

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155636	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  05/14/2015
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NAME OF PROVIDER OR SUPPLIER  HARRISON TERRACE	STREET ADDRESS, CITY, STATE, ZIP CODE 1924 WELLESLEY BLVD INDIANAPOLIS, IN 46219
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F 000  Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00171942.</p> <p>Complaint IN00171942-Substantiated. Federal/State deficiencies related to the allegations are cited at F502.</p> <p>Survey dates: May 7, 8, 11, 12, 13, and 14, 2015</p> <p>Facility number: 000241 Provider number: 155636 AIM number: 100291310</p> <p>Census bed type: SNF/NF: 105 Total: 105</p> <p>Census payor type: Medicare: 10 Medicaid: 87 Other: 8 Total: 105</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 000	<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. This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey review on or after June 5th, 2015. <b>F167: Right to have survey results readily accessible</b> It is the intent of the provider to have the most recent survey binder readily accessible to residents. <b>1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?</b></p> <ul style="list-style-type: none"> <li>· Resident #11 was informed regarding the location of the most recent state inspection. An updated ISDH survey binder kept up front by receptionist desk. All units have new informational posting stating that Survey binder is available in front lobby.</li> <li>· The signage was corrected on 5/14/15 and the binder was updated with the most recent survey.</li> <li>· The old binders on the units were removed.</li> </ul> <p><b>2: How other residents having the potential to be affected by</b></p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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			<p><b>the same deficient practice will be identified and what corrective action will be taken</b></p> <ul style="list-style-type: none"> <li>· All other residents have the potential to be affected by this alleged deficient practice. Every resident will have been met with by 5/29/15, 1:1 by social services and informed of location of the most recent survey binder. <b>3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</b></li> <li>· The systemic changes put into place to ensure this practice does not recur are: <ul style="list-style-type: none"> <li>· Facility staff will be informed by 6/5/15 as to the location of the most recent survey binder.</li> <li>· Monthly the Departments Heads / Managers will ask Residents if they are aware of the location of the most recent survey binder. Any resident stating they are not aware will be told the location. Resident will be brought to the location upon request.</li> <li>· Any new residents will be informed of the location of the most recent survey binder upon admission.</li> <li>· Any new facility staff will be informed of the location of the most recent survey binder during orientation.</li> </ul> </li> </ul> <p><b>4: How the corrective action will be monitored to ensure the</b></p>	

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F 167 SS=C Bldg. 00	<p>483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE</p> <p>A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility.</p> <p>The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.</p> <p>Based on observation, interview, and record review, the facility failed to ensure the most recent state survey was located in a place readily accessible to 105 of 105 residents in the facility.</p> <p>Findings include:</p> <p>An interview was conducted with Resident #11 on 5/14/15, at 9:30 a.m. He indicated he was unaware of the location</p>	F 167	<p><b>deficient practice will not recur i.e. what quality assurance program will be put into place</b></p> <p>The corrective actions will be monitored via the Administration Compliance CQ audit tool, and reviewed during the monthly CQI meeting x 6 months. If the monthly threshold is &lt; 100% an action plan will be created to ensure compliance. The ED oversees the monthly CQI meeting to ensure compliance. Compliance Date: 6/5/15</p> <p>The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.</p> <p>This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey review on or after June</p>	06/05/2015	

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	<p>of the most recent state inspection.</p> <p>An observation of a sign posted on the wall in the Meridian Hills locked unit of the facility indicated the survey results were available at the nurses station.</p> <p>An interview was conducted with Unit Manager #2 on 5/14/15 at 9:39 a.m., who was sitting at the Meridian Hills unit nurses station. He provided a binder, located at the nurses station, of the state surveys. The most recent survey included in the binder was dated 10/17/13. The most recent annual survey, dated 5/1/14, was not included in the binder.</p> <p>A tour of the 3 remaining locked units in the facility was conducted with the DNS (Director of Nursing Services) on 5/14/15 at 9:43 a.m. Two of the three units had signs indicating the survey results were available at the nurses station. One unit had no sign. The survey binders located at the nurses stations for the 3 locked units were reviewed, and none included the results of the most recent state survey.</p> <p>On 5/14/15 at 9:55 a.m., an observation was made at the front desk of the facility of the state survey binder, that included the most recent 5/1/14 annual survey. This binder was not readily accessible to</p>		<p>5th, 2015.</p> <p><b>F167: Right to have survey results readily accessible</b> It is the intent of the providerto have the most recent survey binder readily accessible to residents. <b>1: Whatcorrective action(s) will be accomplished for those residents found to haveaffected by the deficient practice?</b> ·Resident#11 was informed regarding the location of the most recent stateinspection. An updated ISDH surveybinder kept up front by receptionist desk. All units have new informational postingstating that Survey binder is available in front lobby. ·Thesignage was corrected on 5/14/15 and the binder was updated with the mostrecent survey. ·The oldbinders on the units were removed.</p> <p><b>2: How other residents having the potential tobe affected by the same deficient practice will be identified and whatcorrective action will be taken</b> ·All otherresidents have the potential to be affected by this alleged deficientpractice. Every resident will have been met with by5/29/15, 1:1 by social services and informed of location of the most recent survey binder.</p> <p><b>3: Whatmeasures will be put into place or what systemic changes will be made to</b></p>	

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	the 105 residents in the facility who all resided on locked units.  3.1-3(b)(1)		<p><b>ensure that the deficient practice does not recur.</b></p> <ul style="list-style-type: none"> <li>· The systemic changes put into place to ensure this practice does not recur are: <ul style="list-style-type: none"> <li>· Facility staff will be inserviced by 6/5/15 at the location of the most recent survey binder.</li> <li>· Monthly the Departments Heads / Managers will ask Residents if they are aware of the location of the most recent survey binder. Any resident stating they are not aware will be told the location. Resident will be brought to the location upon request.</li> <li>· Any new residents will be informed of the location of the most recent survey binder upon admission.</li> <li>· Any new facility staff will be informed of the location of the most recent survey binder during orientation.</li> </ul> </li> </ul> <p><b>4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place</b></p> <ul style="list-style-type: none"> <li>· The corrective actions will be monitored via the Administration Compliance CQI audit tool, and reviewed during the monthly CQI meeting x 6 months. If the monthly threshold is &lt; 100% an action plan will be created to ensure compliance. The ED oversees the monthly CQI meeting to ensure compliance.</li> </ul> <p>Compliance Date: 6/5/15</p>		

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F 241 SS=D Bldg. 00	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, interview and record review, the facility failed to provide privacy for 1 of 1 resident randomly observed during an environmental tour. (Resident #19)</p> <p>Findings include:</p> <p>An environmental tour was conducted on 5/13/15 at 1:30 p.m. During the environmental tour an observation was made upon entering Resident #19's room. Resident #97, a male ambulatory resident, was lying on the floor in a supine position by the first bed as you enter Resident #19's room. His body was parallel to the bed with the bottoms of his feet facing toward the doorway. Resident #97's head was facing upward toward the ceiling with his eyes closed. Resident #19 was lying on the second bed by the window with her lower legs bare and her brief exposed with her bottoms of her feet facing the bathroom door. The Maintenance Supervisor yelled out, "man down". At this time, Certified Nursing Assistance (CNA) #5 approached Resident #19's room and indicated it was</p>	F 241	<p><b>F 241: DIGNITY AND RESPECT OF INDIVIDUALITY</b> It is the intent of this providerto maintain dignity and respect of the individuality of the residents. <b>1: Whatcorrective action(s) will be accomplished for those residents found to haveaffected by the deficient practice?</b></p> <ul style="list-style-type: none"> <li>·Thecorrective action taken for Resident #19 is the facility staff will beinserviced by 6/5/15 on the importance of maintaining resident's dignity by theMCF (Memory Care Facilitator).</li> <li>·Resident#19 will have privacy curtain pulled and covers draped over her when in bed,per the plan of care.</li> </ul> <p><b>2: How other residents having the potential tobe affected by the same deficient practice will be identified and whatcorrective action will be taken</b></p> <ul style="list-style-type: none"> <li>·Allresidents have the potential to be affected by this alleged deficientpractice.</li> <li>·All otherresidents care plans have been reviewed by social services to ensure resident'swho disrobe in bed have appropriate</li> </ul>	06/05/2015
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	<p>care planned that Resident #97 will place himself on the floor. CNA #5 attempted, but was unable to, get Resident #97 up off the floor and out of Resident #19's room. CNA #9 and CNA #12 at this time came to Resident #19's room and assisted Resident #97 up off the floor and out of room.</p> <p>The clinical record for Resident #19 was reviewed on 5/13/15 at 3:00 p.m. The diagnoses for Resident #19 included, but were not limited to: Alzheimer and senile dementia.</p> <p>An interview was conducted on 5/14/15 at 9:30 a.m., with the Director Nursing Services (DNS). She indicated an investigation was conducted regarding Resident #97 in Resident #19's room. The staff provided statements of what they had observed during the time frame when Resident #97 was lying on the floor in Resident #19's room.</p> <p>Director Nursing Services provided the staffs' statements on 5/14/15 at 11:52 a.m. CNA #4 indicated she brought Resident #19 to her room and placed her in bed. She did not indicate that she pulled the privacy curtain after placing Resident #19 in bed. CNA #4 indicated she had on occasion observed Resident #19 removing her clothes due to</p>		<p>care plan in place.</p> <p><b>3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</b></p> <ul style="list-style-type: none"> <li>· The systemic changes put into place to ensure this alleged deficient practice does not recur is: <ul style="list-style-type: none"> <li>· IDT members will be inserviced by 5/29/15 on the importance of ensuring all residents dignity is maintained during their daily room rounds. This inservice will be conducted by the Director of Nursing Services.</li> <li>· DNS /designee will conduct rounds each shift to ensure residents dignity is maintained.</li> </ul> </li> </ul> <p><b>4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place</b></p> <ul style="list-style-type: none"> <li>· The corrective action will be monitored via the Dignity Compliance CQI tool weekly x 4 weeks, then monthly x 5 months. The audits will be reviewed in the monthly CQI committee meeting. If the threshold of 100% is not achieved an action plan will be developed.</li> </ul> <p>Compliance date: 6/5/15</p>	

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F 250 SS=D Bldg. 00	<p>discomfort. CNA #2 indicated in her statement she observed from the hallway Resident #19 did not have any pants on. CNA #5 indicated when she entered the room the curtain was pulled half way. The Maintenance Supervisor indicated in his statement upon entering Resident #19's room he observed Resident #97 on the floor, and Resident #19 in her bed with a "diaper" on.</p> <p>A care plan was provided on 5/14/15 at 11:55 a.m., by the Director Nursing Services. The care plan, dated 5/14/2014, indicated Resident #19 prefers to unclothe while in bed. The interventions for this care plan were to provide privacy by pulling blinds, curtains, and pull covers up for the resident.</p> <p>3.1-3(t)</p> <p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on observation, interview, and record review, the facility failed to provide a health representative for 1 of 2 residents reviewed for dental services. (Resident #39) Findings include:</p>	F 250	<p><b>F 250: PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</b> It is the intent of this providerto provide medically-related social services to attain or maintain the highest practicablephysical, mental and psychosocial well-being of each resident.</p>	06/05/2015

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	<p>The clinical record for Resident #39 was reviewed on 5/8/15 at 10:00 a.m. The diagnoses for Resident #39 included, but were not limited to: intellectual disabilities and dementia.</p> <p>Resident #39 was admitted on 5/17/2010. Resident #39's admission record indicated his emergency contact did not make health or financial decisions for this resident.</p> <p>A care plan, dated 5/16/14, provided by Director Nursing Services (DNS) on 5/12/15 at 11:00 a.m., indicated Resident #39 was pending legal guardianship due to not having a responsible party.</p> <p>The 6/10/14 progress note indicated the facility is currently seeking guardianship for Resident #39.</p> <p>The 9/11/14 progress note indicated Resident #39 did not have any known family, and a friend was his contact person, but his contact had been limited. Social Services was seeking volunteer guardian, but there was a lack of volunteers. Resident #39 still did not have a guardian. Social Services would seek assistance elsewhere if unable to get a volunteer guardian.</p> <p>An interview was conducted on 5/11/15</p>		<p><b>1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?</b></p> <ul style="list-style-type: none"> <li>The corrective action taken for Resident #39 is that on 5/12/14 the papers were completed and submitted to the court for a guardianship hearing. The facility received the guardianship hearing date on 5/22/15; the hearing has been set for July 1, 2015.</li> </ul> <p><b>2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken</b></p> <ul style="list-style-type: none"> <li>All residents admitted to the facility with a Dementia, Alzheimer's Disease and /or Intellectual Disabilities diagnosis have the potential to be affected by this alleged deficient practice. An all facility audit was conducted on 5/1/15 and all residents with the above diagnosis either have family involved and willing to participate in the plan of care, an appointed health care representative / POA or are awaiting upcoming, schedule court hearing(s) for guardianship.</li> </ul> <p><b>3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</b></p> <ul style="list-style-type: none"> <li>The systemic changes put into place to ensure the alleged deficient practice does not recur is the IDT will conduct an admission</li> </ul>	

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	<p>at 9:54 a.m., with the Social Services Director. She indicated she was still in the process of getting Resident #39 set up for guardianship, because his emergency contact was unavailable and would not make medical decisions for the resident. The Social Services Director indicated Resident #39 was not able to make medical decisions during his 8/21/14 dental exam with recommendations for dentures, and still had no dentures. An interview was conducted on 5/11/15 at 2:29 p.m., with the Director Nursing Services. She indicated Resident #39's chart was audited last month, and it was determined guardianship was still needed for this resident.</p> <p>The 5/12/15 Physician's Report for Guardianship indicated, "In my opinion, the incapacitated person is totally incapable of making personal and financial decisions."</p> <p>3.1-34(a)</p>		<p>review within 24 hours or thenext business day, of all newly admitted residents to see if they have familymembers involved with their plan of care and are willing to participate, thereis a POA in place or a guardian in place to advocate for the residents.</p> <ul style="list-style-type: none"> <li>·Anyresidents found to not have a person already selected / appointed as anadvocate / health representative will be immediately referred for guardianship.</li> <li>·TheClinical IDT was inserved on 5/29/15 on the need for every resident with anycognitive impairment to have either a family member involved in the plan ofcare, previously appointed POA, or a guardian.</li> <li>·ED /designee will review the list of residents pending guardianship to ensureappropriate action is being completed.</li> </ul> <p><b>4: Howthe corrective action will be monitored to ensure the deficient practice willnot recur i.e. what quality assurance program will be put into place</b></p> <ul style="list-style-type: none"> <li>·The correctiveaction will be monitored via the internal Admission Review tool weekly x 4weeks, then monthly x 5 months. The audits will be reviewed in the monthly CQIcommittee meeting. If the threshold of 100% is not achieved an action plan willbe developed.</li> </ul> <p>Compliance date: 6/5/15</p>		

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F 280 SS=D Bldg. 00	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on observation, interview and record review, the facility failed to revise a vision care plan, a dental care plan, and 2 behavior care plans for 3 of 24 residents reviewed for care plans. (Resident #B, #19 and #97)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #97 was reviewed on 5/13/15 at 3:15 p.m. The diagnoses for Resident #97 included, but were not limited to: dementia, senile with delusions, and behavioral disturbances.</p> <p>The 5/11/15, 10:11 a.m., progress note</p>	F 280	<p><b>F 280: RIGHT TO PARTICIPATE PLANNING OF CARE-REVISE CP</b></p> <p>It is the intent of this providerto review and revise care plans periodically and timely when there are changesto the plan of care.</p> <p><b>1: Whatcorrective action(s) will be accomplished for those residents found to haveaffected by the deficient practice?</b></p> <p>·Thecorrective actions accomplished for those residents found to have been affectedby the alleged deficient practice are as follows:</p> <p>· Resident #97's care plan was updatedindicating that he will wander into other residents rooms and at times lie onthe</p>	06/05/2015			

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	<p>indicated Resident #97 was observed placing himself on the floor in the dining room. It indicated this resident was care planned to place his self on the floor.</p> <p>An interview was conducted on 5/13/15 at 3:15 p.m., with CNA #9. She indicated Resident #97 does wander in and out of rooms and sleeps on the floor in residents' room all the time.</p> <p>An environmental tour was conducted on 5/13/15 at 1:30 p.m. During the environmental tour an observation was made upon entering Resident #19's room. Resident #97, a male ambulatory resident, was lying on the floor in a supine position by the first bed as you enter Resident #19's room. His body was parallel to the bed with the bottoms of his feet facing toward the doorway. Resident #97's head was facing upward toward the ceiling with his eyes closed. Resident #19 was lying on the second bed by the window with her lower legs bare and her brief exposed with her bottoms of her feet facing the bathroom door. The Maintenance Supervisor yelled out, "Man down". At this time, Certified Nursing Assistant (CNA) #5 approached Resident #19's room and indicated it was care planned that Resident #97 will place himself on the floor. CNA #5 attempted, but was unable to get, Resident #97 up</p>		<p>floor.</p> <ul style="list-style-type: none"> <li>·Resident#19's care plan was updated indicating she will take clothes off by self whilein bed.</li> <li>·Resident#B's care plan was updated to include intervention of glasses, but will refuset to wear them.</li> <li>·Resident#B's care plan was updated to reflect Resident #B does not have dentures.</li> </ul> <p><b>2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken</b></p> <ul style="list-style-type: none"> <li>·All otherresidents have the potential to be affected by this alleged deficient practice. The following audits have beencompleted: <ul style="list-style-type: none"> <li>· Social Services conducted an audit ofresidents with known wandering to ensure there is a care plan in place.</li> <li>·Socialservices conducted an audit of residents known to remove their clothes to ensure a care plan is in place.</li> <li>·IDTconducted an audit of all residents to ensure accuracy of care plans related to denture &amp; glasses status and use/refusal.</li> </ul> </li> </ul> <p><b>3: Whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur.</b></p> <ul style="list-style-type: none"> <li>·Thesystemic measures put into place to ensure this alleged deficient practice doesnot occur</li> </ul>	

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	<p>off the floor and out of Resident #19's room. CNA #9 and CNA #12 at this time came to Resident #19's room and assisted Resident #97 up off the floor and out of room.</p> <p>An interview was conducted on 5/13/15 at 2:00 p.m., with Registered Nurse (RN) #11. She indicated Resident #97 had a care plan regarding placing himself on the floor. At this time, she was unable to locate the care plan.</p> <p>An interview was conducted on 5/13/15 at 3:30 p.m. Unit Manager #2 indicated there was a progress note entered regarding Resident #97 sits/lays himself on the floor, but no care plan to address it.</p> <p>2. The clinical record for Resident #19 was reviewed on 5/13/15 at 3:00 p.m. The diagnoses for Resident #19 included, but were not limited to: Alzheimer and senile dementia.</p> <p>An environmental tour was conducted with the Maintenance Supervisor and Housekeeping Staff Member on 5/13/15 at 1:30 p.m. During the tour an observation was made upon entering Resident #19's room. Resident #19 was lying on the bed by the window with her lower legs bare and her brief exposed</p>		<p>are:</p> <ul style="list-style-type: none"> <li>·The DNSwill inservice the IDT by 5/29/15 on the policy "IDT Care Plan Review"</li> <li>·The IDTwill discuss orders, ancillary services visits, new / changing behaviors duringthe morning IDT Clinical Review (Monday – Friday) and update the care plan perthe IDT Care Plan Review policy.</li> </ul> <p><b>4: Howthe corrective action will be monitored to ensure the deficient practice willnot recur i.e. what quality assurance program will be put into place</b></p> <ul style="list-style-type: none"> <li>·The correctiveaction will be monitored via the Care Plan Updating CQI tool weekly x 4 weeks,then monthly x 5 months. The audits will be reviewed in the monthly CQIcommittee meeting. If the threshold of 100% is not achieved an action plan willbe developed.</li> </ul> <p>Compliance date: 6/5/15</p>	

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	<p>with her bottoms of her feet facing the bathroom door. Resident #97, a male ambulatory resident, was lying on the floor in a supine position by the other bed as you enter Resident #19's room.</p> <p>Director Nursing Services provided a statement from CNA #4 on 5/14/15 at 11:52 a.m. CNA #4's statement indicated she brought Resident #19 to her room and placed her in bed. She did not indicate that she pulled the privacy curtain after placing Resident #19 in bed. CNA #4 indicated she had on occasion observed Resident #19 removing her clothes due to discomfort. CNA #2 indicated in her statement she observed from the hallway Resident #19 did not have any pants on. CNA #5 indicated when she entered the room the privacy curtain was pulled half way, and Resident #19 was partially dressed. The Maintenance Supervisor indicated in his statement upon entering Resident #19's room he observed Resident #19 in her bed with a "diaper" on.</p> <p>Upon review of Resident #19's behavior care plans, there were no interventions to address her behavior of removing her clothing while in bed.</p> <p>The policy titled, "IDT Care Plan Review", dated 4/2014, was provided on</p>			

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	<p>5/14/15 at 11:00 a.m., by the Director Nursing Services. ... "Policy: It is the policy of this facility that each resident will have a comprehensive care plan developed based on comprehensive assessment. The care plan will include measurable goals and resident specific interventions based on resident needs and preferences to promote the residents highest level of functioning including medical, nursing, and psychosocial needs".</p> <p>3a. The clinical record for Resident #B was reviewed on 5/8/15 at 10:15 a.m. The diagnoses for Resident #B included, but were not limited to, history of urinary tract infections, diabetes mellitus, and Alzheimer's disease.</p> <p>A [name of company] Eye Consultants' report, dated 2/10/15, indicated a refraction (process to determine a prescription for eye glasses) was done for new glasses.</p> <p>A Progress Note, dated 3/4/15 at 4:30 p.m., indicated, "Resident received new glasses. Dark blue case with rose colored metal frame bifocals...."</p> <p>An Impaired Vision care plan, dated 5/30/14 and remained current at the time of review, did not include an intervention of glasses.</p>			

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	<p>3b. During the following observations of Resident #B was not wearing dentures: 5/8/15 at 10:50 a.m., 5/11/15 at 12:00 p.m., &amp; 5/12/15 11:50 a.m.</p> <p>A [name of dental company] visit note, dated 12/4/14, indicated Resident #B does not have dentures and was not a good candidate for dentures.</p> <p>During an interview with Family Member #10, on 5/12/15 at 12:45 p.m., Family Member #10 indicated Resident #B has not had dentures for about two years.</p> <p>A dental care plan, dated 2/24/15, indicated Resident #B had dentures.</p> <p>During an interview with the Director of Nursing Services, on 5/13/15 at 11:23 a.m., the DNS indicated the impaired vision care plan was not updated with the glasses received on 3/4/15 and Resident #B's dental care plan was not updated to reflect that Resident #B did not wear dentures.</p> <p>A policy, titled IDT Care Plan Review, dated 4/2014, was received from the DNS on 5/13/15 at 2:35 p.m. The policy indicated, "...care plan problems, goals and interventions will be updated based on changes in resident</p>			

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F 313 SS=D Bldg. 00	<p>assessment/condition, resident preferences or family input...."</p> <p>3.1-35(a) 3.1-35(d)(2)(B)</p> <p>483.25(b) TREATMENT/DEVICES TO MAINTAIN HEARING/VISION To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident in making appointments, and by arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. Based on interview and record review, the facility failed to ensure a cataract surgery referral was followed-up on for 1 of 3 residents reviewed for vision (Resident B).</p> <p>Findings include:</p> <p>The clinical record for Resident #B was reviewed on 5/8/15 at 10:15 a.m. The diagnoses for Resident #B included, but were not limited to, history of urinary tract infections, diabetes mellitus, and Alzheimer's disease.</p> <p>A [name of company] Eye Consultants' report, dated 8/14/14, indicated,</p>	F 313	<p><b>F 313: TREATMENT/DEVICES TO MAINTAIN HEARING/VISON</b> It is the intent of this providerto ensure residents receive proper treatment to maintain vision and hearingabilities. <b>1: Whatcorrective action(s) will be accomplished for those residents found to haveaffected by the deficient practice?</b> ·Thecorrective action taken Resident #B was to have the Eye Consultant call the POAdirectly on 5/13/15 and discuss his recommendations. ·Resident#B transferred to another facility on 5/26/15. <b>2: How other residents having the potential tobe affected by the same deficient practice will be identified</b></p>	06/05/2015

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	<p>"...Impression Clinical 1. Cat Sev. ou [Cataracts-Severe, both eyes]....Plan 1. ed dx risk/ben sx. [Educated on diagnosis, risks and benefits of surgery discussed] Refer to [name of eye clinic] 2. Referred by [name of eye consultants doing the eye exam]</p> <p>A [name of company] Eye Consultants' report, dated 2/10/15, indicated, "...Impression Clinical 1. Cat sev. worse [cataracts worse than previous visit]....Plan 1. ed dx prev. attempted refused [education on diagnosis previously attempted]...."</p> <p>During an interview with the Eye Consultant (EC) #1 [company who performed the eye exams above], on 5/12/15 at 11:34 a.m., EC#1 indicated they were unable to determine if Resident #B was referred to an eye clinic as candidate for cataract surgery. EC#1 further indicated the refusal noted on the 2/10/15 Eye Consultants' report was from a visit with the resident on 12/5/13 and the refusal was by the resident not the POA [power of attorney]. Resident #B was listed as the responsible party to make medical decisions and the POA was crossed off of EC#1's paperwork, but EC #1 was unable to determine where this information came from.</p>		<p><b>and what corrective action will be taken</b></p> <ul style="list-style-type: none"> <li>· All other residents with referrals for cataract surgery have the potential to be affected by the same alleged deficient practice.</li> <li>· Facility will contact Eye Consultant and request list of residents referred for cataract surgery in the last 3 months prior to exit of annual survey.</li> </ul> <p><b>3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</b></p> <ul style="list-style-type: none"> <li>· The systemic changes that will be put into place are the following: <ul style="list-style-type: none"> <li>· DNS will inservice Social services and IDT on new process titled: Harrison Terrace Process for Reviewing Ancillary Services Consultant's Reports by 5/29/15.</li> <li>· Social Services will review documentation from Eye Consultant prior to their facility exit to ensure appropriate follow up is identified.</li> <li>· Clinical IDT will review Eye Consultant reports the following business day to ensure appropriate follow up has been scheduled / completed.</li> </ul> </li> </ul> <p><b>4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place</b></p> <ul style="list-style-type: none"> <li>· The corrective actions will be</li> </ul>				

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	<p>A MDS (minimum data set), dated 12/13/13 indicated Resident #B had a BIMS (brief interview of mental status) of 3 which was indicative of severe mental impairment. A MDS, dated 8/12/14, indicated Resident #B had a BIMS of 2, which was indicative of severe mental impairment and a MDS, dated 2/11/15, indicated a BIMS of 3.</p> <p>During an interview with the Director of Nursing Services (DNS), on 5/13/15 at 9:50 a.m., the DNS indicated the facility was unable to locate any documentation that indicated a follow up was done by the facility to ensure a referral/appointment was made for a cataract surgery evaluation from the 8/14/14 Eye Consultants' report. The DNS further indicated the facility was going to change their process of reviewing consultant's visits/paperwork.</p> <p>ON 5/14/15, at 9:42 a.m., the DNS indicated someone from [name of company] Eye Consultant's came into the facility the previous day to discuss POA status and follow up for a cataract surgery evaluation for Resident #B.</p> <p>3.1-39(a)</p>		<p>monitored via the Social Services f/u Ancillary Consultant Reports weekly x 4 weeks, monthly x 5 months. The results of these audits will be reviewed by the CQI committee overseen by the ED. If the threshold of 100% is not achieved an action plan will be developed.</p>	

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F 325 SS=D Bldg. 00	<p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE</p> <p>Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>Based on observation, interview, and record review, the facility failed to follow up on a dietary recommendation in a timely manner for 1 of 4 residents reviewed for nutrition (Resident #B).</p> <p>Findings include:</p> <p>The clinical record for Resident #B was reviewed on 5/8/15 at 10:15 a.m. The diagnoses for Resident #B included, but were not limited to, history of urinary tract infections, diabetes mellitus, and Alzheimer's disease.</p> <p>A Registered Dietician Progress Note, dated 4/10/15 at ..., indicated, "...</p> <p>Recommend to provide resident with fortified milk at L [lunch] and D [dinner] to provide additional kcal/protein [calories] and to follow resident's food preferences. Recommend to liberalize diet to regular d/t [due to] increased kcal</p>	F 325	<p><b>F 325: MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE</b></p> <p>It is the intent of this providerto ensure maintenance of acceptable parameters of nutritional status.</p> <p><b>1: Whatcorrective action(s) will be accomplished for those residents found to haveaffected by the deficient practice?</b></p> <ul style="list-style-type: none"> <li>·Resident#B no longer resides at the facility. While resident was residing at facility, the resident's POA and MD werein agreement with the recommendations, which were put into place on 5/12/15.</li> </ul> <p><b>2: How other residents having the potential tobe affected by the same deficient practice will be identified and whatcorrective action will be taken</b></p> <ul style="list-style-type: none"> <li>·Allresidents have the potential to be affected.</li> <li>·RD hasreviewed all residents charts to ensure all dietary recommendations have beenimplemented.</li> </ul> <p><b>3:What measures will be put into place or what systemic</b></p>	06/05/2015

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	<p>intake...."</p> <p>A Progress Noted, dated 5/12/14 at 9:54 a.m., indicated, "Resident's Guardian agreed to a diet change for resident from const carb [consistent carbohydrate] to regular [regular diet] to increase kcal intake and add fortified milk with lunch and dinner.</p> <p>During a meal observation at 5/12/15 starting at 11:45 a.m., Resident #B did not receive milk through the entire meal observation. Resident #B's meal ticket did not indicate Resident #B was to receive fortified milk at lunch.</p> <p>During an interview with CNA #7, on 5/12/15 at 1:05 p.m., CNA #7 indicated Resident #B did not receive fortified milk with their meal. CNA #7 also indicated fortified milk was not listed on Resident #B's meal ticket.</p> <p>The weights for Resident #B were as follows: 12/4/14=203 1/5/15=200 2/4/15=187 3/4/15=182 4/6/15=174 5/11/15=171.</p> <p>During an interview with the Registered</p>		<p><b>changes will be made to ensure that the deficient practice does not recur.</b></p> <ul style="list-style-type: none"> <li>The systemic changes put into place to ensure this does not recur are: <ul style="list-style-type: none"> <li>All RD recommendations will be reviewed daily x 5 days per week during the IDT clinical meeting (occurs Monday – Friday). POA and MD will be contacted for the approval of recommendations by the 3rd business day. If the POA or MD refuses a recommendation, the reason will be documented into the resident's medical record and on the Dietary Recommendation Form. The RD will review all recommendation during the next facility visit and will provide an alternate recommendation, if appropriate.</li> <li>DNS serviced IDT clinical team on 5/29/15 on the importance of following up timely on RD recommendations and implementation.</li> </ul> </li> </ul> <p><b>4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place</b></p> <ul style="list-style-type: none"> <li>The corrective action will be monitored to ensure compliance via the RD Recommendation CQI tool will be reviewed weekly x 4 weeks by the IDT clinical team. The DNS or designee will review the RD Recommendation CQI tool in the monthly CQI committee team x 5 months which</li> </ul>		

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	<p>Dietician (RD), on 5/12/15 at 2:20 p.m., the RD indicated he provides his recommendations to the facility staff within 3 business days of his visit. The RD indicated he was unsure why it took a month for the facility to follow up on a recommendation he made. The RD further indicated he added the recommendation of fortified milk for the added calories to slow down weight loss.</p> <p>On 5/13/15, at 3:30 p.m., the Director of Nursing (DNS) indicated she was unable to determine why the recommendation wasn't completed sooner, so the DNS spoke with the Unit Manager, offsite, about why the recommendation for a diet change and fortified milk was not completed when recommended. The Unit Manager indicated Family Member #10 did not want to change the diet. The DNS indicated she will create a late entry progress note to reflect this information.</p> <p>A Progress Note, dated 5/14/15 at 7:37 a.m., indicated, "Spoke with unit manager regarding RD recommendations from 4/10. Unit Manager states she spoke with [name of Family Member #10], guardian, the following weekend regarding changing diet from consistent carb to regular diet to increase kcal offered to res [resident] each meal. Unit Manager states guardian stated "...no,</p>		is overseen by the ED. If athreshold of 95% is not achieved an action plan will be developed.	

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F 412 SS=D Bldg. 00	<p>why would we change her diet when her sugars are already high..."</p> <p>During an interview with Family Member #10, on 5/14/15 at 10:13 a.m., she indicated the facility did not talk to her until 2 days ago about the RD recommendations.</p> <p>3.1-46(a)(2)</p> <p>483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS</p> <p>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 from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist.</p> <p>Based on observation, interview, and record review, the facility failed to timely schedule an appointment for teeth extractions and to implement a dental recommendation for 2 of 2 residents reviewed for dental status and services. (Residents #39 and #111)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #111</p>	F 412	<p><b>F 412: ROUTINE/EMERGENCY DENTAL SERVICES IN NFS</b></p> <p>It is the intent of this provider to provide timely follow up for dental services recommendations.</p> <p><b>1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?</b></p> <ul style="list-style-type: none"> <li>· The corrective actions taken are as follows:</li> <li>· Resident #111 saw the oral surgeon on 5/20/15 for a</li> </ul>	06/05/2015

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	<p>was reviewed on 5/11/15, at 10:30 a.m. The diagnoses for Resident #111 included, but were not limited to: carries and missing teeth.</p> <p>An interview was conducted with Family Member #13, Resident #111's wife, on 5/8/15 at 9:07 a.m. She indicated Resident #111 had loose teeth.</p> <p>The 9/18/14 dental care plan for Resident #11 indicated he had missing teeth with an intervention for a dental consult as indicated.</p> <p>The 3/9/15 nurses note for Resident #111 indicated, "Resident exhibits increased difficulty with meats during all meals requiring increased time to chew and swallow."</p> <p>The 5/6/15 weekly nursing assessment indicated "obvious or likely cavity or broken teeth" for Resident #111.</p> <p>An observation of Resident #111's oral cavity was made on 5/11/15 at 10:57 a.m. He was missing some of his bottom teeth.</p> <p>The 3/25/15 dental evaluation for Resident #111 indicated, "...missing teeth 1-5, 16, 17-20, 30, 31...tx (treatment) plan: pt (patient) can benefit from sedation, premedication, extract teeth 6,</p>		<p>consultative visit. After the consultative visit, the wife and oral surgeon opted to not proceed with the teeth extractions.</p> <p>Resident#39 has an appointment for guardianship on 7/1/15. After guardianship has been appointed social services obtain consent for dental services and follow up on recommendations.</p> <p><b>2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken</b></p> <p>All residents who have recommendations for teeth extractions are at risk for the same alleged deficient practice.</p> <p>Facility will contact the Dental Consultant and request a list of all residents recommended to have teeth extractions within the last 3 months from the conclusion of annual survey.</p> <p>Social Services will review documentation from Dental Consultant prior to their facility exit to ensure appropriate follow up is identified.</p> <p>Clinical IDT will review Dental Consultant reports the following business day to ensure appropriate follow up has been scheduled / completed.</p> <p><b>3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</b></p>	

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	<p>11-14, 23-26, 28...refer to an oral surgeon to extract teeth...resident has hx (history) of ventricular shunt, needs clearance from M.D. for need for antibiotic premedication prior to dental exam that may cause bleeding. Please document in pt's (patient's) permanent record if pt does/does not need premedication with antibiotic. If premedication is needed, please have an order."</p> <p>An interview was conducted with Unit Manager #2 on 5/11/15 at 11:25 a.m., regarding an appointment for teeth extractions for Resident #111 and the need for premedication prior to extractions. He indicated there was currently no order for premedication, and was going to call Resident #111's doctor for an order for premedication.</p> <p>An interview was conducted with the SSD (Social Services Director) on 5/11/15 at 11:30 a.m. She indicated she made aware of the 3/25/15 dental consult recommending teeth extractions on 3/25/15, but didn't make an appointment for Resident #111's teeth extractions until approximately 2 weeks ago. She indicated she was unsure why the delay in making an appointment for him.</p> <p>On 5/11/15 at 11:47 a.m., a telephone interview was conducted with the front</p>		<p>·Thesystemic changes that will be put into place are the following: ·DNS willinservice Social services and IDT on new process titled: Harrison Terrace Process for ReviewingAncillary Services Consultant's Reports by 5/29/15.</p> <p><b>4: How thecorrective action will be monitored to ensure the deficient practice will notrecur i.e. what quality assurance program will be put into place</b> ·Thecorrective actions will be monitored via the Social Services f/u AncillaryConsultant Reports weekly x 4 weeks, monthly x 5 months. The results of these audits will be reviewedby the CQI committee overseen by the ED. If the threshold of 100% is not achieved an action plan will be developed.</p>		

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	<p>office staffperson of the oral surgeon's office at which Resident #111 was to have his teeth extracted. She indicated the appointment was made by the SSD of the facility on 5/7/15. She indicated an appointment for extractions was usually within 3 weeks of scheduling an appointment.</p> <p>2. The clinical record for Resident #39 was reviewed on 5/8/15 at 10:00 a.m. The diagnoses for Resident #39 included, but were not limited to: intellectual disabilities and dementia. Resident #39 was admitted on 5/17/2010. Resident 39's admission record indicated his emergency contact did not make health or financial decisions for this resident. An observation was made on 5/8/15 at 10:40 a.m. Resident #39 was missing his bottom teeth.</p> <p>A dental exam on 8/21/14 indicated a recommendation in which Resident #39 was to have his remaining teeth extracted and then impressions would be made for upper and lower dentures. Resident #39 had another dental exam on 2/19/15. It indicated Resident #39's oral exam was limited and the extractions had not been done.</p> <p>An interview was conducted on 5/11/15</p>			

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F 502	<p>at 9:54 a.m., with the Social Services Director. She indicated she was in the process of getting Resident #39 set up for guardianship, because his emergency contact was unavailable and would not make medical decisions for the resident. After Resident #39 is appointed a guardian the facility would precede with the dental recommendations of the extractions of his remaining teeth and the impressions would be made for upper and lower dentures. Social Services indicated Resident #39 was not able to make medical decisions during 8/21/14 dental exam.</p> <p>An interview was conducted on 5/11/15 at 2:29 p.m., with the Director Nursing Services. She indicated Resident #39's chart was audited last month, and it was determined guardianship was still needed for this resident.</p> <p>The policy titled, "Dental Services" dated 1/06, was provided by the Director Nursing Services on 5/13/15 at 2:35 p.m."Policy: The facility provides dental services to meet the oral health needs of each resident".</p> <p>3.1-24(a)</p> <p>483.75(j)(1)</p>			

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SS=D Bldg. 00	<p><b>ADMINISTRATION</b></p> <p>The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.</p> <p>Based on interview and record review, the facility failed to ensure an urinalysis was done in a timely manner for 1 of 4 residents reviewed for urinary incontinence (Resident #B).</p> <p>Findings include:</p> <p>The clinical record for Resident #B was reviewed on 5/8/15 at 10:15 a.m. The diagnoses for Resident #B included, but were not limited to, history of urinary tract infections, diabetes mellitus, and Alzheimer's disease.</p> <p>A Physician's Order, dated 3/22/15, indicated to start amoxicillin (antibiotic) 500 milligrams twice a day for 3 days and to obtain a urinalysis after the antibiotic was completed.</p> <p>A Progress Note, dated 3/26/15 at 3:01 p.m., indicated, "...resident is currently on ATB [antibiotic] therapy with repeat UA [urinalysis] scheduled upon completion of ATB therapy...."</p> <p>The March MAR (medication administration record) indicated Resident #B completed the antibiotic on 3/26/15.</p>	F 502	<p><b>F 502: ADMINISTRATION</b></p> <p>The intent of this provider is to provide or obtain laboratory services to meet the needs of its residents.</p> <p><b>1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?</b></p> <ul style="list-style-type: none"> <li>· The corrective action accomplished for Resident #B was a urinalysis was collected on 4/22/15 which showed no signs of infection.</li> </ul> <p><b>2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken</b></p> <ul style="list-style-type: none"> <li>· All other residents who have orders for Urinalysis have the potential to be affected.</li> <li>· A facility audit was completed the IDT clinical team 5/22/15 and all ordered urinalysis have been completed timely.</li> </ul> <p><b>3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</b></p> <ul style="list-style-type: none"> <li>· The systemic changes put into place to ensure the alleged deficient practice does not recur are: <ul style="list-style-type: none"> <li>· The ADNS or designee will review all lab orders on a daily</li> </ul> </li> </ul>	06/05/2015
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	<p>A follow-up urinalysis was not located in the clinical record until 4/22/15.</p> <p>An Event Report, dated 4/19/15, indicated, "...needs urine for F/U UTI..."</p> <p>During an interview with the Director of Nursing Services (DNS), on 5/12/15 at 9:34 a.m., the DNS indicated she was unsure the urinalysis was not completed sooner as it should've been.</p> <p>This Federal Tag relates to Complaint #IN00171942</p> <p>3.1-49(a)</p>		<p>basis and check to ensure appropriate follow up has been completed.</p> <p>·DNS conducted inservice with the IDT Clinical team on 5/29/15 regarding the importance of ensuring completion of all lab orders and urinalysis in a timely fashion.</p> <p><b>4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place</b></p> <p>·The corrective actions will be monitored via the Lab Compliance CQI tool weekly x 4 weeks then monthly x 5 months. The audit tools will be reviewed by the CQI committee which is overseen by the ED. If the threshold of 100% is not achieved an action plan will be developed.</p> <p>Compliance date: 6/5/15</p>		