area with normal saline, pat dry, apply Santyl (a wound agent that removes dead skin tissue) to open area, cover with</p>		<p>interventions are in place per plan of care and resident profile.</p> <ul style="list-style-type: none"> <li>· Director of Nursing or designee will monitor physician orders regarding pressure ulcers to ensure physician orders are followed and dressing changes are conducted per Dressing Change policy by conducting rounds on all shifts</li> </ul> <p><b>How the corrective action(s) 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>· A Skin Management Program CQI tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Continuous Quality Improvement Committee overseen by the Executive Director</li> <li>· If 95% a threshold is not achieved, an action plan will be developed to ensure compliance</li> </ul>	

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	<p>optifoam (a wound covering). Composure mattress. (special mattress for pressure areas)</p> <p>12/2/14-The ADON's documentation indicated the resident had a right gluteal unstageable pressure area which measured 3.0 cm x 5.0 cm x 0.1 cm.</p> <p>12/8/14 -The physician discontinued the Santyl order and apply 0.25 % Dakins (an anti infection dressing) solution to fluffed gauze and place in wound bed. Swab peri wound with skin prep and cover with optifoam dressing.</p> <p>12/9/14-The ADON's documentation indicated the resident had a right gluteal unstageable pressure area which measured 2.2 cm x 3.8 cm x 0.8 cm . The physician also had an order to discontinue the composure mattress to a low air loss mattress (a mattress which uses air to provide less pressure to body areas).</p> <p>12/16/14-The ADON's documentation indicated the resident had a right gluteal unstageable pressure area which measured 1.8 cm x 3.5 cm x 1 cm.</p> <p>12/23/14-The ADON's documentation indicated the resident had a right gluteal Stage IV pressure area which measured 3</p>			

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	<p>cm x 3.2 cm x 1.8 cm.</p> <p>12/30/14-The ADON's documentation indicated the resident had a right gluteal Stage IV pressure area which measured 2.1 x 1.2 cm. The physician ordered a wound treatment of silver alginate (an anti infection agent) and cover with optifoam.</p> <p>1/6/15 -The ADON's documentation indicated the resident had a right gluteal Stage IV pressure area which measured 1.5 cm x 1.8 cm x 1.5 cm.</p> <p>1/10/15-The physician discontinued the silver alginate and corded to cleanse area with normal saline, pat dry, apply Dakins 0.25 % solution to fluffed gauze, pack wound bed. Skin prep peri wound and cover with optifoam. Change daily and as needed.</p> <p>1/13/15-The ADON's documentation indicated the resident had a right gluteal Stage IV pressure area which measured 2 cm x 2.5 cm x 3.5 cm.</p> <p>1/19/15-The ADON's documentation indicated the resident had a right gluteal Stage IV pressure area which measured 2.5 cm x 3 cm x 3 cm. The physician changed the wound order to cleanse wound with sterile water, moisten fluffed</p>			

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	<p>gauze with Silvasorb gel and loosely pack wound , swab area around wound with skin prep and cover with ABD pad and Medifix tape.</p> <p>1/26/15 -The ADON's documentation indicated the resident had a right gluteal Stage IV pressure area which measured 2.6 cm x 2.3 cm x 3.5 cm.</p> <p>The wound clinic was seeing the resident for her right gluteal wound and indicated,"...12/8/14...Location: Right gluteal fold...Duration: Began as excoriation several weeks ago, Deterioration last week...Right Gluteal fold is a Necrotic [dead tissue] Tissue (unstageable) Pressure Ulcer and has received a status of Not Healed. Initial wound encounter measurements are 2.2 cm length x 3.8 cm width, by 0.8 cm depth...Undermining [ a separation of tissue from the surface of the edge of the wound] has been noted...Limit up in wheelchair to meals only...1/19/15...Right Gluteal fold is a Stage 4 Pressure Ulcer and has received a status of Not Healed. Subsequent wound encourage measurements are 2.5 cm length x 3 cm width x 3 cm depth...Undermining has been noted...The wound is deteriorating...."</p> <p>The resident was not being off loaded</p>			

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	<p>and laid down after meals as ordered by wound clinic as evidenced by observation on 1/26/2015 at 10:37 a.m., resident was observed in the main dining room with her eyes closed.</p> <p>An observation on 1/28/15 at 10:30 a.m., the resident was observed with her eyes closed and was sitting in her room by her bed in her Broda chair. At 11:30 a.m., the resident was observed playing Bingo for an activity. At 12:35 p.m., the resident was in main dining room for lunch.</p> <p>On 1/28/2015 10:52 a.m., LPN #4, LPN #5, and RN #8 were present for a dressing change. LPN #4 assisted resident onto her side to start to remove the dressing. The old undated and unmarked dressing was removed. The dressing was a small square of adhesive with a pink color to outside and non adhesive bandage on the other side. Two pieces of gauze were removed. The resident told LPN #4 and LPN #5 her back and legs hurt. The dressing was stopped at that time. LPN #5 rolled the plastic incontinence pad that had been lying on top of the low airloss mattress underneath of the resident, and tucked it underneath of the resident and placed her on her back. The wound was open and had no dressing to cover it.</p>			

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F000323 SS=D	<p>On 1/28/15 at 1:00 p.m., the final dressing change was completed. The resident was observed lying on her left side with wound open to air and the plastic incontinence pad laying underneath of her. LPN #4 used sterile water to clean the wound. LPN #4 then took Silvasorb soaked gauze soaked with sterile water, fluffed the gauze and placed it into the wound. She then applied skin prep around peri wound and covered with a large white ABD pad, then secured the pad with a large piece of Medifix tape. She indicated at that time these were the current orders.</p> <p>On 1/29/15 at 4:50 p.m., the Director of Nursing indicated she expected the nurse to have the wound covered with some sort of dressing after the old dressing was removed. She indicated leaving the wound open on the incontinence pad could potentially cause infection of the wound.</p> <p>3.1-40(a)(1) 3.1-40(a)(2)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident</p>			

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	<p>hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on interviews, record review and observations, the facility failed to ensure appropriate, accident preventative safety measures were in place for 2 of 6 residents, in a sample of 6, reviewed for accidents. (Resident F &amp; B)</p> <p>Findings include:</p> <p>1. The clinical record for Resident F was reviewed on 1/26/15. Diagnoses included, but were not limited to, frontal lobe dementia and insomnia.</p> <p>Reportable incident documentation submitted to the Indiana State Department of Health, Long Term Care Division, on 1/27/15 at 10:03 a.m., and nursing progress notes, dated 1/27/15 at 12:42 a.m., indicated Resident F eloped on 1/27/15, shortly after midnight. Using her body weight, Resident F broke through an exit door that led outside. The alarm sounded and Resident F was in the staff's sight during the entire episode.</p> <p>Immediate action taken, documentation indicated staff were able to take the resident back into the building and the resident was put on 1:1 (one on one supervision).</p>	F000323	<p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b> · Resident F no longer resides in this facility · Resident B is transferred in hoier lift appropriately per policy and manufacturer's instructions. · CNA #1 and CNA #2 are no longer employed with the facility.</p> <p><b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p> <p>·All residents that require 1:1 supervision and are transferred by a hoier lift have the potential to be affected by the alleged deficient practice.</p> <p>· CNAs will have Mechanical Lift skills validation observed by the Clinical Education Coordinator or designee by February 18, 2015.</p> <p>·Staff will be in-serviced on Mechanical Lift Policy, Elopement Policy including following plan of care for continuous 1:1 supervision by the Director of Nursing Services or designee by February 18, 2015</p> <p><b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</b> · Staff will be in-serviced on</p>	02/18/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155149	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/29/2015
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NAME OF PROVIDER OR SUPPLIER  HARCOURT TERRACE NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260
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	<p>IDT (Interdisciplinary Team) notes, dated 1/27/15 at 9:07 a.m., indicated Resident F was receiving 1:1 supervision. A discontinue time was not evidenced during documentation and physician orders reviews.</p> <p>Resident F was observed in her room, laying down in bed, with her eyes closed, during an observation at 12:15 p.m., on 1/28/15. Resident F was the only person in the room.</p> <p>LPN #1 indicated during an interview at 12:15 p.m., on 1/28/15, Resident F was no longer under 1:1 supervision, so, there was not a staff member with her, in her room, to provide 1:1 supervision. The 1:1 was only for yesterday, 1/27/15.</p> <p>The Director of Nursing Services (DNS) indicated during an interview on 1/28/15 at 12:21 p.m., she would have to check the orders, but was pretty sure Resident F should have 1:1 supervision, at that time. The DNS did not know why Resident F was unattended.</p> <p>During an interview with the Executive Director (ED) on 1/28/15 at 12:24 p.m., she indicated Resident F should have 1:1 supervision, at all times, and was unaware Resident F was left unattended.</p>		<p>Mechanical Lift Policy, Elopement Policy including following plan of care for continuous 1:1 supervision by the Director of Nursing Services or designee by February 18, 2015 · Director of Nursing Services or designee will review all physicians orders and facility activity report daily to ensure that 1:1 resident supervision and mechanical lift transfers are added to the care plan and resident profile</p> <p>·Director of Nursing or designee to conduct rounds on all three shifts to ensure that continuous 1:1 supervision is being provided per plan of care and hoyer slings are applied properly during transfers per manufacturer's instructions</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</b></p> <p>·Mechanical Lift and Elopement Risk CQI tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year. Data will be submitted to the CQI committee for follow up.</p> <p>·If 95% a threshold is not achieved, an action plan will be developed</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155149	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/29/2015
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	<p>At 12:45 p.m., on 1/28/15, during an observation, CNA #7 arrived to provide 1:1 supervision for Resident F.</p> <p>The ED indicated during an interview on 1/28/15 at 12:50 p.m., there was a communication error. Apparently, there was an aide in the room with Resident F, earlier, and the aide took a break. Therefore, Resident F was left unattended, during the aide's break. The aide did not communicate with staff, appropriately.</p> <p>During an interview on 1/28/15 at 2:50 p.m., CNA #7 indicated she was the aide scheduled for 1:1 supervision with Resident F that day (1/28/15), and was with Resident F at 8:30 a.m. to 11:55 a.m., when she took a lunch break. The MCF (memory care facilitator) was supposed to relieve her (CNA #7) until she returned. CNA #7 indicated 1:1 supervision was to be provided, continuously, and did not know why Resident F was left unattended.</p> <p>Resident F was not provided 1:1 supervision, as expected, secondary to an elopement on 1/27/15, from 11:55 a.m. to 12:45 p.m., on 1/28/15.</p> <p>2. Resident B's record was reviewed on 1/26/15 at 10:05 a.m. Diagnoses</p>			

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	<p>included, but were not limited to, acute cerebrovascular disease (stroke), hemiplegia (paralysis to one half of the body), convulsions, and iron deficiency anemia.</p> <p>The resident's recapitulation orders dated January 2015, included, but was not limited to, the following: 1/8/15--Hoyer lift for all transfers</p> <p>The Discharge Summary from the hospital dated 1/7/15, indicated she was admitted to the hospital on 1/3/15, after a fall at the facility and had a left femur fracture. She had an open reduction and internal fixation (repair of a fractured left femur) during her hospitalization and was readmitted back to the facility on 1/7/15.</p> <p>A "Fall Event" document dated 1/21/15 at 8:30 p.m., indicated the resident had a witnessed fall. She was sitting in her wheelchair, then being transferred to bed prior to the fall. The fall occurred in the resident's room. The resident was first observed sitting on the floor on her buttocks after the fall. She had clothing and non-skid socks in place. The resident did not have any injuries. Witnesses statement of the fall indicated, "2 cnas placing res [resident] to bed and as lifting res from chair res began to slip from Hoyer padding which prompted cnas to</p>			

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	<p>lower res to floor to prevent fall." The resident was incontinent at the time of the fall. Interventions put into place to prevent another fall was 15-minute checks and remove the mechanical lift for inspection by maintenance.</p> <p>An IDT (Intradisciplinary Team) progress note dated 1/22/15 at 9:54 a.m., indicated "Resident had witness fall on 01/21/15 evening shift. Root cause of fall identified as resident was transferring with two aids and resident began to slide from sling, two CNAs were able to cradle resident and lower her to the ground. There were no injuries during the fall... Immediate intervention was to remove Hoyer lift for maintenance to inspect for proper function. Housekeeping supervisor to inspect slings as well. IDT recommends for CNAs to be checked off by CEC [Clinical Education Coordinator] on proper lift transfers prior to working on the floor. CEC to inservice all staff on 1/27/15 on lift transfers. x-rays obtained to ensure no underlying fracture occurred..."</p> <p>During an interview on 1/27/15 at 5:35 p.m., the DNS (Director of Nursing Services) indicated the resident had an assisted fall due to the Hoyer lift pad was not crisscrossed when the CNA's were transferring her from the wheelchair to</p>			

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F000329 SS=D	<p>her bed and she slid out of the pad.</p> <p>This Federal tag relates to Complaint IN 00162422.</p> <p>3.1-45(2)</p> <p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on interview and record review, the facility failed to quantitatively monitor specific behaviors to justify the use of anti-psychotic and anti-anxiety</p>	F000329	<b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient</b>	02/18/2015

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	<p>medications for 2 of 5 residents reviewed for Unnecessary Medications. (Residents #30 and K). In addition the facility failed to attempt a GDR (gradual dose reduction) of psychotropic medications for a resident for 1 of 5 residents reviewed for Unnecessary Medications. (Resident #30).</p> <p>Findings include:</p> <p>1. On 1/26/2015 at 1:25 p.m., Resident #30's record was reviewed. Diagnoses included, but were not limited to, diabetes, dementia with behavioral disturbances, constipation and depressive disorder.</p> <p>The resident's January 2015 physician's medication order recap indicated the resident was receiving, but was not limited to, the following medications with latest ordered date:</p> <p>7/25/14--Trazodone (an anti-depressant medication) 50 mg (milligrams) 1/2 tablet (25 mg) by mouth daily at bedtime for insomnia.</p> <p>12/19/14--Escitalopram (an anti-depressant medication) 20 mg take 1 tablet by mouth daily for behaviors.</p> <p>12/22/14--Risperidone (an anti-psychotic</p>		<p><b>practice?</b></p> <ul style="list-style-type: none"> <li>· Resident #30's medications and behaviors have been reviewed to ensure that any antipsychotic and anti-anxiety medications are used for specific behaviors and not used as unnecessary medication by the Social Services Consultant.</li> <li>· Resident #30-All anti-psychotics and anti-anxiety medications have been reviewed to ensure they are appropriate related to residents current behaviors by the Social Services Consultant</li> <li>· A GDR has been requested for Resident #30</li> <li>· Resident K- All anti-psychotics and anti-anxiety medications have been reviewed to ensure they are appropriate related to residents current behaviors by the Social Services Consultant</li> <li>· Physician's have been notified that if they disagree with a facility requested Gradual Dose Reduction (GDR) that will write a progress note as to why they feel it is clinically contraindicated</li> </ul> <p><b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p>	
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	<p>medication) 1 mg 1 tablet by mouth once daily, diagnosis schizophrenia.</p> <p>5/16/14--Risperidone 2 mg 1 tablet by mouth at bedtime.</p> <p>1/22/15--Ativan (an anti-anxiety medication) 0.5 mg 1 tablet by mouth TID (3 times per day) to resolve agitation.</p> <p>The resident's record indicated the resident's pharmacy recommendations with response were as follows:</p> <p>On 10/7/2014 the Pharmacist recommended the resident's antidepressant medication escitalopram 5 mg daily oral dose that had been ordered since August of 2014 for anxiety, be considered for a gradual dose reduction. The Physician checked that she disagreed because, "Receiving optimal dose that benefits the resident's function and activities of daily living,...."</p> <p>On 10/6/2014 the Pharmacist recommended the resident's antidepressant Trazodone 25 mg daily at bedtime that had been ordered since July 2014 be considered for a gradual dose reduction. Again the Physician disagreed and checked that the resident was receiving the optimal dose that benefits</p>		<ul style="list-style-type: none"> <li>· All residents who receive an anti-psychotic and anti-anxiety medications have the potential to be affected by the alleged deficient practice.</li> <li>· The IDT team will be in-serviced on the Psychoactive Medication Management and Behavior Management Programs by the DNS/designee by February 18, 2015.</li> <li>· The IDT team reviewed all physician's orders in the clinical meeting to identify all residents receiving antipsychotic and anti-anxiety medications and ensure it is appropriate and relates to resident's specific behavior.</li> <li>· Social Services/designee and Memory Care Facilitator/Designee reviewed all residents receiving anti-psychotic and anti-anxiety medications to ensure that a GDR has been requested per facility policy and that there was resident specific behavior monitoring in place.</li> <li>· Physician's disagreeing with a facility requested GDR will write a progress note why Gradual Dose Reduction is not appropriate</li> </ul> <p><b>What measures will be put into</b></p>	

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NAME OF PROVIDER OR SUPPLIER  HARCOURT TERRACE NURSING AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260		
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	<p>the resident's function.</p> <p>On 10/7/2014 the Pharmacist recommended the resident's antipsychotic medication Risperidone 1 mg orally daily at 8 a.m. and 2 mg daily at bedtime be considered for a gradual dose reduction. The record indicated the Physician disagreed and checked that the resident's, "Most recent attempt to taper medication resulted in return and / or worsening of resident's condition with the facility." The resident's record indicated the behaviors exhibited in the past three months that were being treated with the antipsychotic medication were, "exit seeking, Demanding, Insomnia."</p> <p>During an interview on 1/29/2015 at 11:10 a.m., the nurse consultant indicated the exit seeking, demanding and insomnia were not specific behaviors for the use of the antipsychotic medication the resident was receiving. These were behaviors the resident was exhibiting but not necessarily the behaviors being treated with the antipsychotic medication. It was unclear what behaviors were present with the schizophrenia the resident was diagnosed with in the past. The nurse consultant indicated clarification on what behaviors were being monitored specific to what medication was being given was needed</p>		<p><b>place or what systemic changes you will make to ensure that the deficient practice does not recur?</b></p> <ul style="list-style-type: none"> <li>· The IDT team will be in-serviced on the Psychoactive Medication Management and Behavior Management Programs by the DNS/designee by February 18, 2015</li> <li>· The IDT team will review all physician's orders in the clinical meeting to identify all residents receiving antipsychotic and anti-anxiety medications and ensure it is appropriate and relates to resident's specific behavior.</li> <li>· Social Services/designee and Memory Care Facilitator/Designee will review all residents receiving anti-psychotic and anti-anxiety medications to ensure that a GDR has been requested per facility policy and that there is resident specific behavior monitoring.</li> <li>· Physician's disagreeing with a facility requested GDR will write a progress note stating why a Gradual Dose Reduction is not appropriate.</li> <li>· Pharmacist will follow up on all facility requested GDRs monthly to ensure that appropriate follow up has occurred in monthly Pharmacy</li> </ul>		

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	<p>and would be reviewed.</p> <p>2. Resident K's record was reviewed on 1/26/15 at 12:55 p.m. Diagnoses included, but were not limited to, anxiety state, Alzheimers disease, dementia unspecified with behavior disturbances, post traumatic stress disorder (PTSD), depressive disorder.</p> <p>The resident's recapitulation dated January 2015, included, but were not limited to, the following orders: 4/4/14--Quetiapine (an antipsychotic medication) 50 mg (milligrams) take one and one-half tablets (75 mg) by mouth daily at 1 p.m. to decrease behaviors. 4/4/14--Quetiapine 100 mg take one tablet by mouth daily in the morning and daily at bedtime for dementia with behavior disturbances. 11/7/14--Lorazepam (an anti-anxiety medication) 0.5 mg take one tablet by mouth three times a day.</p> <p>A "Behavioral Medicine Progress Note" dated 10/18/14, indicated "...Chief Complaint:... Patient with history of Alziheimer's [sic] Dementia, Dementia with behavior disturbance and depression, PTSD... he is on the locked unit due to hx of aggression... Interim History of Present Illness:... In talking with nursing staff they have do no [sic] have any concerns... Affect- flat,</p>		<p>Consultant Report.</p> <p><b>How the corrective action(s) 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>Behavior Management and Unnecessary Medications CQI tools will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year. Data will be submitted to the CQI committee for follow up.</li> <li>If 95% a threshold is not achieved, an action plan will be developed to ensure compliance.</li> </ul>				

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	<p>Delusions-denies, Hallucinations-denies... Clinical Status and Impressions:.. Will continue to follow mood over time and consider slow taper of Lorazepam as not a medication known to help with PTSD, but can aggravate...."</p> <p>A "Behavioral Medicine Progress Note" dated 11/10/14, indicated "...Chief Complaint:..Patient with history of Alziheimer's [sic] Dementia, Dementia with behavior disturbance and depression, PTSD... he is on the locked unit due to hx of aggression... Affect-WNL [within normal limits], Delusions-Denines, Hallucinations-Denies...Clinical Status and Impressions:...If pt [patient] continues to be stable would consider slow taper of Lorazepam as can aggravate PTSD... and makes older pts more prone to falling...."</p> <p>A "Diagnostic Interview" dated 11/21/14, indicated "Clinical Signs, Symptoms and Maladaptive Behaviors Currently Exhibited by Patient: Pt had been hospitalized in March, 2014 for agitation, aggressive behavior, and inappropriate touching of female staff... H/o [history of] PTSD... Pyshchotic/Delusional Thinking: unknown... Recommendations To Facility Staff: No recommendations at</p>			

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	<p>this time as he has recently been moved to higher level care and no behaviors have yet been noted in this placement..."</p> <p>A Physicians Initial Assessment dated 1/9/15, indicated there were no acute issues with the resident.</p> <p>The resident had a Care Plan dated 8/5/14, which addressed the problem he had episodes of aggression especially when approached from behind related to his PTSD/paranoia. The approaches included, but were not limited to, "8/5/14--Approach resident from front, using calm, reassuring voice and gestures to diminish resident's aggression, Remove resident from the triggering event and offer snack or a favorite activity, Offer resident the opportunity to call his family."</p> <p>The resident had a Care Plan dated 2/27/14, which addressed the problem he washed his clothes in the sink and may yell at staff when they removed his clothes from the room to take them to laundry. He had a diagnosis of dementia and cultural history of contributing factors. The approaches included, but were not limited to, "2/27/14--allow to wash clothing in sink, redirect to activities, offering to have clothing changed, gently."</p>			

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	<p>The resident had a Care Plan dated 1/24/14, which addressed the problem he engaged in inappropriate touching, grabbing of staff such as grabbing chests and private areas. The approaches included, but were not limited to, "1/24/14--exit room and reapproach [sic] later or with alternative care giver as appropriate, Provide resident with adequate space when communicating and providing care, Attempt to use the work 'stop' and gesturally shake your head 'no'."</p> <p>The "Behavior Symptom Monthly Summary Form" included, but were not limited to, the number of times the following behaviors occurred on each shift:</p> <p>The month of September 2014, dated 12/22/14. The resident engaged in inappropriate touching with staff: Days-0 Evenings-0 Nights-0</p> <p>The month of October 2014, dated 12/22/14. The resident engaged in inappropriate touching with staff Days-0 Evenings-0 Nights-0</p> <p>The month of November 2014, dated 12/22/14.</p>			

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	<p>The resident had episodes of aggression especially when approached from behind related to PTSD/paranoia. Days-0 Evenings-0 Nights-0</p> <p>The resident engaged in inappropriate touching with staff Days-0 Evenings-0 Nights-0</p> <p>The month of December 2014, dated 12/22/14. The resident had episodes of aggression especially when approached from behind related to PTSD/paranoia. Days-0 Evenings-0 Nights-0</p> <p>The resident engaged in inappropriate touching with staff Days-0 Evenings-0 Nights-0</p> <p>The month of January 2015, dated 1/18/15. The resident had episodes of aggression especially when approached from behind related to PTSD/paranoia. Days-0 Evenings-0 Nights-0</p> <p>The resident engaged in inappropriate touching with staff Days-0 Evenings-0 Nights-0</p> <p>No records were found indicating the resident's specific targeted behaviors were being monitored for the Seroquel or</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155149	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/29/2015
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NAME OF PROVIDER OR SUPPLIER  HARCOURT TERRACE NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260
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	<p>the Lorazepam for the months of April 2014 through January 2015.</p> <p>April through June Behavior "Symptom Monthly Summary Forms" were requested on 1/28/15 and 1/29/15 and the Summary forms were not provided by the end of the exit conference on 1/29/15.</p> <p>During an interview on 1/29/15 at 10:13 a.m. the MCF (Memory Care Facilitator) with the Nurse Consultant present, indicated the specific targeted behavior being monitored for the Seroquel medication was the PTSD. She indicated his specific targeted behavior being monitored for the Lorazepam would be any indications of anxiety. She indicated he had episodes of aggression when approached from behind and he had a Care Plan in place that describe the interventions and approaches that staff needed to take when approaching him. She indicated his behavior of inappropriate touching of the staff was being treated with the Seroquel. She indicated she was not able to tell if the resident was having delusions or hallucinations or because he was nonverbal.</p> <p>A current policy titled "Behavior Management Policy &amp; Procedure" undated, provided by the Director of</p>			

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NAME OF PROVIDER OR SUPPLIER  HARCOURT TERRACE NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260
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	Nursing Services on 1/29/15 at 12:00 p.m., indicated "... Procedure: 1...All residents who are taking (either routinely or as needed) antipsychotic, anxiolytic, sedative/hypnotic, or anticonvulsant medication (used for behaviors NOT seizures) are required to have a behavior monitoring program and corresponding care plan in order to assist in assessing the efficacy of both interventions and medication use. -Example: The resident who is taking Risperdal for a diagnosis of dementia with delusions, should have a care plan stating what behaviors the Risperdal is targeting (i.e. paranoid thinking that people are stealing from her, physical aggression, etc). The resident who is taking Zyprexa for schizophrenia should have a care plan indicating what types of behavior symptoms are associated with the diagnosis (hearing voices, hallucinations, physical aggression, etc). 2. The behaviors that have been identified as requiring monitoring (i.e. associated with one of the above medications and/or are consistently distressing to the resident or other residents) and associated interventions identified on the care plan should then be transferred to the monitoring form (either the Behavior Monitoring Record or Monthly Flowsheet depending on the Facility practice)... 7. All other behaviors that are			

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F000371 SS=E	<p>not new or worsening will be reviewed via the monthly summary...."</p> <p>3.1-48(a)(3) 3.1-48(b)(2)</p> <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 failed to provide sanitary conditions in the kitchen which had the potential to affect 96 of 98 residents that receive food from the kitchen.</p> <p>Findings include:  On 1/21/15 at 10:45 a.m., a tour of the kitchen was completed with the Dietary Manager(DM) in attendance.  The freezer floor was observed to have a large amount of scattered peas on both sides of the floor. The DM indicated the floors were to be cleaned daily.  There were 3 out of 7 Dietary staff, which were observed having hair strands</p>	F000371	<p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <ul style="list-style-type: none"> <li>· Dietary staff have all hair secured in hair restraints.</li> <li>· The freezer floor was cleaned and sanitized.</li> </ul> <p><b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p> <ul style="list-style-type: none"> <li>· All residents have the potential to be effected by the alleged deficient practice</li> <li>· Staff hair was inspected by the Executive Director to ensure that hair was properly restrained.</li> </ul>	02/18/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155149	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/29/2015
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	<p>loose outside of their hair net. The Dietary manager, an unidentified dietary aid, and the cook.</p> <p>During an interview on 1/21/15 at 1:45 p.m., the Dietary Manager indicated all dietary staff should have their hair secured either in a net or a hat.</p> <p>3.1-21(i)(3)</p>		<p>·The kitchen floor was cleaned and inspected by Certified Dietary Manager.</p> <p>·Dietary staff will be in-serviced on Dietary Infection Control Policy, Floor Safety Policy, and Dietary Personal Hygiene by Executive Director/Designee by February 18, 2015.</p> <p><b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</b></p> <p>·A cleaning schedule will be made and checked daily by Dietary Manager/Designee to ensure the floors are cleaned every shift by kitchen staff. Floors and cleaning schedule will be checked on the weekends by Weekend Manager.</p> <p>·Mirrors will be placed at all sinks in kitchen by February 18,2015 so that staff can ensure all hair is under hair net.</p> <p>· Dietary Manager or designee will monitor kitchen processes to ensure proper sanitation of the floor is followed, and hair is properly restrained each meal using a sanitation audit tool.</p> <p>·Dietary staff will be in-serviced on Dietary Infection Control Policy, Floor Safety Policy, and</p>	

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F000412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and		Dietary Personal Hygiene by Executive Director/Designee by February 18, 2015.  <b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</b>  · A Kitchen Sanitation/Environmental Review tool will be utilized weekly X 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Continuous Quality Improvement Committee overseen by the Executive Director  · In addition, a full sanitation audit will be conducted by RD Consultant monthly.  · If 95% a threshold is not achieved, an action plan will be developed to ensure compliance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155149	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/29/2015
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	<p>from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist.</p> <p>Based interview and record review, the facility failed to have follow up dental care for a resident needing dental services after an oral abscess. (Resident # 80).</p> <p>Findings include:</p> <p>During an interview on 1/22/2015 at 1:10 p.m., Resident # 80's family member indicated the resident had an infection in his mouth last week and he was on antibiotics, but he needed to see a dentist. The family member indicated the facility was suppose to schedule an appointment with the dentist for a follow up.</p> <p>On 1/26/2015 at 10:35 a.m., Resident # 80 record was reviewed. Diagnoses included, but were not limited to, diabetes, Alzheimer's dementia, and dysphagia (difficulty in swallowing).</p> <p>The resident's NP (Nurse Practitioner) assessment on 1/14/15 indicated, "...Nsg[nursing] noted swelling to R [right] side of face that has progressively worsened throughout the day. No fever, [symbol for no] bleeding, [no symbol] signs of pain - pt [patient] is nonverbal..." Assessment : "suspected R [right] facial / dental abscess... Plan:... clindamycin</p>	F000412	<p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <ul style="list-style-type: none"> <li>·Resident #80 has a scheduled appointment with oral surgeon to have tooth extracted related to oral abscess.</li> </ul> <p><b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p> <ul style="list-style-type: none"> <li>·All residents have the potential to be affected by the alleged deficient practice</li> <li>·Residents/family will be asked by February 18, 2015 during customer care rounds if the resident has any dental needs and if the resident would like to see a dentist.</li> <li>·Social Services Director/Designee and Memory Care Facilitator/Designee will audit all dental consults for the past 6 months to ensure that proper follow up has occurred.</li> <li>·Staff will be in-serviced by DNS or designee by February 18, 2015 on Dental Services Policy.</li> </ul>	02/18/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155149	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/29/2015
NAME OF PROVIDER OR SUPPLIER  HARCOURT TERRACE NURSING AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260		
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	<p>[antibiotic],...."</p> <p>During an interview on 1/27/2015 at 1:40 p.m., the MCF (Memory Care Facilitator) indicated she was responsible for assisting residents with dental appointments. She indicated Resident L was not on the list to see the onsite dentist. She was not aware that he needed to see a dentist. After looking thru notes the MCF indicated she was not sure who exactly was following the resident's dental care and thought it was nursing taking care of it.</p> <p>During an interview on 1/27/2015 at 2:15 p.m., LPN #9 indicated the MCF is responsible for putting residents on a list to see the dentist and was not sure why Resident L was not on the list, if he needed follow up care with the dentist.</p> <p>During an interview on 1/27/2015 at 2:50 p.m., LPN #9 indicated what actually happened was Resident L had been uncooperative in the past with the onsite dentist and must have been dropped from the list to see them and no other dental plan of care was put in place to address this.</p> <p>Resident L's record lacked documentation updating the plan of care and ensuring the resident was able to get professional</p>		<p><b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</b></p> <ul style="list-style-type: none"> <li>·Residents/family will be asked by February 18, 2015 during customer care rounds if the resident has any dental needs and if the resident would like to see a dentist and if requested will be referred to dentist by Social Services.</li> <li>·Social Services Director/Designee and Memory Care Facilitator/Designee will review follow up with residents needing dental care or who prefer to see the dentist and update care plan appropriately.</li> <li>·The IDT will review the facility activity report, physician's orders and weekly summaries daily Monday- Friday and Weekend Supervisor/designee on Saturday/Sunday to review for dental concerns and assessment of oral status that need referral to physician or dentist</li> <li>·Social Services Director/Designee and Memory Care Facilitator/Designee will audit all dental consults within the last 6 months will be audited to ensure proper follow up was completed.</li> <li>·Monthly, IDT Team will audit all dental referrals to ensure all residents were seen by dentists and to ensure that there is appropriate follow up on</li> </ul>		

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NAME OF PROVIDER OR SUPPLIER  HARCOURT TERRACE NURSING AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260		
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F000431 SS=D	<p>dental care as needed.</p> <p>3.1-24(a)(1)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility</p>		<p>recommendations.</p> <ul style="list-style-type: none"> <li>Staff will be in-serviced by DNS or designee by February 18, 2015 on Dental Services Policy.</li> </ul> <p><b>How the corrective action(s) 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>Dental Services CQI tools will be utilized weekly X 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Continuous Quality Improvement Committee overseen by the Executive Director.</li> <li>If 95% a threshold is not achieved, an action plan will be developed to ensure compliance</li> </ul>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155149	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/29/2015
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NAME OF PROVIDER OR SUPPLIER  HARCOURT TERRACE NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260
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	<p>must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview and record review, the facility failed to ensure expired medications were discarded and replaced, appropriately, for 1 of 7 medication storage reviews. (Resident #30)</p> <p>Findings include:</p> <p>The clinical record for Resident #30 was reviewed on 1/28/15.</p> <p>Diagnoses included, but were not limited to, diabetes mellitus, senile dementia with behavioral disturbances, osteoporosis, and</p>	F000431	<p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <ul style="list-style-type: none"> <li>Resident #30 has had all medications reviewed to ensure there are no expired meds in med cart and expired meds, if any, were replaced appropriately.</li> </ul> <p><b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p> <ul style="list-style-type: none"> <li>All residents have the potential to be affected by the alleged deficient practice.</li> <li>Medications stored in the medication carts</li> </ul>	02/18/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155149	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/29/2015
NAME OF PROVIDER OR SUPPLIER  HARCOURT TERRACE NURSING AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260		
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	<p>convulsions.</p> <p>During a memory care unit medication cart observation, on 1/28/15 at 10:40 a.m., an unopened GlucaGen hypoglycemic injection kit (used during hypoglycemia episodes to return blood glucose levels to normal limits) with an expiration date of 12/16/14, was found in the top drawer. Pharmacy label directions, dated 12/16/13, indicated inject 1 ml (milliliter) intramuscularly, "as needed for preventative". The pharmacy label indicated the medication was prescribed for Resident #30.</p> <p>During an interview on 1/28/15 at 10:40 a.m., LPN #9 indicated the GlucaGen hypoglycemic injection kit was expired. LPN #9 explained when a medication expired, nursing staff were expected to send it back to the pharmacy and order a replacement, if necessary. There was not a replacement GlucaGen hypoglycemic injection kit on the unit, in case it was needed. LPN #9 indicated the expired medication should not have been on the cart.</p> <p>"Facility Action Team Meeting" documentation, dated 12/19/14, was submitted on 1/29/14 at 5:29 p.m. The documentation indicated "Top Drawer Medications" were reviewed and</p>		<p>were audited by the DNS/Designee to ensure that medication is labeled with a date when opened and undated and expired medications are destroyed by February 18, 2015.</p> <ul style="list-style-type: none"> <li>· DNS/Designee will audit all med carts weekly to ensure that medication is labeled with a date when opened and undated and expired medications are destroyed destroyed.</li> <li>· DNS/designee will in-service Licensed Nurses by February 18, 2015 on Medication Storage and Expired Medication Policy.</li> </ul> <p><b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</b></p> <ul style="list-style-type: none"> <li>· Medications stored in the medication carts will be audited by the DNS/Designee to ensure that medication is labeled with a date when opened and undated and expired medications are destroyed.</li> <li>· DNS/Designee will audit all med carts weekly to ensure that medication is labeled with a date when opened and undated and expired medications are destroyed.</li> <li>· DNS or designee will in-service Licensed Nurses by February 18, 2015 on Medication Storage and Expired Medication Policy.</li> <li>· Pharmacy consultant will audit medication carts monthly for proper dating and storage.</li> </ul> <p><b>How the corrective action(s) will be monitored to ensure the</b></p>		

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NAME OF PROVIDER OR SUPPLIER  HARCOURT TERRACE NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260
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(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
F000465 SS=D	<p>discussed. "Expired medications in the top drawer" was an "Identified Area Needing Improvement". The action plan indicated the unit manager was the responsible staff person to audit top drawers of med (medication) carts every Monday and Friday, to reorder expired medications every Friday, and to follow up every Monday to ensure delivery and dating.</p> <p>3.1-25(a) 3.1-25(o)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to ensure clean bathroom floors, doors with missing hardware and dents for 3 of 7 rooms observed for sanitary and working doors and bathrooms. (Rooms 56, 60 and 62).</p> <p>Findings include:</p> <p>1. On 1/22/2015 at 11:10 a.m., room 56 was observed with light brown colored buildup on the floor tile on the inside of the resident's room along the metal door strip. The resident's hallway door was observed dragging the floor when closing</p>	F000465	<p><b>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>Medication Storage CQI tool will be utilized weekly x 4, monthly x 6, and quarterly thereafter for one year. Data will be submitted to the CQI committee for follow up.</li> <li>If 95% threshold is not achieved, an action plan will be developed to ensure compliance.</li> </ul> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <ul style="list-style-type: none"> <li>Room #60's doorjamb has been cleaned and the door hinge has been repaired.</li> <li>Room #56's floor has been cleaned, door has been repaired, and non-skid strips have been replaced.</li> <li>Room #62's floor has been cleaned and sanitized with no odor present. <b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></li> <li>All residents who reside in this facility have the</li> </ul>	02/18/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155149	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/29/2015
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NAME OF PROVIDER OR SUPPLIER  HARCOURT TERRACE NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260
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	<p>the door.</p> <p>On 1/29/2015 at 4:30 p.m., with the ED (Executive Director) in attendance, room #56's bathroom door was observed with a golf size dent on the lower middle half of the door. Debris build up on the non-skid strips in the bathroom were observed and the door to the hallway dragged the floor upon closing.</p> <p>2. On 1/22/2015 at 3:08 p.m., room 60's hallway doorjamb was observed with black colored buildup on it.</p> <p>On 1/29/2015 at 4:25 p.m., with the ED in attendance, room 60 was observed with the hallway door's bottom hinge with half of it un-attached to the door.</p> <p>3. On 1/22/2015 at 1:52 p.m., room 62's tile floor had light brown colored buildup. The resident's bathroom had a strong urine odor.</p> <p>On 1/29/2015 at 4:20 p.m., with the ED in attendance, room 62's tile floor was observed with a light brown colored buildup and the bathroom had a urine odor.</p> <p>During an interview on 1/29/2015 at 4:35 p.m., the ED indicated a new floor</p>		<p>potential to be affected by the alleged deficient practice. · An audit will be performed by the Maintenance Director/Designee and Housekeeping Director/Designee will audit all rooms to ensure that resident doors, doorjambs, and door hinges are clean and in working condition and to ensure that rooms are clean, odor free, and free of buildup on floors by February 18, 2015. · Executive Director will educate managers on how to conduct proper room rounds and identify specific needs in relation to keeping environment safe, functional, sanitary, and comfortable by February 18, 2015. · The Executive Director or designee will in-service Maintenance Director and Housekeeping Supervisor on how to keep a safe, functional, sanitary, and comfortable environment by February 18, 2015. <b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</b> · An audit will be performed by the Maintenance Director/Designee and Housekeeping Director/Designee will audit all rooms to ensure that resident doors, doorjambs, and door hinges are clean and in working condition and to ensure that rooms are clean, odor free, and free of buildup on floors by February 18, 2015.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155149	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/29/2015
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NAME OF PROVIDER OR SUPPLIER  HARCOURT TERRACE NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260
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	cleaning person was starting work soon at the facility to help maintain cleaner floors. Maintenance needed to be contacted to repair the hole/dent in the one door and the hinge on the other door.  3.1-19(f)		<ul style="list-style-type: none"> <li>· Customer care representatives will monitor residents rooms for environmental issues in their respective resident rooms daily Monday- Friday as per customer care rounds to ensure that rooms are clean, odor-free and in good repair. They will communicate all needs to Housekeeping Supervisor and/or Maintenance Supervisor to ensure that appropriate follow up occurs. The Manager on duty will check on Saturday and Sunday.</li> <li>· Executive Director will educate managers on how to conduct proper room rounds and identify specific needs in relation to keeping environment safe, functional, sanitary, and comfortable by February 18, 2015.</li> <li>· The Executive Director or designee will in-service Maintenance Director and Housekeeping Supervisor on how to keep a safe, functional, sanitary, and comfortable environment by February 18, 2015</li> </ul> <p><b>How the corrective action(s) 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>· Cottage Environment CQI tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year. Data will be submitted to the CQI committee for follow up.</li> <li>· If 95% a threshold is not achieved, an action plan will be developed</li> </ul>	

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F000520 SS=D	<p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>Based on interview and record review, the facility failed to ensure the appropriate implementation and review of an action plan developed for removal of expired medication in the medication carts implemented on 12/19/14.</p> <p>Findings include:</p> <p>During a memory care unit medication cart observation, on 1/28/15 at 10:40</p>	F000520	<p>to ensure compliance.</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <ul style="list-style-type: none"> <li>An appropriate action plan has been developed, implemented, and followed for expired medications by the Executive Director for the Nurse Management Team</li> <li>The Unit Manager who was</li> </ul>	02/18/2015

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	<p>a.m., an unopened GlucaGen hypoglycemic injection kit (used during hypoglycemia episodes to return blood glucose levels to normal limits) with an expiration date of 12/16/14, was found in the top drawer. Pharmacy label directions, dated 12/16/13, indicated inject 1 ml (milliliter) intramuscularly, "as needed for preventative."</p> <p>During an interview on 1/28/15 at 10:40 a.m., LPN #9 indicated the GlucaGen hypoglycemic injection kit was expired. LPN #9 explained when a medication expired, nursing staff were expected to send it back to the pharmacy and order a replacement, if necessary. There was not a replacement GlucaGen hypoglycemic injection kit on the unit, in case it was needed. LPN #9 indicated the expired medication should not have been on the cart.</p> <p>"Facility Action Team Meeting" documentation, dated 12/19/14, was submitted on 1/29/14 at 5:29 p.m. The documentation indicated "Top Drawer Medications" were reviewed and discussed. "Expired medications in the top drawer" was an "Identified Area Needing Improvement". The action plan indicated the unit manager was the responsible staff person to audit top drawers of med (medication) carts every</p>		<p>responsible for not following the action plan received disciplinary action and education</p> <p><b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p> <ul style="list-style-type: none"> <li>All residents who reside in this facility have the potential to be affected by the alleged deficient practice</li> <li>Executive Director will in-service building managers by February 18, 2015 on implementing and following appropriate action plans for any areas needing follow up during CQI meetings.</li> </ul> <p><b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</b></p> <ul style="list-style-type: none"> <li>Executive Director will in-service building managers by February 18, 2015 on implementing and following appropriate action plans for any areas needing follow up during CQI meetings.</li> <li>ED will review all action plans monthly developed for identified areas needing follow up to ensure it is implemented.</li> </ul>	

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	Monday and Friday, to reorder expired medications every Friday, and to follow up every Monday to ensure delivery and dating.  3.1-52(b)(2)		<p><b>How the corrective action(s) 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>· ED will review all action plans monthly developed for identified areas needing follow up to ensure it is implemented.</li> <li>· Quality Assurance Meeting CQI tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year. Data will be submitted to the CQI committee for follow up.</li> <li>· If 95% a threshold is not achieved, an action plan will be developed to ensure compliance.</li> </ul>		