

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 04/07/2016
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NAME OF PROVIDER OR SUPPLIER HARCOURT TERRACE NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260
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F 0000 Bldg. 00	<p>This visit was for a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on March 1, 2016. This visit included the PSR to the Investigation of Complaints IN00189411 and IN00190705.</p> <p>Complaint IN00189411-not corrected</p> <p>Complaint IN00190705-not corrected</p> <p>Survey dates: April 6 and 7, 2016.</p> <p>Facility Number: 000070 Provider number: 155149 AIM number: 100266190</p> <p>Census bed type: SNF/NF: 76 Total: 76</p> <p>Census payor type: Medicare: 5 Medicaid: 60 Other: 11 Total: 76</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000	The creation and submission of the Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies or any violation or regulation This Plan of Correction is submitted to meet requirements of state and federal law.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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F 0309 SS=D Bldg. 00	<p>Quality Review was completed by 21662 on April 12, 2016.</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, interview and record review, the facility failed to ensure a non-pressure wound dressing change was performed without the potential for infection for 1 of 3 residents reviewed for dressing change. (Resident #93)</p> <p>Finding includes:</p> <p>On 04/06/2016 at 2:40 p.m., LPN #1 was observed performing the dressing change to Resident #93's left plantar wound. LPN #1 gathered and prepared her supplies. LPN #1 removed the resident's left sock. LPN #1 and LPN #2 performed hand hygiene and donned non-sterile gloves. LPN #1 raised the resident's left foot and removed the soiled dressing and placed the resident's foot back onto the</p>	F 0309	<p>F309 Provide Care/Services For Highest Well Being What correctiveaction will be accomplished for those residents found to have been affected bythe deficient practice? LPN # 1 is no longer employed at Harcourt Terrace. 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 impaired skin integrity and Physician's treatment orders in place have the potential to be affected by this deficient practice. DNS observed dressing change treatments on 4/14/16 for all resident's with current wounds. No other residents have been found to be affected by this practice. What</p>	04/28/2016

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	<p>pillow. LPN #1 raised the resident's left foot and took a folded 4 x 4 gauze and moistened it with normal saline and began cleansing the wound from the center outward and dried the wound from the center of the wound outward with another folded 4 x 4. LPN #1 placed the cleansed foot back onto the pillow where it had rested on, prior to cleansing. She removed her gloves and performed hand hygiene and donned clean gloves. She obtained a cotton tipped applicator and placed the MeSalt (a dressing used to debride wounds) dressing into the wound opening, then placed a 4 x 4 Mepilex over the wound. She inadvertently moved the dressing from the wound and dislodged the MeSalt. LPN #1 asked LPN #2 to retrieve an additional Mepilex. LPN #1 again placed the left foot back on the pillow where it had been resting prior to cleansing. LPN #1 did not remove her gloves. When LPN #2 returned with the Mepilex, LPN #1 picked up the foot, and placed a new MeSalt into the wound using a new cotton tipped applicator and covered it with the new Mepilex.</p> <p>During an interview on 04/06/2016 at 2:45 p.m., LPN #1 indicated she should have prepared a clean place for the foot to rest after cleansing it, instead of placing it back on the pillow.</p>		<p>measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Licensed nurses will be re-educated on the proper procedure for dressing changes by DNS/ Clinical Education Coordinator. Education will be completed by 4/27/2016. Dressing Change Skills Validations will be completed for licensed nurses by 4/27/2016, overseen by DNS/designee.</p> <p>How will the corrective actions be maintained to ensure the deficient practice will not reoccur, i.e., what quality assurance program will be put into place? To ensure compliance, the DNS/ CEC will observe one dressing change treatment per week x 4 weeks, and then one dressing change treatment per month x 3 months. Any observed deficient practice during dressing changes will be addressed immediately with education and/ or disciplinary action if indicated. DNS/designee will complete the Skin Management Program CQI weekly x 4 weeks, then monthly x 3 months, and then quarterly until compliance has been met for two consecutive quarters. Results of CQI's will be reviewed during the monthly CQI meeting overseen by the ED and an action plan will be developed for any CQI results below the threshold of 95%. Education will be provided and</p>	

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F 0323 SS=E Bldg. 00	<p>On 04/07/2016 at 10:28 a.m., Resident #93's record was completed. Diagnoses included, but were not limited to, peripheral vascular disease and hypertension.</p> <p>An "IDT weekly update skin events" dated 04/07/2016 indicated the left plantar foot measurement was 0.4 cm x 0.5 cm x 0.3 cm (centimeters) with undermining noted from 10-1 o'clock. The wound color indicated as "100 gran" (granulation) without drainage or odor.</p> <p>A current policy titled, "[name of facility] Dressing Change (Incision or Wound)" Original Date 01/2010 and review date 09/2012, indicated, "Procedure steps:...5. Set up a clean or sterile field to ensure easy access to supplies during procedure...."</p> <p>This deficiency was cited on 03/01/2016. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-37(a)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p>		disciplinary action taken if indicated.		

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	<p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to ensure the potential for elopement did not occur by failing to secure to a set of double doors on the Cedar Bay unit for the safety of 5 of 5 residents reviewed with elopement risk (Residents #96, #95, #52, #81 and #58).</p> <p>Findings include:</p> <p>On 4/6/16 at 10:28 a.m., the Cedar Bay courtyard left sided exit door was observed ajar open. No facility staff was in the immediate vicinity of the door at that time. LPN #4 was alerted to the ajar door. LPN #4 opened the door completely to an enclosed courtyard with patio furniture, a grill and yard ornaments. She closed the door and indicated, at that time one of the residents liked to come out to the courtyard when she was feeling anxious. There were typed signs on the door window indicating "Please Close Door Completely" and "No Smoking in Courtyard." There was a typed sign in red letters on the middle of the door, which indicated "No Exit."</p>	F 0323	<p>F323 Free Of Accident Hazards/ Supervision/ Devices What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident #96, #95, #52, #81 and #58 did not experience any adverse effects from this deficient practice. On 4/8/16, Integrated Electronics of Indianapolis came to facility to upgrade the locking system on the Cedar Bay courtyard doors. This set of doors is both secured and alarmed. 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 assessed as having the risk for elopement have the potential to be affected by this deficient practice. The doors were programmed and tested by Integrated Electronics of Indiana and verified by facility Maintenance Director. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Staff education has been provided to all staff to assure these doors remain</p>	04/08/2016

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	<p>On 4/7/16 at 10:24 a.m., the Cedar Bay courtyard left sided exit door was observed ajarred open. No facility staff was in the immediate vicinity of the door at that time.</p> <p>On 4/7/16 at 10:26 a.m., the Staff Development Coordinator walked by the courtyard door area and was alerted the door was ajarred open. She indicated, at that time the door was not supposed to be open since there was a sign on the door, which indicated "Please Close Door Completely." She indicated she would find the Maintenance Supervisor to check out the door.</p> <p>During an interview on 4/7/16 at 10:40 a.m., the Maintenance Supervisor indicated the Cedar Bay courtyard left sided exit door should be kept closed and locked at all times. He indicated the door was open because a staff member went out to the courtyard for some reason either "to use their phone or to smoke last night and they snuck back in and did not make sure the door was closed." He indicated the door was not alarmed when the door was left open and there were no cameras out in the courtyard, so he could not say how the staff would know if a resident was out in the courtyard unless the staff seen the resident walking around or wheeling around in his or her</p>		<p>secured at all times. How will the corrective actions be maintained to ensure the deficient practice will not reoccur, i.e., what quality assurance program will be put into place? The Maintenance Director or designee will conduct an audit of these doors 5 times per week x 4 weeks, then 3 times per week x 3 months and then weekly x 3 months or until substantial compliance has been met. Results of audit will be reviewed monthly during CQI meeting overseen by the ED.</p>	

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	<p>wheelchair. The Maintenance Supervisor indicated once a person got out into the courtyard and the exit doors were shut, the person had to know the code to get back in the door. He indicated when the staff brought back or came back to this area to obtain equipment, they should have seen the door was open and shut the door. He indicated he had not given the code to the courtyard keypad to any of the staff, but he used a set of codes for all the doors and the staff must have figured the code out to open the door from his other codes he used. The Maintenance Supervisor indicated he had not thought about what would happen if a resident got out into the courtyard and the door was not alarmed to alert staff the resident was in the courtyard.</p> <p>On 4/7/16 at 2:15 p.m., the Social Service Consultant provided a list of seven resident's residing on the Cedar Bay unit who were at risk for elopement, five residents who had wanderguard bracelets in place and she indicated with a star on the paper two of the residents who were at risk for elopement and had a wanderguard bracelet in place wandered.</p> <p>The following residents records were reviewed for elopement risk assessments and their risk for wandering:</p>			

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	<p>1. Resident #96's record was reviewed on 4/7/16 at 2:48 p.m. Diagnoses included, but were not limited to, dementia, anxiety and history of alcohol dependence.</p> <p>A "Social Services--[Name of Company] Elopement Risk Assessment" dated 1/11/16 at 11:52 a.m., indicated the assessment was a annual assessment. The resident was independently mobile either by ambulation or in a wheelchair. She often requested to go home and/or is searching for home. She exhibited significant cognitive impairment that impacted elopement risk (i.e., consider and assess disorientation to surroundings, poor decision making abilities, etc). The assessment indicated the resident was assigned a security bracelet.</p> <p>2. Resident #95's record was reviewed on 4/7/16 at 3:45 p.m. Diagnoses included, but were not limited to, dementia with behavioral disturbances and psychotic disorder with delusions.</p> <p>A "Social Services--[Name of Company] Elopement Risk Assessment" dated 3/30/16 at 12:39 p.m., indicated the resident was at risk for elopement and had been assigned a wander guard. She was care planned for cutting off the wanderguard. The resident was</p>			

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	<p>independently mobile either by ambulation or in a wheelchair. She exhibited significant cognitive impairment that impacted elopement risk (i.e., consider and assess disorientation to surroundings, poor decision making abilities, etc). The assessment indicated the resident was assigned a security bracelet.</p> <p>3. Resident #52's record was reviewed on 4/7/16 at 3:15 p.m. Diagnoses included, but were not limited to, vascular dementia with delusions, nonorganic psychosis and anxiety.</p> <p>A "Social Services--[Name of Company] Elopement Risk Assessment" dated 12/15/15 at 11:34 a.m., indicated the assessment was a quarterly assessment. The resident was independently mobile either by ambulation or in a wheelchair. He was often see wandering aimlessly/without purpose and he exhibited significant cognitive impairment that impacted elopement risk (i.e., consider and assess disorientation to surroundings, poor decision making abilities, etc). The assessment indicated the resident was assigned a security bracelet.</p> <p>4. Resident #81's record was reviewed on 4/7/16 at 4:10 p.m. Diagnoses</p>			

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	<p>included, but were not limited to, dementia, anxiety, hallucinations and depression.</p> <p>A "Social Services--[Name of Company] Elopement Risk Assessment" dated 3/20/16 at 1:15 p.m., indicated the resident was at risk for elopement and is care planned for a wander guard in place. She was independently mobile either by ambulation or in a wheelchair. She has often bee see wandering aimlessly/without purpose. She exhibited significant cognitive impairment that impacted elopement risk (i.e., consider and assess disorientation of surroundings, poor decision making abilities, etc). The assessment indicated the resident was assigned a security bracelet.</p> <p>5. Resident #58's record was reviewed on 4/7/16 at 4:30 p.m. Diagnoses included, but were not limited to, depression, dementia without behavioral disturbance and psychosis.</p> <p>A "Social Services--[Name of Company] Elopement Risk Assessment" dated 12/16/15 at 1:50 p.m., indicated the assessment was a significant change assessment. The resident was independently mobile either by ambulation or in a wheelchair. She had a history of eloping from home or facility</p>			

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	<p>and she exhibited significant cognitive impairment that impacted elopement risk (i.e., consider and assess disorientation to surroundings, poor decision making abilities, etc).</p> <p>The assessment indicated the resident was assigned a security bracelet.</p> <p>A current policy titled "Elopement (Risk and Missing Resident)" dated 4/97 with a revised date of 10/13, provided by the Director of Nursing Services on 4/7/16 at 10:36 a.m., indicated "...Procedure: 1. Resident identified to be at risk for elopement will be identified as follows: a. The facility will utilize an ELOPEMENT RISK ASSESSMENT to identify residents at risk to leave the facility unattended...c. Resident will be identified as an "Elopement Risk", "Wanderguard", "Electronic Monitoring Device", "Security Bracelet", etc on direct care staff communication method (ie Matrix profile, resident care sheets, etc)..."</p> <p>This deficiency was cited on 3/1/16. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-45(a)(1)</p>			

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F 0328 SS=D Bldg. 00	<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 ensure tracheostomy care was performed to prevent the possibility of infection for 1 of 3 residents reviewed for respiratory care and treatment. (Resident #65)</p> <p>Finding includes:</p> <p>On 04/07/2016 at 10:00 a.m., LPN #3 was observed performing hand hygiene. She opened a tracheostomy care kit and attempted to don sterile gloves contained in the kit, which were too small. The Staff Development Coordinator (SDC) opened an additional package of sterile gloves for LPN #3 to use. She donned the sterile gloves. She removed two sterile barriers and placed them on the resident's chest. LPN #3 opened up a sterile container, and using her left hand, poured hydrogen peroxide mixed with sterile water into one container and sterile water</p>	F 0328	<p>F328 Treatment/ Care For Special Needs What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident #65 did not experience any adverse effects from this deficient practice. 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 requiring trach care have the potential to be affected by this deficient practice. LPN #3 was provided one on one education on proper trach care by CEC on 4/7/16 .LPN #3 was able to demonstrate proper trach care following the Tracheostomy Care nursing skills validation. DNS observed trach care for all residents with trach care orders on 4/14/2016.No other residents were found to be affected by this deficient practice. What measures will be put into place</p>	04/28/2016
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	<p>into another container. During the procedure, the SDC held the resident's head straight, as the resident's head tilted to the left. LPN #3 used her right hand and removed the trache collar and trache dressing. She removed one sterile cotton tipped applicator and dipped it in the hydrogen peroxide mixture with her right hand as she held the trache plate with her left hand. She cleansed the area around the distal aspect of the tracheal stoma once with the cotton tipped applicator, then discarded it. LPN #3 dampened a 4 x 4 with hydrogen peroxide/normal saline mixture and wiped around the outside of the trache plate with her right hand. She followed with a normal saline dampened 4 x 4 and wiped the outside of the trache plate with her right hand. She took one dry 4 x 4 and dried around the outside of the trachea plate with her right hand. She used both hands to place a new split dressing beneath the trache plate and stoma. She removed and discarded her gloves and attempted to don new sterile gloves as provided by the SDC, however she contaminated them as they touched the resident's bed linens. The SDC opened another pack of gloves and LPN #3 donned the sterile gloves without washing her hands. She used her gloved left hand to remove the trache inner cannula and swished the tip of the cannula into the hydrogen</p>		<p>or what systemic changes will be made to ensure that the deficient practice does not recur? All licensed nurses will be re-educated on trach care by 4/27/16 by DNS/designee. SMS provided education on trach care in the facility on 4/22/16. DNS/designee will complete a Trach Care Skills Validation for licensed nurses by 4/27/16. How will the corrective actions be maintained to ensure the deficient practice will not reoccur, i.e., what quality assurance program will be put into place? To ensure compliance, the DNS/ CEC will observe trach care once per week x 4 weeks, and then once per month x 3 months. Any deficient practice observed during trach care will be addressed immediately with education and/ or disciplinary action if indicated. DNS/designee will complete the Tracheostomy Care CQI weekly x 4 weeks, then monthly x 3 months, and then quarterly until compliance has been met for two consecutive quarters. Results of CQI's will be reviewed during the monthly CQI meeting overseen by the ED and an action plan will be developed for any CQI results below the threshold of 95%. Education will be provided and disciplinary action taken if indicated.</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 04/07/2016
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NAME OF PROVIDER OR SUPPLIER HARCOURT TERRACE NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260
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	<p>peroxide/sterile water container and followed by using a brush to cleanse the inner portion of the cannula. She rinsed the tip of the cannula in the normal saline container and used two pipe cleaners to cleanse the inside of the cannula. She replaced the inner cannula. During an interview at that time, LPN #3 indicated she should have washed her hands after removing her gloves. Additionally, she indicated she should have cleansed beneath the trache plate, but it was difficult to do so.</p> <p>Record review for Resident # 65 was completed on 04/07/2016 1:36 p.m. Diagnoses included, but were not limited to, respiratory failure and tracheostomy.</p> <p>A current policy titled, "[Name of Company] Tracheostomy-Routine care Cleaning, Changing Inner Cannula and Change Tracheostomy Ties" dated 09/2012 provided by the Director of Nursing Services (DNS) on 04/07/2016 at 2:50 p.m., indicated, "Procedure Steps..9. Empty contents onto drape. Your dominant hand will remain "clean" throughout the procedure. 10. With you (sic) non-dominant hand, pour equal amounts of peroxide and sterile water/saline into the large side of the compartment tray, and pour sterile water/saline into the smaller side of the</p>			

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	<p>tray....13. Using the cotton tip applicators, swab secretions from area around tracheostomy, paying attention to where the tracheostomy tube enters the skin. (Cleanse in one direction from top to bottom of trachea opening, using one applicator on each side.) Discard applicators. 14. Take one 4 x 4 folded into quarters. Dip in peroxide solution. Use to swab area around the trachea and the back of the trachea tube plate. (Cleanse on side then fold 4 x 4 to clean area and cleanse other side of trachea.) Discard 4 x 4. 15. Take new 4 x 4 folded into quarters. Dip in sterile water/saline solution. Using same technique rinse area of peroxide solution. Discard 4 x 4. 16. Take new 4 x 4 folded into quarters. Dry area using same technique. Discard 4 x 4....18. Upon completion-remove gloves and wash. (or continue with cleaning inner cannula procedure.)....19. With non-dominant hand, remove non-disposable inner cannula and place in peroxide solution....21. Rinse inner cannula in sterile water/saline solution...."</p> <p>This deficiency was cited on 03/01/2016. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-47(a)(4)</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED

OMB NO. 0938-0391

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