

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155149	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/01/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER HARCOURT TERRACE NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260
---	---

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

F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included the investigation of Complaints IN00189411, IN00190705 and IN00192039.</p> <p>Complaint IN00189411-Substantiated. Federal/State deficiencies related to the allegations are cited at F309 and F314.</p> <p>Complaint IN00190705-Substantiated. Federal/State deficiencies related to the allegations are cited at F309, F314 and F323.</p> <p>Complaint IN00192039-Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey dates: February 23, 24, 25, 26, 29 and March 1, 2016</p> <p>Facility number: 000070 Provider number: 155149 AIM number: 100266190</p> <p>Census bed type: SNF/NF: 80 Total: 80</p> <p>Census payor type:</p>	F 0000		
------------------------	--	--------	--	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155149	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/01/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HARCOURT TERRACE NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260
---	---

(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
F 0278 SS=D Bldg. 00	<p>Medicare: 9 Medicaid: 60 Other: 11 Total: 80</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review was completed by 21662 on March 7, 2016.</p> <p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155149	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/01/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER HARCOURT TERRACE NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>Based on interview and record review, the facility failed to ensure the Minimum Data Set (MDS) information was correct for 1 of 38 residents reviewed for Minimum Data Set Assessments. (Resident #3)</p> <p>Findings include:</p> <p>On 2/26/16 at 7:48 a.m., the record review for Resident #3 was completed. Diagnoses included, but were not limited to, mental disability, seizures, and dysphasia.</p> <p>The Minimum Data Set Assessment, dated 12/18/15, indicated the resident was impaired on only one side for range of motion for bilateral (both sides) upper and lower extremities.</p> <p>The Minimum Data Set Assessment, dated 2/4/16, indicated the resident was impaired on both sides for range of motion for bilateral (both sides) upper and lower extremities.</p> <p>On 3/1/16 at 3:45 p.m., the MDS</p>	F 0278	<p>This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements by state and federal law. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident #3's MDS assessment that was incorrectly coded was modified to reflect resident's accurate current condition. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? All residents with impairment on one or both sides have the potential to be affected by this deficient practice. The MDS and the DNS and/or Designee reviewed all residents with impairment on one or both sides on 3/17/16 to ensure the most recent Minimum Data Set Assessment information accurately reflects each resident's</p>	03/21/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155149	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/01/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER HARCOURT TERRACE NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Coordinator indicated the documentation was incorrect for the 2/4/16, assessment and the resident had limitation for his upper and lower extremities for the last few years, but the coding for the MDS had been incorrect.</p> <p>3.1-31(c)(3) 3.1-31(i)</p>		<p>mobility status. If an MDS assessment is found to be inaccurate, it will be modified to include the accurate information. The Administrator will be notified and he will ensure MDS Coordinator is educated if indicated. This audit was completed on 3/18/16 and no other residents were found to be affected by this practice. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? MDS coordinator and/or MDS Assistant will keep a log of all MDS assessments completed for next three months, indicating those residents with impairment on one or both sides. The MDS Coordinator and/or MDS Assistant will initial each assessment on the log to indicate accuracy. All MDS assessments for residents with impairment on one or both sides will be double checked for accuracy by the DNS and/or Designee. The Executive Director will review the log weekly and any issues with accuracy will be addressed with the MDS Coordinator. How will the corrective actions be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? To ensure compliance, the MDS Coordinator will bring the log to the monthly Quality Assurance Meeting for review. The MDS</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 03/01/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HARCOURT TERRACE NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260
---	---

(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
F 0309 SS=G Bldg. 00	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>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> <p>Based on interview and record review, the facility failed to discover diabetic ulcers on the left heel and left toes until the ulcers were necrotic (Death of body tissue, which occurs when too little blood flows to the tissue) for 1 of 1 residents reviewed for skin conditions, which were non-pressure related. (Resident C)</p> <p>Findings include:</p> <p>Resident C's record was reviewed on</p>	F 0309	<p>Coordinator and/orMDS Assistant will audit assessments for accuracy five times a week for fourweeks, then three times a week for four weeks and then once a week for fourweeks. Any deficiencies will be corrected on the spot, and the findings of thequality assurance checks will be documented and submitted at the monthlyQuality Assurance Meeting for further review or corrective action. Audits willbe repeated as the Quality Assurance Committee deems necessary.</p> <p>What correctiveaction will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Resident C has been discharged from this facility</p> <p>How other residentshaving the potential to be affected by the same deficient practice will beidentified and what corrective actions will be taken?</p> <p>All residents have the potential to be affected by thispractice. DNS and/or Designee conducted skin sweeps on</p>	03/21/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155149	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/01/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER HARCOURT TERRACE NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>2/29/16 at 12:02 p.m. Diagnoses included, but were not limited to, depressive disorder, End Stage Renal Disease, Diabetes Mellitus (DM) type 2, protein-calorie malnutrition, debility, and dementia with behavioral disturbances.</p> <p>The resident had a Care Plan, dated 6/16/15, indicating she was at risk for skin breakdown due to decreased mobility, ESRD (End Stage Renal Disease) with dialysis, DM malnutrition, debility, anemia and dementia. Approaches included, but were not limited to, "...Assess and document skin condition weekly and as needed, Notify MD [Medical Doctor] of any changes..."</p> <p>An IDT (Interdisciplinary Team) progress note, dated 7/30/15 at 3:45 p.m., indicated a skin assessment was completed on the resident and she was noted to have boggy (spongy) heels.</p> <p>A document titled "Weekly Summary," dated 8/17/15 at 3:48 p.m., indicated the resident's skin integrity had no current skin altercations.</p> <p>The document titled "IDT [Interdisciplinary Team] Weekly Update Skin Events [Name of Company] Non-Pressure Wound Skin Event," dated 8/27/15 at 8:04 a.m., indicated the left</p>		<p>all residents to ensure any area of impaired skin integrity was identified. These skin sweeps were completed on 3/18/16. No other residents were found to be affected by this practice. All resident's with impaired skin integrity had been identified timely prior to these skin sweeps.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</p> <p>Interdisciplinary Team will review all new/ readmissions on the first business day after admission to identify skin breakdown risk factors and implement preventative measures as indicated.</p> <p>Interdisciplinary Team will perform bi-weekly skin sweeps on all residents x 3 months to identify any areas of skin impairment and timely obtain treatment orders. Nursing staff were re-educated on immediate reporting of any new skin issues to Nurse Management on 3/17/16. Shower sheets will be reviewed by the DNS and/or Designee Monday – Friday to ensure any new areas of skin impairment have been addressed. Weekly Summaries will be reviewed by DNS and/or Designee at a minimum of weekly to ensure all areas of skin impairment are being monitored.</p> <p>How will the corrective actions be maintained to ensure the deficient practice will not recur, i.e., what</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155149	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/01/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER HARCOURT TERRACE NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>heel wound was a new area, which was facility acquired with an original noted date of 8/27/15. The wound type was a diabetic ulcer with a status of FTW (Full Thickness Wound). The wound measured 2.0 x 3.5 x 0.1 cm (centimeters). The wound color was 100% black.</p> <p>The document titled "IDT [Interdisciplinary Team] Weekly Update Skin Events[Name of Company] Non-Pressure Wound Skin Event," dated 8/27/15 at 8:06 a.m., indicated the left 1st, 4th and 5th toes on the left foot were new areas, which were facility acquired with an original noted date of 8/27/15. The wound types were diabetic ulcers with a status of FTW. The wound measurements indicated generalized. The wound colors were 100% black.</p> <p>A Wound Clinic document, dated 8/27/15 at 9:26 a.m., indicated the resident had a left lateral heel and toe wounds due to suspected vascular disease with known diabetes. The note indicated that visit was the initial consult for several necrotic toe wounds and a heel wound and the wounds were consistent with emboli showering. The note indicated the resident indicated she had increasing pain over the last week.</p>		<p>quality assurance program will be put into place?</p> <p>To ensure compliance, the DNS and/or Designee is responsible for the completion of the Skin Management Program CQI tool weekly x 4 weeks, then monthly x 6 months. The findings of the quality assurance checks will be documented and submitted at the monthly Quality Assurance Meeting for further review or corrective action. CQI's will be repeated as the Quality Assurance Committee deems necessary.</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 03/01/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HARCOURT TERRACE NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>The document titled "IDT [Interdisciplinary Team] Weekly Update Skin Events[Name of Company] Non-Pressure Wound Skin Event," dated 9/3/15 at 8:03 a.m., indicated the left heel wound was an existing area, which was facility acquired with an original noted date of 8/27/15. The wound type was a diabetic ulcer with a status of FTW. The wound measured 2.0 x 1.9 x 0.1 cm. The wound color was 75% black and 25% epithelial.</p> <p>The document titled "IDT [Interdisciplinary Team] Weekly Update Skin Events[Name of Company] Non-Pressure Wound Skin Event," dated 9/3/15 at 8:23 a.m., indicated the left 1st, 4th and 5th toes on the left foot were existing areas, which were facility acquired with an original noted date of 8/27/15. The wound types were diabetic ulcers with a status of FTW. The wound measurements indicated generalized. The wound colors were 75% black and 25% epithelial.</p> <p>The document titled "IDT [Interdisciplinary Team] Weekly Update Skin Events[Name of Company] Non-Pressure Wound Skin Event," dated 9/10/15 at 8:17 a.m., indicated the left heel wound was an existing area, which was facility acquired with an original</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 03/01/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HARCOURT TERRACE NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>noted date of 8/27/15. The wound type was a diabetic ulcer with a status of FTW. The wound measured 2.0 x 2.5 x 0.1 cm. The wound color was 100% necrotic.</p> <p>The document titled "IDT [Interdisciplinary Team] Weekly Update Skin Events[Name of Company] Non-Pressure Wound Skin Event," dated 9/10/15 at 7:59 a.m., indicated the left 1st, 4th and 5th toes on the left foot were existing areas, which were facility acquired with an original noted date of 8/27/15. The wound types were diabetic ulcers with a status of FTW. The wound measurements indicated generalized including the entire 5th toe and plantar of the 1st and 4th toes (bottom of the toes). The wound colors were 100% black.</p> <p>The document titled "IDT [Interdisciplinary Team] Weekly Update Skin Events[Name of Company] Non-Pressure Wound Skin Event," dated 9/17/15 at 6:59 a.m., indicated the left heel wound was an existing area, which was facility acquired with an original noted date of 8/27/15. The wound type was a diabetic ulcer with a status of FTW. The wound measured 1.0 x 1.5 x 0.0 cm. The wound color was black.</p> <p>The document titled "IDT</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155149	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/01/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER HARCOURT TERRACE NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>[Interdisciplinary Team] Weekly Update Skin Events[Name of Company] Non-Pressure Wound Skin Event," dated 9/17/15 at 6:59 a.m., indicated the left 1st, 4th and 5th toes on the left foot were existing areas, which were facility acquired with an original noted date of 8/27/15. The wound types were diabetic ulcers with a status of FTW. The wound measurements indicated generalized. The wound colors were black.</p> <p>The document titled "IDT [Interdisciplinary Team] Weekly Update Skin Events[Name of Company] Non-Pressure Wound Skin Event," dated 9/24/15 at 6:58 a.m., indicated the left heel wound was an existing area, which was facility acquired with an original noted date of 8/27/15. The wound type was a diabetic ulcer with a status of FTW. The wound measured 0.8 x 1.0 x 0.0 cm. The wound color was black.</p> <p>The document titled "IDT [Interdisciplinary Team] Weekly Update Skin Events[Name of Company] Non-Pressure Wound Skin Event," dated 9/24/15 at 6:59 a.m., indicated the left 1st, 4th and 5th metatarsals on the left foot were existing areas, which were facility acquired with an original noted date of 8/27/15. The wound types were diabetic ulcers with a status of FTW.</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 03/01/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HARCOURT TERRACE NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>The wound measurements indicated generalized. The wound colors were black.</p> <p>On 3/1/15 at 8:47 a.m., with the Director of Nursing Services (DNS) and LPN #5 in attendance, they were notified of the concern of the resident's diabetic ulcers on her left heel and left 1st, 4th and 5th toes being found when they were necrotic (black). Further information was requested to indicate if these wounds were discovered any earlier than when they were necrotic. The DNS indicated they would look into this.</p> <p>During an interview on 3/1/15 at 3:48 p.m., with LPN #5 and the CEC (Clinical Education Coordinator) in attendance, the CEC indicated they were continuing to work on the black wound issue.</p> <p>During an interview on 3/1/16 at 5:00 p.m., the DNS indicated the resident's left heel wound and left toe wounds were discovered on 8/27/15, when a skin sweep was completed.</p> <p>A current policy titled "Skin Management Program," dated 6/2014 with a revised of 1/2016, was provided by the DNS on 3/1/16 at 3:45 p.m., indicated "POLICY: It is the policy of [Name of Company] to assess each</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 03/01/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HARCOURT TERRACE NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260
---	---

(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
F 0312 SS=D Bldg. 00	<p>resident to determine the risk of potential skin integrity impairment, upon admission, quarterly, annually and with significant change. Residents will have a skin assessment completed no less than weekly by the licensed nurse in an effort to assess overall skin condition, skin integrity, and skin impairment. PROCEDURE: 1. A head to toe assessment will be completed by a licensed nurse upon admission/re-admission and weekly...."</p> <p>This Federal tag relates to Complaint IN00190705 and IN00189411.</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 follow their policy and procedure while providing peri care for 1 of 1 resident reviewed for incontinence care. (Resident #19)</p> <p>Findings include:</p>	F 0312	<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident #19 experienced no adverse effects of by this deficient practice. How other residents having the potential to be affected by the</p>	03/21/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155149	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/01/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER HARCOURT TERRACE NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Resident #19's record was reviewed on 02/26/2016 at 10:12 a.m. Diagnoses included, but were not limited to, dementia with behavior disturbance, Alzheimer's disease, chronic stage 3 kidney disease, Congestive Heart Failure and hypertension.</p> <p>A current Care Plan indicated, "Potential for skin breakdown related...episode of incontinence...check and change every 2 hours. Assist resident with toileting and peri care after each incontinent episode...."</p> <p>A current Care Plan indicated, "Resident is incontinent due to: decreased cognitive ability RT (related to) Alzheimer need assist with toileting, medication which increases urinary urgency/frequency...assist with incontinent care as needed. Check and change every 2 hours for incontinence...."</p> <p>During a continuous observation on 02/26/2016 from 9:09 a.m., through 11:35 a.m., the following observations were made:</p> <p>On 02/26/2016 at 9:09 a.m., the resident was sitting in her wheelchair at the dining room table with her eyes closed. A strong odor of urine was evident when</p>		<p>same deficient practice will be identified and what corrective actions will be taken? All other residents requiring ADL care have the potential to be affected by this practice</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? One on one education was provided to the C.N.A's providing care to resident #19 on proper peri care on 2/26/16. Nursing staff was re-educated on providing proper peri care on 3/18/16.</p> <p>How will the corrective actions be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? DNS and/or Designee will complete Perineal Care Skills validations with a C.N.A. three times a week x 4 weeks, then twice weekly x 4 weeks, then once weekly x 4 weeks. Any deficient practice will be corrected on the spot, and the finding of the quality assurance checks will be documented and submitted at the monthly Quality Assurance Committee Meeting for further review or corrective action. Skill validations will be repeated as the Quality Assurance Committee deems necessary.</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 03/01/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HARCOURT TERRACE NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>standing in close proximity to the resident.</p> <p>On 02/26/2016 at 9:25 a.m., CNA #1 addressed the resident by name and she opened her eyes briefly. CNA #1 transported the resident to her room. CNA #2 joined CNA #1 in the resident's room. Both CNA's washed their hands for 20 seconds and donned clean gloves. CNA #1 placed a gait belt around the resident's waist, then both CNA's assisted the resident to stand, then ambulated the resident to the bathroom. The resident had a very strong, pungent urine smell, which was evident when she stood up from her wheelchair. The resident's brief and black colored slacks were saturated from her waist to thighs when removed by CNA #2 as the resident sat on the commode. The resident was asked to stand as CNA #1 prepared one end of a bath towel with soap and running water from the sink. CNA #1 cleansed the resident's buttocks with the end of the soapy towel. He placed the same end of the towel under the running water from the sink and cleansed the resident's buttocks and patted it dry with the opposite end of the towel. CNA #1 placed the dampened end of the same towel in the sink with running water and applied more soap. He cleansed the resident's peri area. He placed the soapy</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 03/01/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HARCOURT TERRACE NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>end of the towel under running water in the sink, then rinsed the peri area and patted the area dry using the opposite end of the same towel. CNA #2 placed a clean brief and tan slacks on the resident. Both CNA's ambulated the resident to her recliner and assisted her to sit down.</p> <p>On 02/26/2016 at 11:20 a.m., CNA #1 and CNA #2 entered the resident's room. CNA #1 placed a gait belt around the resident's waist. Both CNA's assisted the resident to stand and the resident's tan colored slacks were saturated from her waist to lower thighs when removed by CNA #2 as the resident sat on the commode. The resident was asked to stand as CNA #1 prepared one end of a bath towel with soap and running water from the sink. CNA #1 cleansed the resident's buttocks with the end of the soapy towel. He placed the same end of the towel under the running water from the sink and cleansed the resident's buttocks and patted it dry with the opposite end of the towel. CNA #1 placed the dampened end of the same towel in the sink with running water and applied more soap. He cleansed the resident's peri area. He placed the soapy end of the towel under running water in the sink, then rinsed the peri area and patted the area dry using the opposite end of the same towel. CNA #2 placed a</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 03/01/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HARCOURT TERRACE NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>clean brief and denim skirt on the resident. Both CNA's ambulated the resident to her wheelchair and assisted her to sit down.</p> <p>During an interview on 02/26/2016 at 11:34 a.m., CNA #1 indicated if a female resident was incontinent of urine and she was standing in the restroom for incontinence care, he would cleanse the resident from the back or buttocks area first, then work forward to the front or peri area.</p> <p>During an interview on 02/26/2016 at 1:00 p.m., the DNS (Director of Nursing Services) indicated the method of cleansing the peri area should be performed using the front to back method.</p> <p>A current policy titled "PERINEAL CARE" dated 02/2010, provided by the DNS on 02/26/2016 at 2:05 p.m., indicated: "...Procedure Steps:...2. Provide for privacy...6. Drape resident as needed. 7. Fill wash basin with warm water and have resident check temperature...9. Wet and soap folded wash cloth...11. Obtain clean wash cloth. Wet, soap and fold wash cloth. Females: 12. Separate labia and wash urethral area first. 13. Wash between and outside labia in downward strokes. 14. Alternate</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 03/01/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HARCOURT TERRACE NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260
---	---

(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
F 0314 SS=D Bldg. 00	<p>from side to side-wipe from front to back and from center of perineum outward.</p> <p>15. Use a clean area of the wash cloth with each wipe. Do not rewipe area, unless using a clean area of the wash cloth. Change wash cloth as needed...20. Change water in basin. With a clean wash cloth, rinse area, thoroughly in the same direction when washing. 21. Gently pat area dry in same direction as when washing. 22. Assist resident turn onto side away. 23. Wet and soap wash cloth. 24. Clean anal area from front to back, using a clean are of wash cloth with each wipe. Do not rewipe area, unless using a clean area of the wash cloth. Change wash cloth as needed. 25. Change water in basin. With a clean wash cloth, rinse area, thoroughly in the same direction as when washing. 26. Gently pat area dry in same direction as when washing...."</p> <p>3.1-38(a)(2)(c) 3.1-38(a)(3)(A)</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES 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</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155149	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/01/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER HARCOURT TERRACE NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>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 interview and record review, the facility failed to ensure pressure ulcers were assessed appropriately for 1 of 3 residents reviewed for pressure ulcers. (Resident C)</p> <p>Findings include:</p> <p>Resident C's record was reviewed on 2/29/216 at 12:02 p.m. Diagnoses included, but were not limited to, depressive disorder, End Stage Renal Disease, Diabetes Mellitus type 2, protein-calorie malnutrition, debility, and dementia with behavioral disturbances.</p> <p>A document titled "New Skin Event," dated 7/2/15 at 1:50 p.m., indicated the resident had shearing and excoriation to her buttocks, which were new areas with an original date of occurrence of 7/2/15, which were facility acquired. The wound color was pink. The wound type was an abrasion by friction and shearing.</p> <p>A document titled "IDT (Interdisciplinary Team) Update Skin Events--[Name of Company] Pressure Wound Skin Evaluation Report," dated 7/6/15 at 7:00</p>	F 0314	<p>What correctiveaction will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Resident C has been discharged from this facility</p> <p>How other residentshaving the potential to be affected by the same deficient practice will beidentified and what corrective actions will be taken?</p> <p>All residents with pressure ulcers have the potential to beaffected by this deficient practice. All residents with pressure ulcers' documentation was reviewed to ensure assessments were correct and accuratelyreflected residents skin condition. This review was completed by the DNS and/orDesignee on 3/17/16. No other residents were found to be affected by thispractice.</p> <p>What measures will beput into place or what systemic changes will be made to ensure that thedeficient practice does not recur?</p> <p>Education wasprovided by DNS and/or Designee to Licensed Nurses on accurate woundassessments, staging, and documentation. DNS and/or Designee will review weekly summaries completed by Licensed Nursingfor all residents with</p>	03/21/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155149	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/01/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER HARCOURT TERRACE NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>a.m., indicated the resident had open areas to the left and right gluteal folds, which were existing areas with an original date of occurrence of 7/2/15, which was facility acquired. The wound was a Stage 1 (Intact skin with nonblanchable redness of a localized area, usually over a bony prominence. Darkly pigmented skin may not have visible blanching; it's color may differ from the surrounding area.) The most severe tissue type was Epithelial (new skin growing in superficial ulcer, which may be pink and shiny). The site was the right gluteal fold. The wound measured 5.0 x 2.0 cm (centimeters). The wound color was pinkish-red.</p> <p>A document titled "IDT (Interdisciplinary Team) Update Skin Events--[Name of Company] Pressure Wound Skin Evaluation Report," dated 7/6/15 at 7:01 a.m., indicated the resident had an open area to the left gluteal fold, which was an existing area, with an original date of occurrence of 7/2/15, which was facility acquired. The wound was a Stage 1 with the most severe tissue type being Epithelial tissue. The site was the left gluteal fold. The wound measured 3.0 x 0.8 cm. The wound color was pinkish-red.</p> <p>A document titled "IDT (Interdisciplinary</p>		<p>pressure ulcers weekly to ensure assessments are accurate. . DNS and/or Designee will review all NewSkin Events Monday through Friday to ensure timely assessment of all areas of impaired skin integrity are completed and accurate. DNS and/or Designee will be responsible for all staging of pressure wounds after reviewing initial skin event. DNS was wound care certified on 12/08/2015.</p> <p>How will the corrective actions be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>To ensure compliance, the DNS and/or Designee is responsible for the completion of the Skin Management Program CQI tool weekly x 4 weeks, then monthly x 6 months. The results of these audits will be reviewed by the Quality Assurance Committee. The findings of the quality assurance checks will be documented and submitted at the monthly Quality Assurance Meeting for further review or corrective action. CQI's will be repeated as the Quality Assurance Committee deems necessary.</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 03/01/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HARCOURT TERRACE NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Team) Update Skin Events--[Name of Company] Pressure Wound Skin Evaluation Report" dated 7/9/15 at 9:35 a.m., indicated the resident had an open area to the right gluteal fold, which was an existing area with an original date of occurrence of 7/2/15, which was facility acquired. The wound was an Unstageable wound (Full thickness tissue loss in, which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the ulcer bed. Until enough slough or eschar is removed to expose the base of the ulcer, the true depth and therefore the stage, cannot be determined.) The most severe tissue type was slough (Necrotic or avascular in the process of separating from viable tissue. Usually soft, moist and light in color, may be stringy.) The site was the right gluteal fold. The initial wound measurement was 3.0 x 1.5 x 0.1 cm. The wound color was yellow.</p> <p>A wound note from a Wound Clinic, dated 7/9/15, indicated the resident's Wound #1 was a pressure ulcer to her right buttock. The wound had necrotic tissue (Death of body tissue, which occurs when too little blood flows to the tissue) and was an Unstageable wound. The wound measured 3.0 x 1.5 x 0.1 cm. The wound bed was 51-75% slough.</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 03/01/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HARCOURT TERRACE NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Wound #2 was a Suspected Deep Tissue Injury Pressure Ulcer to her left buttock. The initial wound measurement was 3.3 x 0.8 x 0.1 cm.</p> <p>A document titled "IDT (Interdisciplinary Team) Update Skin Events--[Name of Company] Pressure Wound Skin Evaluation Report," dated 7/16/15 at 7:15 a.m., indicated the resident had an open area to the right gluteal fold, which was an existing area with an original date of occurrence of 7/2/15, which was facility acquired. The wound was an Stage III (Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle was not exposed. Slough may be present but did not obscure the depth of tissue loss. May include undermining and tunneling.) The most severe tissue type was Granulation (pink or red tissue with shiny, granular appearance.) The site was the right gluteal fold. The wound measured 1.5 x 1.0 x 0.1 cm. The wound color was pink.</p> <p>A document titled "IDT (Interdisciplinary Team) Update Skin Events--[Name of Company] Pressure Wound Skin Evaluation Report," dated 7/23/15 at 10:41 a.m., indicated the resident had an open area to the right gluteal fold, which was an existing area with an original date of occurrence of 7/2/15, which was</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 03/01/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HARCOURT TERRACE NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>facility acquired. The wound was an Stage II (Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink ulcer bed without slough. May also present as an intact or open/ruptured serum filled blister.) The most severe tissue type was Granulation (pink or red tissue with shiny, granular appearance.) The site was the right gluteal fold. The wound measured 1.1 x 1.0 x 0.1 cm. The wound color was pink.</p> <p>An IDT note dated 7/30/15 at 3:45 p.m., indicated the gluteal fold was healed.</p> <p>On 3/1/15 at 8:57 a.m., with LPN #5 and the Director of Nursing Services (DNS) in attendance, the concerns regarding the conflict in assessment information of the resident's pressure ulcers of the gluteal folds being open and staged as a 1 and down staging from a Stage III to a Stage II were discussed with LPN #5 and the DNS and they were going to get further information regarding these issues.</p> <p>During an interview on 3/1/16 at 3:48 p.m., with LPN #5 and the CEC (Clinical Educator Coordinator) in attendance, the CEC indicated she would have to check for further information on the downstaging of the Stage III to a Stage II.</p> <p>During an interview on 3/1/16 at 4:07</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 03/01/2016
NAME OF PROVIDER OR SUPPLIER HARCOURT TERRACE NURSING AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>p.m., CEC indicated when the Wound clinic was not here assessing and measuring the wounds, she was not sure who was responsible to assess and measure the wounds in the facility. She indicated she did not have any further information other than what she had already provided regarding assessing the resident's pressure wounds.</p> <p>During an interview on 3/1/15 at 5:00 p.m., the DNS indicated when the wound clinic did not come to the facility to assess the wounds, the Assistant Director of Nursing Services was responsible for measuring the resident's wounds.</p> <p>A current policy titled "Skin Management Program," dated 6/2014 with a revised of 1/2016, was provided by the DNS on 3/1/16 at 3:45 p.m., indicated "POLICY: It is the policy of [Name of Company] to assess each resident to determine the risk of potential skin integrity impairment, upon admission, quarterly, annually and with significant change. Residents will have a skin assessment completed no less than weekly by the licensed nurse in an effort to assess overall skin condition, skin integrity, and skin impairment. PROCEDURE: 1. A head to toe assessment will be completed by a licensed nurse upon</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 03/01/2016	
NAME OF PROVIDER OR SUPPLIER HARCOURT TERRACE NURSING AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260			
(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			
F 0315 SS=D Bldg. 00	<p>admission/re-admission and weekly... The wound nurse (licensed nurse assigned responsibility for wounds for the building or assigned unit) will be notified of alteration in skin integrity... 5. Wound rounds will be completed on a weekly basis to assess wounds following the wound meeting guidelines. The facility must have an assigned wound nurse that assesses the wounds on a weekly basis. The wound nurse is responsible for updating the wound composite reports on a weekly basis and reporting the results to the DNS...."</p> <p>This Federal tag relates to Complaint IN00189411.</p> <p>This Federal tag relates to Complaint IN00190705.</p> <p>3.1-40(a)(1)</p> <p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155149	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/01/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER HARCOURT TERRACE NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>possible.</p> <p>Based on interview and record review, the facility failed to provide an antibiotic in a timely manner to treat a resident with a urinary tract infection for 1 of 6 residents being reviewed for unnecessary medications (Resident #48) and failed to prevent the possibility of a urinary tract infection due to improper incontinence care for 1 of 1 residents reviewed for urinary incontinence. (Resident #19)</p> <p>Findings include:</p> <p>1. On 02/26/2016 at 4:03 p.m., Resident #48's record was reviewed. Diagnoses included, but were not limited to, hypertension, hypothyroidism and Diabetes Mellitus type 2.</p> <p>A Care Plan, dated 02/19/2016, indicated the resident had a UTI. Approaches included, but were not limited to, "...Administer meds as ordered...."</p> <p>A U/A/C&S (urinalysis/culture and sensitivity) was ordered on 02/12/2016. Urine culture results were obtained on 02/17/2016, and a new order was obtained for Cipro (an antibiotic medication) 250 mg (milligrams) twice daily for 7 days from the physician.</p> <p>A document titled "Event report" dated</p>	F 0315	<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Resident, MD, and family were notified immediately upon identification of failure to administer antibiotic timely. Resident #19 was provided her antibiotic as ordered. Resident was assessed by licensed nurse with no adverse effects of deficient practice noted. RN #3 was provided one on one education from DNS on 3/17/16.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?</p> <p>All other residents who received a physician's order for an Antibiotic have the potential to be affected by this practice. On 3/17/16 the DNS and/or Designee reviewed all residents who received an order for an Antibiotic for the past 30 days to ensure that all Antibiotic orders were entered into the electronic medical record accurately.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</p> <p>DNS and/or Designee re-educated Licensed Nurses regarding properly entering physician's orders into electronic medical record on</p>	03/21/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155149	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/01/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER HARCOURT TERRACE NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>02/18/2016 at 3:36 p.m., initiated by RN #3 indicated the "...Resident ordered to start Cipro for UTI today. Vitals WNL (within normal limits). First dose administered...."</p> <p>During an interview on 02/29/2016 at 3:30 p.m., the DNS (Director of Nursing Services) indicated the resident had experienced a medication error regarding Cipro ordered on 02/18/2016. She indicated RN #3 received the order from the physician on 02/18/2016, and failed to order the medication in the computer. The DNS indicated the resident did not receive the Cipro in a timely manner. The DNS indicated the resident began receiving the Cipro routinely as ordered on 02/22/2016.</p> <p>During an interview on 02/29/2016 at 4:15 p.m., the ADNS (Assistant Director of Nursing Services) indicated RN #3 retrieved the initial dose of Cipro from the EDK (emergency drug kit) on 02/18/2016 and administered it to the resident.</p> <p>2. Resident #19's record was reviewed on 02/26/2016 at 10:12 a.m. Diagnoses included, but were not limited to, dementia with behavior disturbance, Alzheimer's disease, chronic stage 3 kidney disease, Congestive Heart Failure</p>		<p>3/17/16. Physician's orders will be reviewed daily by the Interdisciplinary Team and/or ChargeNurse, including weekends and holidays to ensure Antibiotic orders are followed through on appropriately.</p> <p>How will the corrective actions be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>DNS and/or Designee will be responsible for completing the Antibiotic Therapy CQI tool weekly x 4 weeks, then monthly x 6 months. The findings of the quality assurance checks will be documented and submitted at the monthly Quality Assurance Meeting for further review or corrective action. CQI's will be repeated as the Quality Assurance Committee deems necessary.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155149	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/01/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER HARCOURT TERRACE NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>and hypertension.</p> <p>A current Care Plan indicated, "Potential for skin breakdown related...episode of incontinence...check and change every 2 hours. Assist resident with toileting and peri care after each incontinent episode...."</p> <p>A current Care Plan indicated, "Resident is incontinent due to: decreased cognitive ability RT (related to) Alzheimer need assist with toileting, medication which increases urinary urgency/frequency...assist with incontinent care as needed. Check and change every 2 hours for incontinence...."</p> <p>During a continuous observation on 02/26/2016 from 9:09 a.m. through 11:35 a.m., the following observations were made:</p> <p>On 02/26/2016 at 9:09 a.m., the resident was sitting in her wheelchair at the dining room table with her eyes closed. A strong odor of urine was evident when standing in close proximity to the resident.</p> <p>On 02/26/2016 at 9:25 a.m., CNA #1 addressed the resident by name and she opened her eyes briefly. CNA #1 transported the resident to her room.</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 03/01/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HARCOURT TERRACE NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>CNA #2 joined CNA #1 in the resident's room. Both CNA's washed their hands for 20 seconds and donned clean gloves. CNA #1 placed a gait belt around the resident's waist, then both CNA's assisted the resident to stand, then ambulated the resident to the bathroom. The resident had a very strong, pungent urine smell, which was evident when she stood up from her wheelchair. The resident's brief and black colored slacks were saturated from her waist to thighs when removed by CNA #2 as the resident sat on the commode. The resident was asked to stand as CNA #1 prepared one end of a bath towel with soap and running water from the sink. CNA #1 cleansed the resident's buttocks with the end of the soapy towel. He placed the same end of the towel under the running water from the sink and cleansed the resident's buttocks and patted it dry with the opposite end of the towel. CNA #1 placed the dampened end of the same towel in the sink with running water and applied more soap. He cleansed the resident's peri area. He placed the soapy end of the towel under running water in the sink, then rinsed the peri area and patted the area dry using the opposite end of the same towel. CNA #2 placed a clean brief and tan slacks on the resident. Both CNA's ambulated the resident to her recliner and assisted her to sit down.</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 03/01/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HARCOURT TERRACE NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>On 02/26/2016 at 11:20 a.m., CNA #1 and CNA #2 entered the resident's room. CNA #1 placed a gait belt around the resident's waist. Both CNA's assisted the resident to stand and the resident's tan colored slacks were saturated from her waist to lower thighs when removed by CNA #2 as the resident sat on the commode. The resident was asked to stand as CNA #1 prepared one end of a bath towel with soap and running water from the sink. CNA #1 cleansed the resident's buttocks with the end of the soapy towel. He placed the same end of the towel under the running water from the sink and cleansed the resident's buttocks and patted it dry with the opposite end of the towel. CNA #1 placed the dampened end of the same towel in the sink with running water and applied more soap. He cleansed the resident's peri area. He placed the soapy end of the towel under running water in the sink, then rinsed the peri area and patted the area dry using the opposite end of the same towel. CNA #2 placed a clean brief and denim skirt on the resident. Both CNA's ambulated the resident to her wheelchair and assisted her to sit down.</p> <p>During an interview on 02/26/2016 at 11:34 a.m., CNA #1 indicated if a female</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 03/01/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HARCOURT TERRACE NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>resident was incontinent of urine and she was standing in the restroom for incontinence care, he would cleanse the resident from the back or buttocks area first, then work forward to the front or peri area.</p> <p>During an interview on 02/26/2016 at 1:00 p.m., the DNS (Director of Nursing Services) indicated the method of cleansing the peri area should be performed using the front to back method.</p> <p>A current policy titled "PERINEAL CARE" dated 02/2010, provided by the DNS on 02/26/2016 at 2:05 p.m., indicated: "...Procedure Steps:...2. Provide for privacy...6. Drape resident as needed. 7. Fill wash basin with warm water and have resident check temperature...9. Wet and soap folded wash cloth...11. Obtain clean wash cloth. Wet, soap and fold wash cloth. Females: 12. Separate labia and wash urethral area first. 13. Wash between and outside labia in downward strokes. 14. Alternate from side to side-wipe from front to back and from center of perineum outward. 15. Use a clean area of the wash cloth with each wipe. Do not rewipe area, unless using a clean area of the wash cloth. Change wash cloth as needed...20. Change water in basin. With a clean</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 03/01/2016	
NAME OF PROVIDER OR SUPPLIER HARCOURT TERRACE NURSING AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260			
(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			
F 0323 SS=G Bldg. 00	<p>wash cloth, rinse area, thoroughly in the same direction when washing. 21. Gently pat area dry in same direction as when washing. 22. Assist resident turn onto side away. 23. Wet and soap wash cloth. 24. Clean anal area from front to back, using a clean are of wash cloth with each wipe. Do not rewipe area, unless using a clean area of the wash cloth. Change wash cloth as needed. 25. Change water in basin. With a clean wash cloth, rinse area, thoroughly in the same direction as when washing. 26. Gently pat area dry in same direction as when washing...."</p> <p>3.1-41(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 hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on interview and record review, the facility failed to prevent a fall resulting from a staff to resident behavioral interaction resulting in the resident sustaining a fractured right hip</p>	F 0323	<p>What correctiveaction will be accomplished for those residents found to have been affected bythe deficient practice? Resident was transferred to the ER on 2/17/2016 forevaluation and tx.</p>	03/21/2016			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155149	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/01/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER HARCOURT TERRACE NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>and being hospitalized for 1 of 3 residents being reviewed for accidents. (Resident E)</p> <p>Findings include:</p> <p>Resident E's record was reviewed on 2/26/16 at 2:18 p.m. Diagnoses included, but were not limited to, episodic mood, depressive disorder, personality disorder and epilepsy.</p> <p>Annual MDS (Minimum Data Set) Assessment, dated 12/20/15, indicated the resident's BIMS (Brief Interview Mental Status) was a 15.</p> <p>The resident had a Care Plan, dated 1/20/15, which indicated he had a behavior he exhibited verbal aggressive behaviors of yelling out and cursing at staff and he had a diagnosis of mood disorder. Approaches included, but were not limited to, "...1/20/15--Intervention #2 provide Resident personal space during acute periods...."</p> <p>The resident had a Care Plan, dated 2/6/15, which indicated he had a behavior of periods of physical aggression as evidenced by attempting and throwing items and hitting others with his wheelchair. Approaches included, but were not limited to, "...2/6/15-</p>		<p>Resident returned to facility on 2/20/2016. InterdisciplinaryTeam reviewed resident's plan of care on 2/22/16 and updated care plan andresident profile with appropriate fall interventions. DNS and/or Designeeducated staff on appropriate behavior management approaches for resident E on3/17/16. C.N.A # 6 is no longer employed at this facility. Two staff memberswill be present during any care provided for resident E.</p> <p>How other residentshaving the potential to be affected by the same deficient practice will beidentified and what corrective actions will be taken?</p> <p>All other residents have the potential to be affected bythis deficient practice. DNS and/or Designee reviewed all facility falls forpast 30 days on 3/18/16 to attempt to identify any resident having been affected.No other residents were found to be affected by this practice. No additional fallsoccurred relating to staff not following resident's Behavioral Management careplans. On 3/18/16 all residents who havehad falls within the last 30 days have been reviewed, and their care plans andprofiles updated as needed.</p> <p>What measures will beput into place or what systemic changes will be made to ensure that thedeficient practice does not recur?</p> <p>Staff education was provided</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155149	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/01/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER HARCOURT TERRACE NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>-Intervention #2 provide personal space when appropriate...."</p> <p>The resident had a Care Plan, dated 2/11/15, which indicated he had periods of refusing care as evidenced by refusing medications and care usually when upset regarding other factors. Approaches included, but were not limited to, "2/11/15--Do Not Challenge-Inform Physician... 2/11/15--re-approach at later time."</p> <p>A document titled "A Fall Event," dated 2/17/16 at 11:57 p.m., indicated the resident had a witnessed fall. Prior to the fall according to the aide the resident was "running" in the hallway and fell back when he grabbed at the door. He was sitting on the floor in the hallway when the nurse observed him on the floor. He complained of left hip pain and was sent to the Emergency room.</p> <p>A Progress note, dated 2/18/16 at 12:18 a.m., indicated "Writer was passing medication in another hallway when aid told writer resident was running in hallway and fell. Aid said resident was upset that his bathroom was dirty and pacing down the hallway and got upset when Aid bought a coke and cookies for residents room mate. Writer can confirm that resident had walked down and back</p>		<p>regarding Fall Management andfollowing Behavioral Management approaches per care plans by DNS and/or Designeeon 3/17/16. Interdisciplinary Team, including Social Services Director willreview all falls on the next business day to identify whether or not root causeof fall is related to non compliance with Behavior Management Care Planapproaches. DNS in conjunction with MDS have initiated a behavior log availableto staff that provide resident's current behavior interventions and spaceavailable to record any new observed behaviors. Manuals are made available at nurse'sstation. Interdisciplinary Team willmeet with direct care staff Monday through Friday to review resident careprofiles of residents sustaining recent fall. Updated resident care profileswill be provided to weekend staff through communication binder.</p> <p>How will thecorrective actions be maintained to ensure the deficient practice will notrecur, i.e., what quality assurance program will be put into place?</p> <p>DNS and/or Designee will be responsible for completing theFall CQI tool weekly x 4 weeks, then monthly x 6 months. The results of these CQI'swill be reviewed by the Quality Assurance Committee and the findings of thequality assurance checks will be documented and submitted at the monthlyQuality Assurance Meeting for further</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 03/01/2016	
NAME OF PROVIDER OR SUPPLIER HARCOURT TERRACE NURSING AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>the hallway that the writer was currently passing meds. Resident had stopped writer to complain that the aid had not cleaned the mess his room mate had made in their bathroom. Shortly after the resident had left aid had told writer that the resident had fallen. When writer approached resident, resident was sitting on the hallway floor scooting to his room. Resident said he had fallen on his surgical hip and couldn't get up and requested 911 and police be called. Writer helped resident to side railing and at the request of the resident, brought his rolling walker from his room. Resident was not using his walker at the time of the accident. Resident had said aid had pushed him. Writer contacted DON [Director of Nursing] and 911. Police were also contacted at the request of the resident. However, resident has a behavior history that correlates with aid's story. Behavior eval [evaluation] will be conducted when resident returns. Resident was sent to ER [Emergency Room] for further evaluation Writer will contact ER for evaluation."</p> <p>A report sent to the ISDH (Indiana State Department of Health) indicated an incident occurred on 2/17/16 at 10:46 p.m., Resident E was involved with CNA #6. The resident indicated he was pushed by an aide. He had a hip fracture. The</p>		<p>review or corrective action. CQI's will be repeated as the Quality Assurance Committee deems necessary.</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 03/01/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HARCOURT TERRACE NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>follow up section of the report indicated the investigation was completed and showed the resident was exhibiting behaviors at the time of the fall and he fell on his own.</p> <p>An interview with the resident, dated 2/17/16, indicated Resident E had given his roommate four cokes and his roommate had repaid three cokes back to him. CNA #6 bought his roommate a coke when other aides would not do it. She placed the coke on the roommate's table and Resident E took the can of coke from his roommate's table and headed toward the library. CNA #6 followed him and grabbed a hold of the can of coke and both of them had their hands on the can of coke. Resident E indicated CNA #6 used a "judo-wrestling move" on him and flipped him over her back and then took the can of coke and he landed on the hip he had already had replaced. He could not move after that and yelled for help.</p> <p>A statement from LPN #7, dated 2/17/16, indicated he was passing medications on another hallway when a resident came down the hall yelling about his bathroom. He saw the resident head back toward his room. Shortly after that the aide came and got him and told him the resident was running down the hall and fell He</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155149	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/01/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER HARCOURT TERRACE NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>assessed the resident and found him sitting on the floor scooting to his room. The resident indicated he fell on his hip and was in pain. The resident added that the aide had pushed him. 911 was contacted and the resident was sent to ER.</p> <p>A statement written by CNA #6, indicated Resident E was "acting up" because his roommate used the restroom and he indicated his roommate made a mess in the restroom. After that she got the resident's roommate a coke and some cookies, then the resident started yelling at her to get out of his room and he "snatched" the coke and cookies out of her hand. Resident E threw the cookies on the floor and started walking out to the restroom in the back room. Once he got to the restroom door he stopped to open the soda and that was when CNA #6 tried reaching for the coke. CNA #6 indicated she did not know if Resident E turned really fast and she was not sure if he tripped because his feet were not fast enough. She indicated as soon as he hit the floor she went to get LPN #7. She indicated she did not touch him. She indicated the resident was being verbally abusive to her since the restroom incident in his room prior to getting the coke and cookies for his roommate.</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 03/01/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HARCOURT TERRACE NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>A telephone interview from CNA #6, dated 2/18/16, indicated the DNS (Director of Nursing Services) and ED (Executive Director) contacted her and she indicated she had taken the resident's roommate to the restroom and told him to turn on the light when he was finished. Resident E was upset because the toilet was dirty and there was "S*** everywhere." CNA #6 went to get Resident E's roommate a nighttime snack and when she returned the resident started yelling at her to get out of his room. Resident E took the beverage and indicated his roommate owed him. CNA #6 indicated as she was reaching for the coke the resident proceeded to pull his arm back and he fell on the floor. She immediately went to get the charge nurse. The resident indicated the CNA #6 pushed him. CNA #6 denied pushing or touching the resident.</p> <p>A "Hospital Consultation Note," from (Name of Hospital) dated 2/18/16 at 7:27 a.m., indicated the resident presented to the hospital with right hip pain that began immediately after an injury, which occurred as he reported being thrown down by a worker at his facility, causing him to fall onto his right hip. The note indicated the resident's X-ray report of the right hip indicated he had a fracture of the right hip. The note indicated he</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 03/01/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HARCOURT TERRACE NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>was going to be treated nonoperatively.</p> <p>During an interview on 2/26/16 at 10:34 a.m., Resident E indicated CNA #6 was going to purchase a coke for his former roommate and he told her that the other CNA's did not purchase the cokes for him because he made a mess with them in the room and he did not want him to have one either. He indicated she went ahead and got one for him anyway. He indicated after she purchased the coke for him and gave it to his former roommate, Resident E "grabbed" it off his roommates table and he walked to the library with the coke. CNA #6 "grabbed" the coke in the library and he and CNA #6 were wrestling over the coke. He indicated she had taken the coke out of his hands by performing a wrestling move. Resident E indicated both of them had a hold of the coke can and the wrestling move flipped the coke over her body and he was holding onto the coke can and that move threw him over her back and his body went along with the coke and he landed flat on his right hip on the tile floor in the library. He indicated his right hip had already been replaced. He indicated he had written this CNA up before, but did not elaborate why he had written her up. He indicated his roommate owed him 4 cokes, which he had given him prior to that day and he</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 03/01/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HARCOURT TERRACE NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>should have been made to pay him back before the aides bought his roommate any cokes.</p> <p>During an interview on 2/26/16 at 3:25 p.m., CNA #6 indicated Resident E's roommate was going to use the restroom and Resident E started "acting up". Resident E indicated to her that whatever mess his roommate made she had to clean up. Resident E's roommate put on his light and she got him ready for bed and Resident E got loud with her. CNA #6 indicated Resident E's roommate threw the toilet paper and soap on the floor and she picked up the toilet paper and soap off the floor. She went and got the resident's roommate a coke and snacks and the resident told her to get out of the room and he tried to push her and she moved. Resident E grabbed the snacks and the coke and threw the snacks on the floor and took the coke and "headed" to the library. Resident E went to the bathroom in the back hallway and tried to open the coke. She indicated she told Resident E to give it back and she tried to reach for the coke and he turned and lost his balance and fell backwards. She went to get LPN #7 and told him that Resident E fell. She indicated she was suspended and the facility called her and told her she could come back to work, but she never came back to work. CNA</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 03/01/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HARCOURT TERRACE NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>#6 indicated she did not want to come back to work because she had trouble with Resident E before and the facility was stressful and she did not want to deal with him and the facility anymore. She indicated she had seen him crushing his pills in his room and reported it to the nurse and he had harassed her since then by taking her linen barrel at the end of the hall and he came into a resident's room while she was caring for that resident. Also, he placed a cup of juice in front of a resident's door, so she would kick it and spill it everywhere when she came out of the room.</p> <p>During an interview on 3/01/16 at 8:57 a.m., LPN #5 with the DNS (Director of Nursing Services) in attendance. LPN #5 indicated she expected CNA #6 to walk with the resident and explain to the resident the coke was not his and it was his roommates. The DNS indicated she thought CNA #6 thought she was protecting the roommate by trying to get the coke back for him. LPN #5 indicated she would have expected CNA #6 to let Resident E go knowing he had behaviors to prevent him from having another behavior that evening.</p> <p>This Federal tag relates to Complaint IN00190705.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155149	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/01/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER HARCOURT TERRACE NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260
---	---

(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
F 0328 SS=D Bldg. 00	<p>3.1-45(a)(1)</p> <p>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>Based on observation, interview and record review, the facility failed to provide tracheostomy (trach) care and a nebulizer breathing treatment following facility protocol. The facility also failed to timely change oxygen, nebulizer, and tracheal tubing for 1 of 1 residents reviewed for tracheostomy care and respiratory treatments. (Resident #24)</p> <p>Findings include:</p> <p>1. On 3/01/16 at 9:30 a.m., the record review for Resident #24 was completed. Diagnoses included, but were not limited to, respiratory failure, tracheotomy, dementia, mental retardation and high blood pressure.</p>	F 0328	<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident #24 experienced no adverse effects by this deficient practice. Tubing was replaced and dated for Resident #24.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? All other residents requiring treatment/care for special needs have the potential to be affected by this practice.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</p>	03/21/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155149	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/01/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER HARCOURT TERRACE NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>a) During an observation on 2/26/16 at 9:50 a.m., Resident #24 was observed being given a nebulizer treatment by LPN #4. LPN #4 gathered her vital machine and took the residents blood pressure and pulse, LPN #4 was unable to get the resident's pulse oxygen level (SP O2) because the monitor on the machine was not working. She placed the nebulizer breathing treatment solution into the chamber of the nebulizer trach mask, then hooked the mask up against the resident's trach collar after removing the cap. The nebulizer treatment ran for 10 minutes and LPN #4 after being asked, indicated she was supposed to check the residents lung sounds, heart rate and respirations before and after the treatment.</p> <p>During an observation on 3/1/16 at 9:30 a.m., the resident had in her room the following respiratory equipment:</p> <p>The bag for the respiratory nebulizer mask equipment had a date of 2/24/16. The nebulizer mask and the nebulizer medication cup holder in the tubing for the trach was not dated. The nebulizer trach mask was hanging over the bedside table and dangling by the bed side and was not covered. The tubing for the oxygen hooked up to the suction machine was not dated. The nebulizer trach mask</p>		<p>One on one education was provided to the LPN providing care to Resident #24 on proper Nebulizer, Trach care and Oxygen tubing replacement on 2/26/16. Licensed Nursing Staff were re-educated on providing proper Nebulizer, Trach care and Oxygen tubing replacement on 3/17/16.</p> <p>How will the corrective actions be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>DNS and/or Designee will complete Nebulizer/Trach care Skills validations with a Licensed Nurse twice weekly for 4 weeks, then once weekly for one month, and then monthly for 3 months. The DNS and/or Designee will be responsible for the completion of the Oxygen Therapy CQI tool x 4 weeks, then monthly x 6 months. Any deficiencies will be corrected on the spot, and the findings of the quality assurance checks will be documented and submitted at the monthly Quality Assurance Committee Meeting for further review or corrective action. Audits will be repeated as the Quality Assurance Committee deems necessary.</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 03/01/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HARCOURT TERRACE NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>had clear dried liquid debris on it.</p> <p>b) During an observation of trach care on 3/01/16 at 1:48 p.m., LPN #4 prepared to do trach care for Resident #24. LPN #4 washed her hands for 20 seconds. The trach care procedure papers fell on the floor face down and she picked them up off the floor. She picked up the residents belongings off the bedside table and set them on a chair. LPN #4 then, without washing her hands, donned the gloves from the trach care kit, which included sterile gloves, saline, gauze, and swabs. She took and squeezed the saline and peroxide onto the dry gauze. She removed the dirty gauze with her left hand and placed it on the bedside table surface. The old piece of trach collar gauze had green yellow colored debris on it. LPN #4 took a swab in her right hand and dipped in the saline and washed underneath of the trach collar on the right side with her right hand. She took another swab and dipped it in the saline with her left hand and cleaned the lower left side underneath the trach cannula plate and used her left hand, but was not observed cleaning the upper left top of corner of the trach. She then looked at her trach care procedure paper and stopped the procedure.</p> <p>On 3/01/16 at 2:12 p.m., LPN #4</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 03/01/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HARCOURT TERRACE NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>indicated she observed green drainage on the gauze. She indicated it was not new that the resident had been having pain and drainage when nursing staff touched the stoma area. LPN #4 indicated she had cross contaminated during the trach care. She indicated she was not sure how often the trach, oxygen or nebulizer treatment tubing and equipment had to be changed. She indicated the nebulizer trach mask should be inside of the plastic bag, which was dated 2/24/16.</p> <p>On 3/1/16 at 4:30 p.m., the Director of Nursing Services (DNS) provided the current Nebulizer Treatment Policy, dated 9/2012, which indicated,"...6. Perform pre-assessment including pulse, respiration, and breath sounds...."</p> <p>On 3/1/16 at 4:30 p.m., the DNS provided the Tracheotomy-Routine Care Policy, dated 9/2012. The policy indicated,"...9. Empty contents onto drape. Your dominant hand will remain, 'clean' throughout the procedure...11. With no dominant hand, remove soiled dressing and discard. 12. With clean hand, dampen cotton tip applicators in the peroxide solution. 13. Using the cotton tip applicators swab secretions from around the tracheostomy, paying attention to where the tracheotomy tube enters the skin. Cleanse in one direction</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155149	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 03/01/2016
NAME OF PROVIDER OR SUPPLIER HARCOURT TERRACE NURSING AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260		
(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	
	from top to bottom...." 3.1-47(a)(4) 3.1-47(a)(6)				