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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155636 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 07/14/2014 |
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| NAME OF PROVIDER OR SUPPLIER HARRISON TERRACE | STREET ADDRESS, CITY, STATE, ZIP CODE 1924 WELLESLEY BLVD INDIANAPOLIS, IN 46219 |
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| F000000 | <p>This visit was for a second Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on May 1, 2014.</p> <p>This visit was in conjunction with the PSR to the Investigation of Complaint IN00150753 completed on June 19, 2014.</p> <p>Survey Dates: July 14, 2014.</p> <p>Facility number: 000241 Provider number: 155636 AIM number: 100291310</p> <p>Survey Team: Karina Gates, Generalist TC Tom Stauss, RN Beth Walsh, RN</p> <p>Census Bed Type: SNF/NF: 104 Total: 104</p> <p>Census Payor Type: Medicare: 11 Medicaid: 81 Other: 12 Total: 104</p> <p>These deficiencies reflect state findings</p> | F000000 | The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. | |
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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| F000309 SS=A | <p>cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on July 17, 2014 by Cheryl Fielden, RN.</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 urinalysis was obtained as ordered for 1 of 3 residents reviewed for laboratory services. (Resident A)</p> <p>Findings include:</p> <p>The clinical record for Resident A was reviewed on 7/14/14 at 10:30 a.m. The diagnoses for Resident A included, but were not limited to, Alzheimer's disease.</p> <p>The 7/10/14 Physician Telephone Order indicated, "Obtain CMP (comprehensive metabolic panel), CBC (complete blood</p> | F000309 | <p>F309 Provide care/ services for highest well being It is the practice of this provider to ensure that all alleged violations involving the notice to residents of rights, rules, services, and charges are in accordance with State and Federal law.</p> <p>What corrective action(s) will be taken for those residents found to have been affected by the deficient practice? Resident A had a urine sample obtained on 7-15-2014 and the results show Resident A had no evidence of a Urinary Tract Infection.</p> | 07/25/2014 | | | |

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| | <p>count) with diff (differential), U/A (urinalysis) & urine cx (culture)." The order was written by Physician #1.</p> <p>The results of the urinalysis and urine culture could not be found in the clinical record.</p> <p>An interview was conducted with UM (Unit Manager) #2 on 7/14/14 at 11:30 a.m. regarding the results of the urinalysis ordered on 7/10/14. He reviewed Resident A's lab results and stated, "I don't see the urinalysis. Let me go call (name of laboratory services company.) At this time, UM #2 called the laboratory services company. After getting off the phone, he indicated, "The nurse called and canceled it. I don't know why. I'll look into it." At this time, the DON (Director of Nursing) joined the conversation and indicated, "It seems like they couldn't get the specimen, but since the white blood cell count wasn't high, the doctor said to forget about the urinalysis, but let me double check."</p> <p>The 7/14/14, 11:53 a.m. IDT (Interdisciplinary Team) note, created by UM #2, indicated, "Spoke with charge nurse regarding reason for canceling urine order. Nurse stated she forgot to write order confirmed with (name of Physician #1) to D/C (discontinue) order</p> | | <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>All residents with orders for urinalysis have the potential to be affected by this alleged deficient practice. The Clinical Education Coordinator will inservice the licensed nursing staff on the importance of obtaining urine specimens when ordered and if unable to obtain the urine specimens, will document attempts to collect, in the progress notes and notify the MD if unable to obtain. All labs orders received within the last 7 days were reviewed to ensure urine specimens were collected per physician's orders by DNS/Designee.</p> <p>What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?</p> <p>When a urinalysis order is obtained, the facility nurse will attempt to collect the urine specimen. If unable to obtain the urine specimen during their shift, they will document attempts in the progress notes and pass information along to the next shift. If the next shift nurse is unable to obtain the specimen, they will also document their efforts in the progress notes and notify the MD. The nurse management team will review all urinalysis orders Monday thru Friday</p> | | | | |

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| | <p>due to unable to obtain."</p> <p>The above mentioned 7/14/14, 11:53 a.m. IDT note was edited by UM #2 on 7/14/14 at 12:02 p.m. It indicated, "Spoke with charge nurse regarding reason for canceling urine order. Nurse stated she forgot to write order confirmed with (name of Physician #1) to D/C order."</p> <p>Another interview was conducted with the UM #2 and the DON on 7/14/14 at 12:20 p.m. UM #2 stated, "I talked to (name of Nurse #3). She spoke with (name of Physician #1) who said we could go ahead and cancel if they couldn't obtain the lab." The DON indicated (name of Physician #1) and (name of Physician #2) work together very closely." The DON provided the telephone numbers for Nurse #3 and Physician #1.</p> <p>A telephone interview was conducted with Nurse #3 on 7/14/14 at 12:30 p.m. regarding the urinalysis order for Resident A. She indicated, "He is a hard person to get the urinalysis from. He's not able to make that connection. He gets guarded when you mess with that area. He knows I'm not his wife because he says "No, (name of Resident A's wife.)" She indicated she attempted to</p> | | <p>to ensure appropriate efforts to attempt to collect the specimen, documentation and MD notification. House Supervisor will review residents with orders for urinalysis on Saturdays and Sundays. The DNS/Designee will also review residents with orders for urinalysis Monday through Friday, to assure specimens are collected, attempts are documented in progress notes and appropriate MD notification.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?</p> <p>A lab diagnostics CQI will be completed for 6 months with audits being completed once weekly for one month, then monthly thereafter for a total of 6 months by a nurse manager or designee.</p> <p>A lab diagnostics CQI tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 100% threshold is not achieved an action plan will be developed.</p> <p>Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee.</p> | |

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| | <p>collect the urine specimen on Friday, 6/11/14. She indicated she worked from 6:00 p.m. on 7/11/14 to 6:00 a.m. on 7/12/14 "When I came in at 6 p.m. on 7/11, (name of nurse on previous shift) told me I needed to get the culture. I don't know if it was attempted prior to me. I faxed the doctor an FYI 'not able to get u/a.' I didn't hear anything back. I haven't worked since then." Regarding an order to discontinue the urinalysis and urine culture, she indicated, "I believe (name of Physician #2 dc'd (discontinued) the order because we cant force the u/a, so I assume that is what (name of Physician #2) would do." Regarding the original fax sent to to Physician #2, Nurse #3 indicated, "I put the original in the shredder." Regarding a fax confirmation page, Nurse #3 indicated, "I imagine I got the confirmation, but I don't remember. That's typically what I always do." She did not indicate she ever spoke with Physician #2 or received an order to discontinue the urinalysis and urine culture.</p> <p>The progress notes from 7/10/14 to 7/14/14 at 11:52 a.m. did not indicate any attempts to collect a urine culture from Resident A. No where in the clinical record was there an order to discontinue the urinalysis and urine culture ordered</p> | | | |

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| | <p>on 7/10/14, or evidence of a fax sent to Physician #1 or Physician #2 informing of inability to obtain a u/a from Resident A.</p> <p>A telephone interview was conducted with Physician #1 on 7/14/14 at 12:42 p.m. He indicated, "(Name of UM #2) just told me about not getting the urinalysis. I told him we should in and out cath (catheterize) him. I'm concerned with his changes lately....He's been pretty ramped up lately. We need to in and out cath him. No one told me before today, they couldn't get the u/a. I know his white blood cell count was normal, but I still think he needs the in and out to rule out a UTI (urinary tract infection.) I wrote for the order (7/10/14 urinalysis order.) It's difficult to know if it's delirium or progression of dementia."</p> <p>A telephone interview was conducted with Physician #2 on 7/14/14 at 1:05 p.m. regarding whether the facility informed her they could not obtain the u/a from Resident A. She indicated, "I don't know if anyone ever told me they couldn't get the u/a. I was in the building on Friday (7/11/14), and no one ever mentioned anything to me about not being able to get the u/a. I don't have a problem with an in and out (catheterization), even though he (Resident A) might not like it</p> | | | |

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

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| | very much." 3.1-37(a) | | | | |