

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  08/21/2013
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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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F000000	<p>This visit was for the Investigation of Complaints IN00133954 and IN00134432.</p> <p>Complaint: IN00133954 Substantiated. Federal/State deficiency related to the allegation is cited at F314.</p> <p>Complaint IN00134432 Substantiated. Federal/State deficiencies related to the allegations are cited at F241, F249 and F323.</p> <p>Survey dates: August 19 &amp; 21, 2013</p> <p>Facility Number: 000070 Provider Number: 155149 AIM Number: 100266190</p> <p>Survey Team: Mary Jane G. Fischer RN</p> <p>Census Bed Type: SNF: 9 SNF/NF: 92 Total: 101</p> <p>Census Payor Type: Medicare: 12 Medicaid: 80 Other: 9</p>	F000000	F000 Request a face to face IDR for disagreement of scope and severity for F314.	

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

TITLE

(X6) DATE

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

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	<p>Total: 101</p> <p>Sample: 9 Supplemental sample: 23</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review was completed by Tammy Alley on August 26, 2013.</p>				

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F000241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on interview and record review the facility failed to ensure the dignity of each resident in that when residents had direct interaction with the Activity Director the residents indicated the staff member treated and spoke to them in a rude manner for 3 of 3 resident's interviewed in a sample of 9. (Resident's "D", "E" and "H").</p> <p>Findings include:</p> <p>1. During an interview on 08-19-13 at 12:00 p.m., Resident "D" approached this surveyor with concerns related to the Activity Director. The resident indicated the following: "She's horrible and talked down to me and the other residents. I asked her if she treated me like this because I am Caucasian and she denied it but I've had other African Americans take care of me and they don't treat me the way she does. We made muffins on Saturday and I was testing to see if they were done and she told me I didn't need to do that - it's the way</p>	F000241	<p>The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Post Survey Review on or after September 5, 2013. F241 Dignity and Respect of Individuality It the practice of this provider to promote care for the residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The Activity Director was suspended on August 21, 2013 and terminated on August 23, 2013. Residents D, E and H complaints were reported to the Indiana State Board of Health. How will you identify other residents having the potential to be affected by the same deficient practice</p>	09/05/2013			

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	<p>she talked to me in front of everyone. She got me so upset, I left the activity and took my muffin to my room. When we went to [name of local department store] she kept telling me I didn't have the money to buy this or that. I know how much money I had - it was around \$50.00 and she didn't need to tell me what I can and can't buy. She did this when other residents were around. She is always at the Resident Council meetings and we can't really complain about her when she is taking the minutes. I'm going to talk to [name of Administrator] today and let her know what happened on Saturday."</p> <p>Review of the resident's record on 08-19-13 at 11:30 a.m., indicated the resident, who was assessed on 06-13-13 for the Minimum Data Set assessment, indicated the resident had no cognitive impairment.</p> <p>2. During an interview on 08-19-13 at 12:20 p.m., Resident "E" who was also assessed without cognitive impairment, indicated she had tried to talk to the Activity Director but she acts like I'm not there. She indicated this made her feel bad about herself. When interviewed if she attended the out of building activities the resident indicated she had gone to the (name</p>		<p>and what corrective action will be taken? All residents have the potential to be effected by the alleged deficient practiceActivity staff will be re-educated on Dignity and Respect of individuality of residents by September 5, 2013.Nursing staff will be educated on Dignity and Respect of individuality of residents by September 5, 2013by the Staff Development Administrator/designee to monitor for compliance. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? Activity staff will be re-educated on Dignity and Respect of individuality of residents by September 5, 2013.Nursing staffwill bere-educated on Dignity and Respect of individuality of residents by September 5, 2013by the Staff Development Noncompliance with the facility policy and procedures may result in employee education and /or disciplinary action.ED/designee will provide supervision of staff/residents of activities outside of the facility to ensure dignity.ED/Designee will ensure staff attending resident council will be rotated with permission from resident council residents to ensure residents can voice concerns freely. ED/Designee will ensure rotation will occur within resident council with resident's permission.</p>				

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	<p>of local area department store). "She told everyone how much money everyone had to spend. It's no one else's business."</p> <p>3. During an interview on 08-21-13 at 1:30 p.m., with a resident [Resident "H"], and identified as alert and oriented indicated "She is just snooty and I could tell she really wanted to get in to it with me. She told us she paid for Netflix [a movie channel], and then she wouldn't let us watch it. She wanted to decide what we could and couldn't see. She actually hid the remotes. She yelled at [name of Resident "D"] in front of everyone over the weekend. [Name of Resident "D"] left the activity. I don't know what her problem was, you can't even have a conversation with her, she won't let that happen."</p> <p>4. A review of the Activity Director's employee file indicated she had had been disciplined on 06-27-13 as being "unapproachable" and cautioned her to "watch her tone."</p> <p>This Federal tag relates to Complaint IN00134432.</p> <p>3.1-3(t)</p>		<p>Administrator/designee will monitor for compliance. 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? A Dignity and Privacy CQI tool will be utilized weekly x 4, monthly x 2, and quarterly thereafter for one year. Data will be submitted to the CQI committee for follow up. If 95% a threshold is not achieved, an action plan will be developed. Completion Date: September 5, 2013.</p>		

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F000249 SS=E	<p>483.15(f)(2) QUALIFICATIONS OF ACTIVITY PROFESSIONAL</p> <p>The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who is licensed or registered, if applicable, by the State in which practicing; and is eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or has 2 years of experience in a social or recreational program within the last 5 years, 1 of which was full-time in a patient activities program in a health care setting; or is a qualified occupational therapist or occupational therapy assistant; or has completed a training course approved by the State.</p> <p>Based on interview and record review the facility failed to ensure the Activity Director monitored and supervised the activity program for the resident's, in that when the facility scheduled out of the building activities at a local area department store the Activity Director failed to ensure documentation of participation, and accountability of the activity program. This deficient practice effected 2 of 9 sampled and 23 supplemental sampled resident's.</p> <p>(Residents "E", "J", "K", "L", "M", "N" "O", "P", "Q", "R", "S", "T" "U", "V" , "W", "X", "Y", "Z", "AA", "BB", "CC", "EE", "FF", "GG" and "HH").</p>	F000249	F249 Qualifications of Activity Professional It the practice of this to have activities program directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who is licensed or registered, if applicable, by the state in which practicing; and is eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1190; or has 2 years experience in a social or recreational. Program within the last 5 years, 1 of which was full-time in a patient activities program in a health care setting; or is a qualified occupational therapist or occupational therapy	09/05/2013

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	<p>Findings include:</p> <p>During an interview on 08-19-13 at 10:35 a.m., Activity Assistant #6, indicated the facility bus was used when the residents go on an outing. "It holds 2 wheelchairs and usually 3 - 6 residents go. I don't like going because the residents who are not in a wheelchair will just walk off. [Name of the Activity Director] went to [name of the local area department store] alone with the residents - that happened a few times."</p> <p>A review of the individual resident specific attendance calendars for the months of June, July and August 2013 indicated the facility had scheduled outing to a local area department store on June 4, 11, 18 and 25, 2013 and July 2, 9 and 30, 2013 and August 13, 2013.</p> <p>On 08-19-13 at 10:15 a.m., the individual resident activity records were reviewed and 10 residents (Residents "W", "L", "N", "X", "E", "Y", "S", "P", "K", and "AA") went to the June 4th outing, 7 residents (Residents "Z", "BB", "L", "O", "Q", "P", and "CC") went on the June 11th outing, 13 residents (Residents "W", "J", "U", "N", "O", "X", "V", "R", "T", "K" "S", "Q" and "P") went on the</p>		<p>assistant; or has completed a training course approved by the state. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Upon review Activity Directors certification was verified to be in compliance. The Activity Director was suspended on August 21, 2013 and terminated on August 23, 2013. Activity staffs are monitoring resident participation and document participation accordingly for residents attending outside facility activities.</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? Upon review Activity Directors certification was verified to be in compliance. Personnel certified as Activity Director is currently in place until a qualified replacement is determined. The Administrator is currently reviewing qualified candidates for the Activity Director position. ED/designee will send at minimum 2 staff members with proper qualifications on activity outings to ensure safety and proper supervision. ED/Designee will provide education to activity staff on proper documentation for facility outings.</p> <p>Administrator/designee to monitor for compliance. What measures will be put into place or what systemic changes you will make</p>				

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	<p>June 18th outing and 2 residents (Resident's "E" and "K") went on the June 25th outing.</p> <p>The documentation indicated on July 2nd (2013) 6 residents (Residents "J", "L", "EE", "M", "K", and "E"), attended the outing, 4 resident's (Resident's "N", "FF", "E" and "K") attended the July 9th outing and 3 resident's (Residents "S", "D" and "GG") attended the July 30 outing.</p> <p>The records indicated 5 resident's (Resident's "Q", "HH", "K", "O" and "G") attended the August 13 outing.</p> <p>During an interview on 08-19-13 at 1:37 p.m., the Activity Director indicated the facility bus "holds 8 residents plus 2 residents in wheelchairs. An aide usually goes with me." The specific resident participation calendars were reviewed with the Activity Director who indicated she was unsure of the "color coding system" used to identify which resident's attended and those who didn't attend the activities. A request was made for her to review and provide the names of the resident's who attended the facility outings to the local area department store and which facility employees assisted her in the supervision of the resident's.</p>		<p>to ensure that the deficient practice does not recur? Personnel certified as Activity Director is currently in place until a qualified replacement is determined. ED/designee will send at minimum 2 staff members with proper qualifications on activity outings to ensure safety and proper supervision. Administrator/designee will monitor for compliance. 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? An audit of activity calendar/logs was conducted by ED/Designee to ensure participation of residents in facility outings was accurate. The Activity CQI tool will be utilized weekly x 4, monthly x 2, quarterly thereafter. Administrator/designee will continue to ensure proper licensure/certification of staff. Completion Date: September 5, 2013.</p>				

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	<p>On 08-21-13 at 8:30 a.m., the Executive Director provided the list as requested. The list as provided by the Activity Director included the names, dates and facility staff who participated in the facility outings as follows:</p> <p>June 4th - 3 residents (Residents "K", "E" and "S") and 2 staff members          June 11th - 5 residents (Residents "O", "Q", "BB", "CC", "T") and 3 staff members          June 18th - 5 resident's (Residents "K", "O", "V", "J" and "N") and 2 staff members          June 25th - no documentation          July 2nd - 3 residents (Residents "J", "O" and "K") and the Activity Director          July 9th - 4 resident's (Residents "E", "K", "BB" and "N") and 2 staff members          July 30th - 2 residents (Residents "D" and "K") and 2 staff members.</p> <p>On 08-21-13 the Executive Director reviewed the specific resident activity participation documentation, since the documentation provided by the Activity Director did not correlate with the specific resident attendance records.</p> <p>The Executive Director reviewed the</p>				

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	<p>documentation with the Administrator in Training and the Director of Nurses in attendance. The color coded system was used to validate attendance/participation and indicated the following:</p> <p>June 4th - 6 residents (Residents "N", "E", "Y", "S", "P", and "K") were identified as participating in the outing, with 3 residents with questionable participation.</p> <p>June 11th - 5 residents (Residents "BB", "O", "Q", "P" and "CC") participated in the outing with 1 resident questionable in participation.</p> <p>June 18th - 10 resident's (Residents "J", "N", "O", "V", "R", "T", "K", "S" "Q" and "P") participated in the outing with 3 resident's with questionable participation.</p> <p>July 2nd - 6 resident's (Residents "J", "L", "EE", "M", "K" and "E") participated in the outing.</p> <p>July 9th - 3 resident's (Residents "N", "E" and "K") participated in the outing with 1 resident with questionable participation.</p> <p>July 30th - 2 resident's (Residents "D" and "GG") participated in the outing</p>			

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	<p>with 1 resident with questionable participation.</p> <p>On 08-21-13 the Corporate Social Service/Activity staff arrived at the facility to determine if the participation documentation was accurate and the availability of facility staff intervention was adequate for the supervision of the residents while away from the facility.</p> <p>Further investigation of the Activity scheduled outing on June 18th indicated 10 resident's attended, with 5 residents wheelchair bound (Resident's "P", "J", "O", "R", and "S") and 2 residents ambulatory with the use of a cane (Resident "N" and "T"), 1 resident ambulatory with the use of a walker (Resident "V") and the remaining residents ambulatory. The residents who attended this activity, 2 of the residents had "severe cognitive impairment (Residents "R" and "U").</p> <p>The Activity scheduled outing on July 2nd indicated 5 residents attended, with 4 of the 5 residents wheelchair bound (Resident's "J", "L", "M", and "E") and the one resident was ambulatory (Resident "K"). In addition 1 family member met Resident "J" at the local area department store to assist her with</p>						

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	<p>shopping and was not there to assist other residents needs or supervise. On this shopping trip, the Activity Director supervised the remaining resident's.</p> <p>The facility was unable to provide documentation which indicated actual participation of the residents who attended out of the building shopping trips and questionable supervision on July 2, 2013 with only the Activity Director in attendance.</p> <p>Review of the Activity Director's, date of hire 05-31-13, with a signed, but undated job description indicated the following:</p> <p>"Summary of Position Functions [bold type and underscored] - manages and assumes administrative authority, responsibility and accountability a program of therapeutic activities designed to meet the interests and enhance the functional abilities and self esteem of each resident in accordance with state and federal laws and regulations."</p> <p>This Federal tag relates to Complaint IN00134432.</p> <p>3.1-33(d)(4)</p>				

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F000314 SS=G	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>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 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 observation, record review and interview the facility failed to ensure a resident did not acquire a pressure ulcer, in that when a dependent resident entered the facility without a pressure ulcer, acquired an ulcer which progressed in size and required additional interventions by a contracted wound specialist to aide in the resolution of the area. This deficient practice affected 1 of 4 residents reviewed with pressure ulcers in a sample of 9. (Resident "A").</p> <p>Findings include:</p> <p>The record for Resident "A" was reviewed on 08-19-13 at 8:50 a.m. Diagnoses included, but were not limited to, cerebral vascular accident, myocardial infarction, hypertension, diabetes mellitus and ischemic heart</p>	F000314	<p>F314 Requesting face to face IDR for disagreement of scope and severity. F314 Treatment/SVCS to prevent/heal pressure sores It the practice of this provider to ensure to ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical 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. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident A no longer resides at the facility. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be</p>	09/05/2013			

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	<p>disease. These diagnoses remained current at the time of the record review. The resident was admitted to the facility on 04-16-13.</p> <p>At the time the resident was admitted to the facility, the previous Extended Care Facility included a physician's "History and Physical," dated 04-13-13, in which the resident had "slit ulcers under each breast - slight slough" and included the physician orders which instructed the nursing staff to apply Xenaderm ointment to the right breast and Voltaren 1% gel to bilateral breasts.</p> <p>A facility "observation report," dated 04-19-13 indicated the resident was alert to time, place and person, and had lower body and right handed weakness and did not have a pressure ulcer. The resident's skin was intact.</p> <p>A review of the Admission Minimum Data Set assessment, dated 04-22-13, indicated the resident required extensive assistance with bed mobility, and transfer. In addition the resident was frequently incontinent of bowel and bladder, had physical limitations to one side and did not have a pressure ulcer at the time of the assessment.</p>		<p>effected by the alleged deficient practiceA skin sweep has been conducted by DNS/designee to ensure all interventions are in place to promote healing, prevent infection and prevent new sores from developingNursing staff will bere-educated on skin management program by September 5, 2013by the Staff Development DNS/designee to monitor for compliance. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? Nursing staff will be educated on skin management program by September 5, 2013by the Staff DevelopmentSkin sweeps will be held monthly Noncompliance with the facility policy and procedures may result in employee education and /or disciplinary action.A Nurse rounds sheet will be completed each shift to ensure residents are receiving services per plan of care Director of Nursing Services/designee will monitor for compliance. 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? A skin management program CQI tool will be utilized weekly x 4, monthly x 2, and quarterly thereafter for one year.Data will be submitted to the CQI committee for follow up.If95% a threshold is not achieved, an action plan will be</p>		

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	<p>A plan of care, dated 04-23-13 indicated the resident had the "potential for skin breakdown related to decreased mobility and urinary and bowel incontinence." Interventions to this plan of care included, "turn and reposition at least every 2 hours and as needed, positioning wedge in bed to aid in positioning, assist resident with toileting and pericare after each incontinent episode, pressure reducing/redistribution cushion in chair/wheelchair."</p> <p>The Director of Nurses provided documentation, the Resident Care sheet, dated 04-23-13 in regard to the resident, where the resident was without a pressure ulcer.</p> <p>A nurse progress note, dated 04-28-13 indicated the resident had "redness to left buttocks." The nurses received physician orders to apply Calmoseptine to the area.</p> <p>A report, titled "Event Report," dated 04-29-13 indicated the resident was assessed with a Stage Two (partial thickness loss of skin layers that presents clinically as an abrasion, blister or shallow crater), which measured 1 cm (centimeter) in length, by 1 cm in width by 1 cm in depth.</p>		developed. Completion Date: September 5, 2013.				

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	<p>The report indicated the tissue had "granulation [pink or red tissue with shiny, granular appearance], with no drainage noted."</p> <p>A physician order dated 05-10-13 indicated the need for a local wound care service to "eval. [evaluate] and tx. [treat] - bottom OA [open area]."</p> <p>A progress note dated 05-10-13 indicated the resident had a "wound to left buttocks and measured 1.7 cm by 2.3 cm by 0.1 cm with scant amount of serosanguinous drainage. Resident assessed by [name of wound care company] due to poor response to previous treatment."</p> <p>Review of the contracted wound care company report, dated 05-10-13, indicated the following: "Wound #1 location: left buttocks...is a result of pressure. Modifying factors included fecal and urinary incontinence, DM [diabetes mellitus], morbid obesity and debility, with diminished sensation in lower extremities. Wound left buttocks Stage 3 [Full thickness of skin is lost, exposing the subcutaneous tissue - presents as a deep crater with/without undermining tissue] pressure ulcer has received a status of not healed. Measurements are 1.7 cm length by 2.3 cm in width</p>						

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	<p>by 0.1 dm depth with scant amount of serosanguinous drainage noted which has no odor."</p> <p>A subsequent plan of care, dated 05-13-13 indicated the "resident has h/o (history of) impaired skin integrity" pressure area left buttock." Interventions to this plan of care included "incontinent care as needed, observe for signs of infection: redness, pain, drainage, malodorous drainage, fever, increase in size/depth of wound, turn and reposition every two hours, treatment as ordered."</p> <p>The wound care report, dated 05-17-13 indicated the area remained a Stage 3 pressure ulcer which measured "1.2 cm in length by 1.4 cm in width by 0.1 cm in depth with scant amount of sero-sanguineous drainage noted which has no odor."</p> <p>Further review of the consultant wound care report, dated 05-24-13, the area was assessed as "not healed" and measured "1.1 cm in length by 2.1 cm in width by 0.1 cm in depth."</p> <p>The 05-31-13 report indicated the area was "not healed" and measured "1.8 cm in length by 1.7 cm in width</p>			

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	<p>by 0.2 cm in depth. The wound is deteriorating." Instructions to the nursing staff included "keep pt (patient) clean and dry without stool or urine in the wound. Staff education regarding proper dressing placement was provided."</p> <p>The 06-14-13 report indicated the pressure ulcer was "healed," however presented with "fragile epithelium."</p> <p>On 07-26-13 the local wound care consultant assessed the resident and indicated the "Wound #2 - patient presents with open area on buttocks - is a result of pressure," and located on the resident's "coccyx." The area was noted as a "Stage 3 pressure ulcer" and measured "0.2 cm in length by 0.2 cm in width by 0.1 cm in depth." The "plan" included "calmoseptine - cleanse wound are with mild soap and water, rinse thoroughly. dry. apply calmoseptine or equivalent to wound area once per shift and PRN [as needed], incontinent. Off Loading - wedge cushion or pillow/s for positioning in bed and turn every 2 hours."</p> <p>The 08-02-13 report indicated the resident's pressure ulcer was "healed."</p>			

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	<p>Observation on 08-19-13 at 9:45 a.m., the resident was observed lying in bed. With permission of the resident a body assessment was conducted with the Director of Nurses. During this assessment, the resident indicated she was unable to turn herself in bed without the help of the nursing staff. The resident was turned to the left side. The resident's buttocks and coccyx were observed without open or pressure areas noted.</p> <p>A subsequent observation on 08-19-13 at 3:00 p.m., the resident was seated upright in bed. The resident indicated her spouse "cleaned me up and got me dressed, that was about noon. I just got back in bed a few minutes ago." When questioned if the nursing staff checked or provided incontinent care after being transferred back to bed the resident indicated "no." With permission of the resident, an assessment was conducted with the Director of Nurses. The resident was turned to the right side. Although the previous pressure ulcerated areas were not opened, the resident was found to be incontinent of urine, and had not received additional nursing care for approximately 3 hours from the time the resident's spouse assisted the resident with daily care.</p>			

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	<p>This Federal tag relates to Complaint IN00133954.</p> <p>3.1-40(a)(1) 3.1-40(a)(2)</p>			

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F000323 SS=E	<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 ensure adequate supervision of residents, in that when the facility scheduled out of the building activities at a local area department store the Activity Director failed to ensure adequate supervision of 2 sampled and 23 supplemental sampled resident's. (Residents "E", "J", "K", "L", "M", "N", "O", "P", "Q", "R", "S", "T", "U", "V", "W", "X", "Y", "Z", "AA", "BB", "CC", "EE", "FF", "GG" and "HH").</p> <p>Findings include:</p> <p>During an interview on 08-19-13 at 10:35 a.m., Activity Assistant #6, indicated the facility bus was used when the residents go on an outing. "It holds 2 wheelchairs and usually 3 - 6 residents go. I don't like going because the residents who are not in a wheelchair will just walk off. [Name of the Activity Director] went to [name of the local area department store] alone with the residents - that happened a few times."</p>	F000323	<p>F323 Accidents and Supervision It is the practice of this provider to ensure the resident's environment remains as free of accident hazards as is possible and each resident receives adequate supervision and assistance devices to prevent accidents. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The Activity Director was suspended on August 21, 2013 and terminated on August 23, 2013. All residents will receive adequate supervision and assistance devices to prevent accidents during activities/outings. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken All residents have the potential to be affected by the alleged deficient practice. Activity Staff have been re-educated on providing adequate supervision of resident's during outings/activities SDC/designee by September 5, 2013. Facility will keep an ongoing log of resident's/staff who are transported. What measures will be put into place or what</p>	09/05/2013

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	<p>A review of the individual resident specific attendance calendars for the months of June, July and August 2013 indicated the facility had scheduled outing to a local area department store on June 4, 11, 18 and 25, 2013 and July 2, 9 and 30, 2013 and August 13, 2013.</p> <p>On 08-19-13 at 10:15 a.m., the individual resident activity records were reviewed and 10 residents [Residents "W", "L", "N", "X", "E", "Y", "S", "P", "K", and "AA"] went to the June 4th outing, 7 residents [Residents "Z", "BB", "L", "O", "Q", "P", and "CC"] went on the June 11th outing, 13 residents [Residents "W", "J", "U", "N", "O", "X", "V", "R", "T", "K", "S", "Q" and "P"] went on the June 18th outing and 2 residents [Resident's "E" and "K"] went on the June 25th outing.</p> <p>The documentation indicated on July 2nd (2013) 6 residents [Residents "J", "L", "EE", "M", "K", and "E"], attended the outing, 4 resident's [Resident's "N", "FF", "E" and "K"] attended the July 9th outing and 3 resident's [Residents "S", "D" and "GG"] attended the July 30 outing.</p> <p>The records indicated 5 resident's</p>		<p>systemic changes you will make to ensure that the deficient practice does not recur Activity Staff have been re-educated on providing adequate supervision of resident's during outings/activities SDC/designee by September 5, 2013. Facility will keep an ongoing transportation log to ensure participation calendar/logs are current and accurate. Staff that are noncompliant may be re-educated and /or receive disciplinary action up to and including termination.</p> <p>Administrator/designee will monitor for compliance. 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? Daily review of the activity log to ensure accuracy of documentation will be completed. The Activity CQI tool will be utilized weekly x 4, monthly x 2, quarterly thereafter. The CQI committee will review the data. If a 95% threshold is not achieved, an action plan will be developed. Noncompliance with facility policy and procedure may result in employee education and/or disciplinary action up to and including termination.</p> <p>Compliance date: September 5, 2013</p>	

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	<p>[Residents "Q", "HH", "K", "O" and "G"] attended the August 13 outing.</p> <p>During an interview on 08-19-13 at 1:37 p.m., the Activity Director indicated the facility bus "holds 8 residents plus 2 residents in wheelchairs. An aide usually goes with me." The specific resident participation calendars were reviewed with the Activity Director who indicated she was unsure of the "color coding system" used to identify which resident's attended and those who didn't attend the activities. A request was made for her to review and provide the names of the resident's who attended the facility outings to the local area department store and which facility employees assisted her in the supervision of the resident's.</p> <p>On 08-21-13 at 8:30 a.m., the Executive Director provided the list as requested. The list as provided by the Activity Director included the names, dates and facility staff who participated in the facility outings as follows:</p> <p>June 4th - 3 residents [Residents "K", "E" and "S"] and 2 staff members June 11th - 5 residents [Residents "O", "Q", "BB", "CC", "T"] and 3 staff members</p>			

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	<p>June 18th - 5 resident's [Residents "K", "O", "V", "J" and "N"] and 2 staff members</p> <p>June 25th - no documentation</p> <p>July 2nd - 3 residents [Residents "J", "O" and "K"] and the Activity Director</p> <p>July 9th - 4 resident's [Residents "E", "K", "BB" and "N"] and 2 staff members</p> <p>July 30th - 2 residents [Residents "D" and "K"] and 2 staff members.</p> <p>On 08-21-13 the Executive Director reviewed the specific resident activity participation documentation, since the documentation provided by the Activity Director did not correlate with the specific resident attendance records.</p> <p>The Executive Director reviewed the documentation with the Administrator in Training and the Director of Nurses in attendance. The color coded system was used to validate attendance/participation and indicated the following:</p> <p>June 4th - 6 residents [Residents "N", "E", "Y", "S", "P", and "K"] were identified as participating in the outing, with 3 residents with questionable participation.</p> <p>June 11th - 5 residents [Residents</p>			

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	<p>"BB", "O", "Q", "P" and "CC"] participated in the outing with 1 resident questionable in participation.</p> <p>June 18th - 10 resident's [Residents "J", "N", "O", "V", "R", "T", "K", "S" "Q" and "P"] participated in the outing with 3 resident's with questionable participation.</p> <p>July 2nd - 6 resident's [Residents "J", "L", "EE", "M", "K" and "E"] participated in the outing.</p> <p>July 9th - 3 resident's [Residents "N", "E" and "K"] participated in the outing with 1 resident with questionable participation.</p> <p>July 30th - 2 resident's [Residents "D" and "GG"] participated in the outing with 1 resident with questionable participation.</p> <p>On 08-21-13 the Corporate Social Service/Activity staff arrived at the facility to determine if the participation documentation was accurate and the availability of facility staff intervention was adequate for the supervision of the residents while away from the facility.</p> <p>Further investigation of the Activity scheduled outing on June 18th</p>						

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	<p>indicated 10 resident's attended, with 5 residents wheelchair bound [Resident's "P", "J", "O", "R", and "S"] and 2 residents ambulatory with the use of a cane [Resident "N" and "T"], 1 resident ambulatory with the use of a walker [Resident "V"] and the remaining residents ambulatory. The residents who attended this activity, 2 of the residents had "severe cognitive impairment [Residents "R" and "U"].</p> <p>The Activity scheduled outing on July 2nd indicated 5 residents attended, with 4 of the 5 residents wheelchair bound [Resident's "J", "L", "M", and "E"] and the one resident was ambulatory [Resident "K"]. In addition 1 family member met Resident "J" at the local area department store to assist her with shopping and was not there to assist other residents needs or supervise. On this shopping trip, the Activity Director supervised the remaining resident's.</p> <p>The facility was unable to provide documentation which indicated actual participation of the residents who attended out of the building shopping trips and questionable supervision on July 2, 2013 with only the Activity Director in attendance.</p> <p>This Federal tag relates to Complaint</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  08/21/2013
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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