

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  04/18/2016
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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 the Investigation of Complaint IN00197967.</p> <p>Complaint: IN00197967 - Substantiated. Federal/State deficiencies related to the allegation are cited at F309 and F327.</p> <p>Survey dates: April 14, 15, and 18, 2016</p> <p>Facility Number: 000070 Provider Number: 155149 AIM Number: 100266190</p> <p>Census Bed Type: SNF: 7 SNF/NF: 69 Total: 76</p> <p>Census Payor Type: Medicare: 5 Medicaid: 59 Other: 12 Total: 76</p> <p>Sample: 6</p> <p>These deficiencies reflect State finding cited in accordance with 410 IAC 16.2-3.1.</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.

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F 0309 SS=E Bldg. 00	<p>Quality review completed April 20, 2016 by 29479.</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, record review and interview, the facility failed to ensure residents who required hemodialysis were assessed for potential complication of dialysis access site and failed to ensure ongoing communication with the dialysis provider for 4 of 4 residents reviewed who received dialysis. (Resident C, D, E, and G)</p> <p>Findings include:</p> <p>1. 4/14/16 at 10 a.m., during initial tour, RN # 1 indicated Resident C had ran a fever the past couple of days and the facility was concerned he might have an infection at his dialysis access site. He was in bed at this time, alert and oriented and indicated he was feeling better.</p> <p>4/14/16 at 11:50 p.m., during an observation with LPN #2, the resident</p>	F 0309	<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. <b>F309 Provide Care/Services For Highest Well Being What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident is no longer in the facility How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?</b> All residents receiving hemodialysis have the potential to be effected by this practice. DNS and IDT team reviewed all</p>	05/11/2016

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	<p>was in bed with the right subclavian intravenous catheter without dressing. It had a double lumen port. At the entrance site to the catheter, there was yellow/gray crusted discharge on the catheter 0.5 centimeters down the catheter and the cite was raised at the entrance and darkened in color. At that time during interview, LPN # 2, indicated the Resident had no orders for the right subclavian catheter on admission and it was "deactivated at the hospital."</p> <p>The record for Resident C was reviewed on 4/14/16 at 11:23 a.m. Diagnoses included, but were not limited to, end stage renal disease, chronic kidney disease and dependence on renal dialysis.</p> <p>(Name of Hospital) discharge orders indicated the resident was set up to receive hemodialysis in the hospital. He had required placement of a catheter in house as his fistula was no longer functioning. He required blood products to control his anemia. At the time of discharge he was working well in therapy, tolerating his diet and was stable.</p> <p>Admission orders, dated 4/8/16, did not indicate orders how to treat or monitor the right subclavian perma-cath.</p>		<p>orders for residents who receive dialysis. All care plans were reviewed for residents with dialysis. DNS visualized all resident's access sites on 4/19/2016 and no signs of infection were noted. No other residents were found to be affected by this deficient practice.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</b></p> <p>Licensed nurses will be re-educated by DNS/ designee on assessing all dialysis access sites upon return from dialysis and as ordered, completing postdialysis assessments, on ensuring appropriate dialysis orders are put into place when resident admits/ initiates dialysis, and on communicating with dialysis after every resident appointment. Education will be completed by 5/11/16. Orders will be obtained to assess blood pressure upon return from dialysis for each resident and will be in place by 5/3/16. Dialysis communication binders were re-initiated and will include resident face sheet, physician's orders, and any other pertinent information. A Dialysis Communication Form will be included in the binders to include any abnormal events that occurred during dialysis on that day. IDT team will review all new admissions on the next</p>	

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	<p>A care plan, dated 4/11/16, indicated the resident received hemodialysis and was at risk for complications such as infection-right subclavian Perma-cath. Approaches included, but were not limited to, assess dialysis access site every shift for excessive bleeding, drainage, swelling, redness, warmth. Document findings and report abnormal to physician and dialysis center.</p> <p>Progress notes indicated:</p> <p>4/8/16 at 2:31 p.m., resident had a right subclavian Perma-cath present with a dressing that was clean dry and intact.</p> <p>4/9/16 at 7:02 p.m., resident not feeling well, temperature 100.9, and was given as needed Tylenol and temp went down to 100.2. Blood pressure was elevated but decreased after p.m., medications.</p> <p>4/10/16 at 3:01 a.m., resident vitals stable except elevated temperature, was given Tylenol, and had a dialysis fistula in his left arm with positive thrill and bruit.</p> <p>4/11/16 at 6 a.m., resident had a dialysis fistula to his left arm with positive bruit and thrill.</p> <p>4/11/16 at 12:02 returned from dialysis, bruit and thrill present and left arm fistual</p>		<p>business day to ensure that all appropriate dialysisorders have been obtained. <b>How will thecorrective actions be maintained to ensure the deficient practice will notrecur, i.e., what quality assurance program will be put into place?</b></p> <p>To ensure compliance, the DNS/designee will complete theDialysis Care CQI weekly x 4 weeks, then monthly x 3 months, and then quarterlyuntil compliance has been met for two consecutive quarters. Results of CQI's will be reviewedduring the monthly CQI meeting overseen by the ED and an action plan will bedeveloped for any CQI results below the threshold of 95%. Education will beprovided and disciplinary action taken if indicated.</p>	

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	<p>present and the right subclavian port was clean dry and intact.</p> <p>4/13/16 the resident complained of nausea and medication given for nausea that was somewhat effective. He also had a fever of 102 degrees Fahrenheit (F) and Tylenol was given and it came down to 101 degrees F. The physician was notified.</p> <p>4/13/16 at 10:10 p.m., resident was found naked with both knees in front of his bed. No injury and the resident denied pain and placed on 15 minute checks.</p> <p>4/14/16 6:43 a.m., temperature was 103.1 degrees F and Tylenol was given and physician and family were notified.</p> <p>4/14/16 at 8:34 a.m., Nephrology office was called and waiting for return call. The note indicated the resident was admitted with a Perma-cath for dialysis and did not receive site care but the site was maintained at dialysis.</p> <p>4/14/16 at 4:02 p.m., new orders were received for chest x-ray, Urinalysis with culture and sensitivity.</p> <p>4/14/16 at 4:08 p.m., new orders were received to send the resident to the hospital.</p>			

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	<p>Admission Assessment dated 4/8/16 indicated the resident had a Right Subclavian Permacath and dialysis fistula in his left forearm.</p> <p>A 72 hour Admission Shift Charting indicated: 4/9/16 at 3:54 a.m., indicated no vascular access device. 4/9/16 at 7:04 p.m., central line with no additional assessment. 4/11/16 at 2:40 a.m., indicated no vascular access device. 4/11/16 at 9:54 a.m., indicated a dialysis fistula with no additional assessment. 4/11/16 at 12:03 p.m., indicated a dialysis fistula with no additional assessment.</p> <p>A physician progress note, dated 4/13/16 at 1:10 p.m., indicated the resident's fistula wasn't functioning and a temporary catheter was placed at hospital in March. The resident was "suspect of SIRS [Systemic Inflammatory Response Syndrome] possible caused line inf. [infection]...."</p> <p>A physician progress note, dated 4/14/16 at 2 p.m., indicated the resident's right chest had "redness and tenderness to palpation," and the resident was being sent to the Emergency Room due to anemia, fever and line pain.</p>			

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	<p>An infection control report, dated 4/14/16 at 9:53 a.m., with occurrence date of 4/13/16 indicated signs and symptoms: change in functional status, temp 100-103 degrees F with invasive devices of right subclavian Perma-cath and left arm fistula.</p> <p>During an interview with the Nurse Practitioner on 4/14/16 at 2:44 p.m., she indicated the right subclavian Perma-cath was being utilized for dialysis. She was informed at this time, the Perma-cath did not have a dressing on it this morning.</p> <p>During an interview with LPN # 6 on 4/14/16 at 2:46 p.m., she indicated the resident had a dressing on the Perma-cath yesterday and she had no way to ensure how long the dressing had been off.</p> <p>A (name of dialysis center) hemodialysis flowsheet, dated 4/11/16, indicated the resident arrived at the center without a dressing on the Perma-cath. The flowsheet also indicated the fistula did not work.</p> <p>During an interview the RN Educator of the (name of dialysis center) on 4/15/16 at 11:40 a.m., she indicated the resident had arrived at the facility without a dressing on the Perma-cath site. She</p>			

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	<p>indicated the center had contacted the facility regarding the missing dressing and the facility was unsure how long or why the dressing had been off. The facility staff indicated the resident may have removed it himself. The RN Educator indicated she had not been contacted by the facility staff for orders or directives oh how to treat the Perma-cath site.</p> <p>A (name of hospital) emergency room record, dated 4/14/16, indicated the resident presented with a temperature on 100.1 degrees F, and was seen for fever and abdominal pain.</p> <p>Resident facility admission orders failed to have an order for right subclavian Perma-cath site checks every shift and the record failed to accurately assess the site and the non-functional fistula.</p> <p>On 4/18/16 at 12:10 p.m., the DON indicated she had no additional information to provide regarding the inaccurate documentation of the dialysis access site or the failure to assess the site.</p> <p>2. The record for Resident D was completed on April 14, 2016 at 3:31 p.m. Diagnoses included, but were not limited to, dependence on renal dialysis.</p>			

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	<p>During an interview on 4/14/16 at 2:15 p.m., with LPN # 4, she indicated the dialysis communication book should be updated monthly with face sheet, medications, and labs. She indicated when the resident came back from dialysis she would check the book to make sure there were no new orders. At that time LPN # 3 went to the resident's room and nursing station and could not locate the book. She indicated it must have been left at dialysis. LPN # 3 indicated at that time, the facility does utilize a communication book for residents on dialysis.</p> <p>3. The record for Resident E was reviewed on 4/14/16 at 3:50 p.m. Diagnoses included, but were not limited to, renal dialysis status.</p> <p>A plan of care dated 3/22/16 indicated the resident was cognitively unimpaired.</p> <p>During an interview with Resident E on 4/14/16 at 2:32 p.m., he indicated he went to dialysis 3 times a week and that he had not seen his communication book for several weeks.</p> <p>During an interview with the LPN # 6 on 4/14/16 at 2:34 p.m., he indicated the resident kept possession of his book and was unsure at this time where it was</p>			

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	<p>located.</p> <p>4. The record for Resident G was reviewed on 4/15/16 at 4:45 p.m. Current diagnoses included but were not limited to, Diabetes Mellitus and end stage renal disease.</p> <p>During an interview with LPN # 5 on 4/14/16 at 2:35 p.m., she indicate the resident went to dialysis and she provided his dialysis communication book. The last orders in the book was dated 9/23/15 and the most recent communication with the dialysis center was 2/1/16.</p> <p>A policy titled Dialysis Care was provided by the Executive Director on 4/14/16 at 4:30 p.m., and deemed as current. The policy indicated: "...1. Dialysis residents will be assessed at admission to include dialysis access site, bruit and thrill, drainage, condition of skin, and vital signs. 2. Orders will be received at the time of admission specific to the Dialysis resident's specific care as ordered by the physician, such as...Site care...4. An assessment of the resident's dialysis access site will be completed every shift to include...condition of skin drainage, warmth, redness...7. The nurse in charge at time of return will review paperwork for new orders and/or paperwork accompanying the resident...."</p>			

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F 0327 SS=G Bldg. 00	<p>This Federal tag relates to complaint IN00197967.</p> <p>3.1-37(a)</p> <p>483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.</p> <p>Based on record review and interview, the facility failed to ensure hydration needs were met to prevent significant dehydration and hospital admission for 1 of 3 residents reviewed for hydration needs. (Resident B)</p> <p>Finding includes:</p> <p>The record for Resident B was reviewed on 4/14/16 at 10:23 a.m. Diagnoses included, but were not limited to, Alzheimer's Disease, malignant neoplasm of lung, secondary malignant neoplasm of bone, acute cystitis, and stage 3 chronic kidney disease.</p> <p>Admission assessment, dated 3/28/16,</p>	F 0327	<p><b>F327 Sufficient FluidTo Maintain Hydration</b></p> <p><b>What correctiveaction will be accomplished for those residents found to have been affected bythe deficient practice?</b></p> <p>Resident B no longer resides in this facility</p> <p><b>How other residentshaving the potential to be affected by the same deficient practice will beidentified and what corrective actions will be taken?</b></p> <p>All residents have the potential to be affected by thisdeficient practice. DNS/Designeeconducted Hydration reviews on all residents on May 11, 2016. Any residentfound to be at risk for dehydration was addressed immediately and new ordersfor additional fluids obtained.</p> <p><b>What measures will beput into</b></p>	05/11/2016

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	<p>indicated the residents oral mucous was moist and intact and was a full code.</p> <p>Progress notes, dated 3/28/16, indicated the resident was alert and oriented x 2, and was able to verbalize needs and wants to staff, able to take medications without difficulty, and the family was very involved.</p> <p>A 3/29/16 hydration assessment indicated the resident needed assistance with food and fluids and the resident needed individualized interventions to meet fluid needs and if the intake of fluids provided decreased, then the physician would be notified.</p> <p>A plan of care, dated 3/29/16, indicated the resident was at risk of fluid imbalance, with approaches that included, but were not limited to, encourage fluids, record intake, and notify the physician of dry mucous membranes, change in mental status and poor skin turgor.</p> <p>A plan of care, dated 3/30/16, indicated the resident refused his medication or spit them out at times, with approaches that included, but were not limited to, staff will attempt various methods of administration per doctors orders to help the resident take his medications.</p>		<p><b>place or what systemic changes will be made to ensure that the deficient practice does not recur?</b></p> <p>DNS/ Designee will run the intake/output report Monday through Friday to determine all resident's intakes and identify those who are at risk for fluid imbalance r/t consuming less than 1000ml daily. The Weekend Supervisor/Designee will run the intake/output report on Saturday and Sunday, reviewing all fluids at meals. Interventions will be put in place to promote hydration as indicated. Department heads have been educated by the DNS/ ED on the Dining Room Manager Observation Checklist to observe residents for adequate consumption of fluid intake. All Dining Room Checklists will be completed daily and be overseen by the ED/Designee. All checklists will be reviewed on the next business day and reviewed monthly in QA meeting. DNS/Designee have in-serviced nursing staff on adequate fluid consumption. ED has educated dietary staff on providing additional large cups (240cc) and making a sufficient amount of drinks so that at least 480cc of fluid may be served to residents at each meal. Hydration carts have been made available daily to encourage increased fluid intake.</p> <p><b>How will the corrective actions be maintained to ensure the deficient</b></p>	

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	<p>A nutrition assessment, dated 4/5/16 at 11:23 a.m., from the Dietician, indicated the resident required cueing and staff assistance during meals. The resident's fluid intake was low, less than 1000 milliliters per day. After discussion with he residents daughter who inquired about oral supplements, it was recommended to provide Ensure Plus 237 milliliters at 10 a.m., and 2 p.m., and increase fluids to provide additional 240 milliliters between meals to promote adequate hydration.</p> <p>Physician orders, dated 4/6/16, indicated Ensure plus 237 milliliters twice a day at 10 a.m., and 8 p.m., and offer 240 milliliters of fluid at 10 a.m., 2 p.m., and 8 p.m.</p> <p>The April 2016 Medication Administration Record indicated the new orders for Ensure Plus and the extra 240 milliliters of fluids was first implemented on 4/7/16 at 8 p.m.</p> <p>The record indicated the following amounts of fluids consumed daily, and daily amounts were not totaled by the facility to ensure fluid needs were met.</p> <p>4/3/16 840 milliliters 4/4/16 340 milliliters</p>		<p><b>practice will not recur, i.e., what quality assurance program will be put into place?</b></p> <p>To ensure compliance, the DNS/Designee will complete the Hydration Management CQI weekly x 4 weeks, then monthly x 3 months, then quarterly until compliance has been met for two consecutive quarters. DNS/Designee will run the intake/output report daily x 4 wks, then weekly ongoing. 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  04/18/2016
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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>4/5/16 500 milliliters 4/6/16 170 milliliters 4/7/16 797 milliliters 4/9/16 765 milliliters 4/10/16 540 milliliters</p> <p>A progress note, dated 4/10/16 at 6:58 p.m., indicated, "Resident daughter came in due to the visitors, calling her complaining resident did not look right to them..." Vital signs were taken and blood pressure was 110/63, pulse was 88 and heart rate was 18, pulse oximetry was 95 % and blood sugar was 144. Resident appeared to be in no distress...due to the family demanding the resident be sent out, resident was sent out 911."</p> <p>On 4/10/16 at 6:40 p.m., a "Physician Communication Tool" indicated the resident was a full code, skin was warm and dry, he was alert and oriented and confused, the "problem uncertain, patient deteriorating" and "family requested..."</p> <p>A event note, dated 4/10/16 and timed 7:02 p.m., indicated at 6:17 p.m., the resident was in bed, was pocketing medications in his mouth and "talked resident into swallowing his medications" and under "note their effectiveness" documented "was not effective." The note indicated the physician was notified and the daughter was notified.</p>			

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	<p>Interventions included "educate resident on swallowing meds."</p> <p>A (Name of Hospital) emergency room note, dated 4/10/16, indicated the resident had a temp of 100.1 degrees Fahrenheit (F), had "remembrance of medications on tongue and roof of mouth upon arrival," had altered mental status and somnolence. He was found unresponsive at the Nursing Home and his mouth was dry, and his tongue was coated with "yellow film." He was given 1000 milliliters of fluid intravenous over 1 hour at 7:35 p.m., and at 8:49 p.m.</p> <p>(Name of Hospital) laboratory report, dated 4/10/16, indicated the resident's chloride was 119 (high, normal 96-106), Sodium was 153 (high, normal 135-145) his BUN (Blood Urea Nitrogen) was 91 (high, normal 7-20), Creatinine was 4.02 (high, normal 0.7-1.2).</p> <p>A (Name of Hospital) physician note, dated 4/10/16, indicated the resident was "significantly dehydrated" and the resident would be admitted to the hospital on the Progressive care unit. The resident was hypernatremic (high sodium) and hyperchloremic (high chloride) and had a total body free water deficit was 3.5 liters. The note indicated the resident had "apparently has been</p>			

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	<p>pocketing food in his mouth" and had Acute Renal Failure secondary to dehydration.</p> <p>Additional information was requested regarding Resident B's intakes and delay in implementing hydration recommendations on 4/18/16 at 10:50 a.m.</p> <p>On 4/18/16 at 12:10 p.m., the DON indicated she had no further information to provide.</p> <p>This Federal tag relates to complaint IN00197967.</p> <p>3.1-46(b)</p>				