

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  02/24/2012
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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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F0000	<p>This visit was for a Recertification and State Licensure survey. This visit included the investigation of Complaint IN00103026.</p> <p>Complaint IN00103026: Substantiated. Federal/State deficiency related to the allegations are cited at F282 and F312.</p> <p>Survey dates: February 20, 21, 22, 23, and 24, 2012</p> <p>Facility number: 000241 Provider number: 155636 AIM number: 100291310</p> <p>Survey team: Janet Stanton, R.N.--Team Coordinator Rita Mullen, R.N. Michelle Hosteter, R.N. Heather Lay, R.N. Michelle Carter, R.N. Melanie Strycker, R.N.</p> <p>Census bed type: SNF/NF--105 Total--105</p> <p>Census payor type: Medicare--8 Medicaid--85 Other--22</p>	F0000	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 this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance. The facility requests desk review for the following F tags.	

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--105</p> <p>Sample: 21</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 3/1/12 Cathy Emswiller RN</p>			

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F0282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, interview, and record review, the facility failed to ensure Hospice orders for protective boots for Resident #P, and Care Plan interventions for toileting for Resident #F, were implemented; for 2 of 2 residents in a sample of 21 residents reviewed. [Resident #F and #P]</p> <p>Findings include:</p> <p>1. In an interview during the initial orientation tour on 2/20/12 at 11:45 A.M., L.P.N. #3 indicated Resident #F was incontinent of bowel and bladder, used a wheelchair propelled by staff for mobility, and scratched and picked at the skin on her left lower leg.</p> <p>On 2/22/12, the resident was observed continuously from 10:00 A.M. to 1:10 P.M.</p> <p>At 10:00 A.M., the resident was observed sitting in her wheelchair at a table in the Dining/Activity room. She remained in the Dining room through a Bible study activity and then the lunch meal. At</p>	F0282	<p><b>F282§483.20(k)(3)(ii) Be provided by qualified persons in accordance with each resident's written plan of care.</b></p> <p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? -Resident #F was immediately assisted to bed and peri-care was given. The CNA assigned to the resident was immediately interviewed and inserviced on the resident's toileting plan of care and re-educated on the usage of the CNA assignment sheets.</p> <p>-Resident #P was given a head to toe skin assessment with no skin issues noted. Upon auditing physician/hospice nurse orders and interview of hospice nurse, it was found that the protective heel boots were to be worn temporarily until new Broda chair arrived from the manufacturer. However, the hospice nurse admittedly failed to write an order to discontinue said boots upon the arrival of the Broda chair the following day. During the IDT clinical meeting, the original order was reviewed and care planned. An order was obtained to discontinue the boots as of 2/22/12 and care plan</p>	03/14/2012			

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	<p>12:42 P.M., the resident was transported from the Dining room to the Nurse's Station. She remained in that area until 1:10 P.M.</p> <p>At 1:10 P.M., C.N.A. #5 transported the resident to her room, accompanied by C.N.A. #4 and #6.</p> <p>At 1:15 P.M., C.N.A. #5 transferred Resident #F to the bed, and then left the room.</p> <p>The other C.N.A.s [# 4 and # 6] positioned the resident on her left side and removed the adult incontinence brief. The brief was wet and had a small amount of soft bowel movement. The resident's buttocks were observed to be reddened, with red and white wrinkle marks on the buttocks and upper thigh area from the brief. Two nickel-size blister areas were observed at the crease between the upper thigh and buttock area. One blister was open, and the other was fluid-filled, but appeared to be leaking. An open area was observed on the upper lateral right hip area at the iliac crest, with the top layer of skin gone. In an interview at that time, C.N.A. #4 indicated the area had not been there that morning.</p> <p>The clinical record for Resident #F was reviewed on 2/21/12 at 1:10 P.M.</p>		<p>updated accordingly. 2. How will you identify other residents having the potential to be affected by these same deficient practice and what corrective action will be taken? -All residents will have the potential to be affected. Incontinent residents are checked and changed per policy and inservices are held periodically to re-educate and remind staff on that same policy. Skills validation tests on toileting and peri-care are held during general orientation and periodically for the clinical staff and re-education is provided as necessary. Skills validations tests were completed for CNA's for toileting and pericare. An inservice was held by DNS with a post-test on 3/13/12 for the clinical staff to re-educate on the toileting policy. -Physician and hospice nurse orders are reviewed during the IDT meeting the business day following the order being written and care plans are updated during that time. On weekend days, the physician orders are implemented by the charge nurses. A meeting was held with the hospice provider on 2/22/12. Communication for clinical changes, updates and physicians' orders related to hospice residents will be given to the DNS or designee by providing a copy of the visit report, following each hospice nurse visit. The new procedure was initiated immediately following that</p>				

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	<p>Diagnoses included, but were not limited to, senile dementia--Alzheimer's type, metabolic encephalopathy, osteoporosis, hyperglycemia, macular degeneration, and hearing deficit.</p> <p>A significant change M.D.S. [Minimum Data Set] assessment, dated 8/12/11, and a quarterly M.D.S. assessment, dated 1/30/12, indicated the resident made poor decisions and required cues/supervision related to daily care decisions; required extensive physical assistance for transfers and toileting; and was always incontinent of bowel and bladder.</p> <p>On 1/11/12, the attending physician ordered "Calmoseptine to reddened area on buttocks every shift and P.R.N. [as needed]." Nurse's Notes on 1/28 and 2/6/12 indicated the resident had "reddened buttocks."</p> <p>One Care Plan entry, dated 8/10/11, addressed a problem of "Resident is incontinent due to poor cognition, declining condition." The approaches included: "Assess and document skin condition weekly and as needed; Assist with incontinent care as needed; Check every 2 hours for incontinence...."</p> <p>In an interview on 2/20/12 at 11:30 A.M., L.P.N. #3 indicated the "Resident</p>		<p>meeting. 3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? -The DNS held an inservice for clinical staff on 3/13/12 regarding the toileting program policy and a post test was administered to all attendees. Skills validation tests on toileting and pericare are held during general orientation and periodically. Skills validations tests were completed for CNA's for toileting and peri-care. The charge nurse on every shift will conduct rounds to ensure residents are toileted every two hours per monitoring tool. -The DNS held a meeting with the hospice provider on 2/22/12 to discuss the new procedure regarding the writing of and discontinuing of new orders and how they are to be communicated to the DNS/designee. At the end of each nurse's visit, a copy of the visit report will be given to the DNS/designee for review. 4. 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? -The CQI Toileting Plan Monitoring Audit tool will be utilized by the DNS/designee to monitor compliance with toileting in accordance with each residents' toileting plan of care. Audits will be completed weekly x four weeks, bi-weekly x two</p>		

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	<p>Care/Need Sheet" forms were used as communication with the assigned C.N.A. to direct care given to each resident.</p> <p>The "Resident Care/Need Sheet" entry for Resident #F indicated "Incontinent-Check and change every 2 hours;" and "BR [Bathroom] every 2 hours when awake...."</p> <p>2. The clinical record for Resident #P was reviewed on 2/21/12 at 9:50 A.M. Diagnoses included, but were not limited to, cerebral palsy, dementia, seizure</p>		<p>weeks and quarterly x two quarters. The results of these audits will be presented to the CQI committee monthly to review for compliance and follow-up. If threshold of 95% is not met, an action plan will be developed. The CQI Charge Nurse Toileting Monitoring audit tool will be utilized by the charge nurse to monitor compliance with toileting in accordance with each residents' toileting plan of care. Audits will be completed weekly x four weeks, bi-weekly x two weeks and quarterly x two quarters . If threshold of 95% is not met, an action plan will be developed. -The CQI Hospice Resident Order Review Monitoring audit tool will be utilized by the DNS/designee to monitor compliance with physician/hospice orders, careplanning of and communication of new orders. Audits will be completed weekly x four weeks, bi-weekly x two weeks and quarterly x two quarters. The results of these audits will be presented to the CQI committee monthly to review for compliance and follow-up. If threshold of 95% is not met, an action plan will be developed. 5. The facility alleges date of compliance on March 14, 2012.</p>		

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	<p>disorder and left sided hemiplegia. The resident was currently receiving hospice services.</p> <p>A Care Plan dated 7/8/11 addressed a problem of "Has risk for injury related to seizure activity; Has potential (sic) for seizure activity." Another Care Plan dated 4/13/11 addressed a problem of "Fall risk," with an intervention dated 1/23/12 which indicated the Therapy department was assisting in wheelchair positioning.</p> <p>A Significant change M.D.S. (Minimum Data Set) assessment, dated 12/27/11, indicated the resident had increasing dependency on staff for assistance with eating, hygiene, and bathing.</p> <p>On 2/9/12, the Hospice agency nurse ordered "Cushioned heel protectors when patient up in Broda [specialty wheelchair] --bilateral 20 inches wide Broda Chair. Physical Therapy evaluation one time to determine if chair is right size for patient and for positioning (would like arms up on arm rests or lap-not wedged between chair and body)."</p> <p>The order for the cushioned heel protectors had not been transcribed to the February 2012 M.A.R. (Medication Administration Record) or the T.A.R.</p>				

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	<p>(Treatment Administration Record).</p> <p>A C.N.A. assignment sheet, dated 2/17/12 and provided by L.P.N. #2, did not list any instructions regarding the protective boots.</p> <p>The Resident was observed at follows: 2/21/12 at 10 A.M.--resident had no protective boots on. 2/21/12 at 11:45 A.M.--resident had no protective boots on. 2/21/12 at 2:45 P.M.--resident had no protective boots on. 2/22/12 at 11:20 A.M.--resident had no protective boots on.</p> <p>In an interview on 2/22/12 at 11:40 A.M., L.P.N. #2 indicated Resident #P had been receiving Hospice services due to a decline since December, 2011. She indicated she knew nothing about the protective boots order. The 2/9/12 order from the Hospice nurse was shown to her, and she indicated she had not seen this order.</p> <p>In the interview, L.P.N. #2 described the manner in which orders were processed as follows: Orders were written on a form with three copies. The night nurse checked and signed off on the orders, and would remove the pink copy and place in the "Hot Charting" or "24 Hour" charting</p>			

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	<p>book. The Medical Records staff person would then retrieve the "Hot Charting" log and take it to the daily I.D.T. (interdisciplinary team) meetings for review. The Medical Records staff person would also transcribe any pertinent care information onto the C.N.A. assignment sheets at that time. L.P.N. #2 indicated this was a new procedure initiated within the last two weeks. The nurse looked through the chart and other books, and indicated she did not know why the order for the cushioned heel protectors got missed. She also indicated it could take from 1 day to 2 weeks to receive equipment, devices, or items ordered by Hospice.</p> <p>In an interview on 2/22/12 at 2:04 P.M., the Hospice nurse indicated she wrote the order on 2/9/12 after noticing some bruising on the resident's toes, which she felt was caused when the resident caught her feet in the netting over the foot pedals of the wheelchair when she tried to reposition herself. A new wheelchair had been ordered, which would allow the resident to be positioned without getting her feet caught. She indicated she realized she did not follow up on discontinuing the order once the new chair arrived. She indicated most of the communication with the facility was verbal, and they did not have any written</p>				

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	<p>communication regarding information they exchange.</p> <p>This Federal tag relates to Complaint IN00103026.</p> <p>3.1-35(g)(2)</p>			

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F0309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, interview, and record review, the facility failed to provide specialty cushioned heel protector boots to 1 of 1 resident who had boots ordered by a Hospice nurse; in a sample of 21 residents reviewed. [Resident #P]</p> <p>Findings include:</p> <p>The clinical record for Resident #P was reviewed on 2/21/12 at 9:50 A.M. Diagnoses included, but were not limited to, cerebral palsy, dementia, seizure disorder and left sided hemiplegia. The resident was currently receiving hospice services.</p> <p>A Care Plan dated 7/8/11 addressed a problem of "Has risk for injury related to seizure activity; Has potential (sic) for seizure activity." Another Care Plan dated 4/13/11 addressed a problem of "Fall risk," with an intervention dated 1/23/12 which indicated the Therapy department was assisting in wheelchair positioning.</p>	F0309	<p><b>F309§483.25 Quality of Care</b></p> <p><b>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.</b> 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? -Resident #P was given a head to toe skin assessment with no skin issues noted. Upon auditing physician/hospice nurse orders and interview of hospice nurse, it was found that the protective heel boots were to be worn temporarily until new Broda chair arrived from the manufacturer. However, the hospice nurse admittedly failed to write an order to discontinue said boots upon the arrival of the Broda chair the following day. During the IDT clinical meeting, the original order was reviewed and care planned. An order was obtained to discontinue the boots as of 2/22/12 and care plan</p>	03/14/2012			

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	<p>A Significant change M.D.S. (Minimum Data Set) assessment, dated 12/27/11, indicated the resident had increasing dependency on staff for assistance with eating, hygiene, and bathing.</p> <p>On 2/9/12, the Hospice agency nurse ordered "Cushioned heel protectors when patient up in Broda [specialty wheelchair] --bilateral 20 inches wide Broda Chair. Physical Therapy evaluation one time to determine if chair is right size for patient and for positioning (would like arms up on arm rests or lap-not wedged between chair and body)."</p> <p>The order for the cushioned heel protectors had not been transcribed to the February 2012 M.A.R. (Medication Administration Record) or the T.A.R. (Treatment Administration Record).</p> <p>A C.N.A. assignment sheet, dated 2/17/12 and provided by L.P.N. #2, did not list any instructions regarding the protective boots.</p> <p>The Resident was observed at follows: 2/21/12 at 10 A.M.--resident had no protective boots on. 2/21/12 at 11:45 A.M.--resident had no protective boots on. 2/21/12 at 2:45 P.M.--resident had no</p>		<p>updated accordingly. 2. How will you identify other residents having the potential to be affected by these same deficient practice and what corrective action will be taken? -All residents will have the potential to be affected. Physician and hospice nurse orders are reviewed during the IDT meeting the business day following the order being written and care plans are updated during that time. During the weekend days, the charge nurse implements the physician orders. A meeting was held with the hospice provider on 2/22/12. Communication for clinical changes, updates and physicians' orders related to hospice residents will be given to the DNS or designee by providing a copy of the visit report, following each hospice nurse visit. The new procedure was initiated immediately following that meeting. 3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? -The DNS held a meeting with the hospice provider on 2/22/12 to discuss the new procedure regarding the writing of and discontinuing of new orders and how they are to be communicated to the DNS/designee At the end of each nurse's visit, a copy of the visit report will be given to the DNS/designee for review. CP and CNA assignment sheet will be</p>		

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	<p>protective boots on. 2/22/12 at 11:20 A.M.--resident had no protective boots on.</p> <p>In an interview on 2/22/12 at 11:40 A.M., L.P.N. #2 indicated Resident #P had been receiving Hospice services due to a decline since December, 2011. She indicated she knew nothing about the protective boots order. The 2/9/12 order from the Hospice nurse was shown to her, and she indicated she had not seen this order.</p> <p>In the interview, L.P.N. #2 described the manner in which orders were processed as follows: Orders were written on a form with three copies. The night nurse checked and signed off on the orders, and would remove the pink copy and place in the "Hot Charting" or "24 Hour" charting book. The Medical Records staff person would then retrieve the "Hot Charting" log and take it to the daily I.D.T. (interdisciplinary team) meetings for review. The Medical Records staff person would also transcribe any pertinent care information onto the C.N.A. assignment sheets at that time. L.P.N. #2 indicated this was a new procedure initiated within the last two weeks. The nurse looked through the chart and other books, and indicated she did not know why the order for the cushioned heel</p>		<p>updated accordingly. 4. 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? -CQI Hospice Resident Order Review Monitoring audit tool will be utilized by the DNS/designee to monitor compliance with physician/ hospice orders, careplanning of and communication of new orders. Audits will be completed weekly x four weeks, bi-weekly x two weeks and quarterly x two quarters. The results of these audits will be presented to the CQI committee monthly to review for compliance and follow-up. If threshold of 95% is not met, an action plan will be developed. 5. The facility alleges date of compliance on March 14, 2012.</p>				

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  02/24/2012
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	<p>protectors got missed. She also indicated it could take from 1 day to 2 weeks to receive equipment, devices, or items ordered by Hospice.</p> <p>In an interview on 2/22/12 at 2:04 P.M., the Hospice nurse indicated she wrote the order on 2/9/12 after noticing some bruising on the resident's toes, which she felt was caused when the resident caught her feet in the netting over the foot pedals of the wheelchair when she tried to reposition herself. A new wheelchair had been ordered, which would allow the resident to be positioned without getting her feet caught. She indicated she realized she did not follow up on discontinuing the order once the new chair arrived. She indicated most of the communication with the facility was verbal, and they did not have any written communication regarding information they exchange.</p> <p>3.1-37(a)</p>			

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F0312 SS=D	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>Based on observation, interview, and record review, the facility failed to ensure 1 of 5 residents, who were incontinent of bowel and bladder and required extensive assistance for toileting and hygiene care, was checked and given incontinence and perineal care in a timely manner; in a sample of 21 residents reviewed. [Resident #F]</p> <p>Findings include:</p> <p>In an interview during the initial orientation tour on 2/20/12 at 11:45 A.M., L.P.N. #3 indicated Resident #F was incontinent of bowel and bladder, used a wheelchair propelled by staff for mobility, and scratched and picked at the skin on her left lower leg.</p> <p>On 2/22/12, the resident was observed continuously from 10:00 A.M. to 1:10 P.M.</p> <p>At 10:00 A.M., the resident was observed sitting in her wheelchair at a table in the Dining/Activity room. She remained in the Dining room through a Bible study</p>	F0312	<p><b>F312§483.25(a)(3) (3) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.1.</b></p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? -Resident #F was immediately assisted to bed and peri-care was given. The CNA assigned to the resident was immediately interviewed and inserviced on the resident's toileting plan of care and re-educated on the usage of the CNA assignment sheets. 2. How will you identify other residents having the potential to be affected by these same deficient practice and what corrective action will be taken? -All residents will have the potential to be affected. Incontinent residents are checked and changed per policy and inservices are held periodically to re-educate and remind staff on that same policy. Skills validation tests on toileting and peri-care are held during general orientation and periodically for the clinical staff and re-education is</p>	03/14/2012			

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	<p>activity and then the lunch meal. At 12:42 P.M., the resident was transported from the Dining room to the Nurse's Station. She remained in that area until 1:10 P.M.</p> <p>At 1:10 P.M., C.N.A. #5 transported the resident to her room, accompanied by C.N.A. #4 and #6.</p> <p>At 1:15 P.M., C.N.A. #5 transferred Resident #F to the bed, and then left the room.</p> <p>The other C.N.A.s [#4 and #6] positioned the resident on her left side and removed the adult incontinence brief. The brief was wet and had a small amount of soft bowel movement. The resident's buttocks were observed to be reddened, with red and white wrinkle marks on the buttocks and upper thigh area from the brief. Two nickel-size blister areas were observed at the crease between the upper thigh and buttock area. One blister was open, and the other was fluid-filled, but appeared to be leaking. An open area was observed on the upper lateral right hip area at the iliac crest, with the top layer of skin gone. In an interview at that time, C.N.A. #4 indicated the area had not been there that morning.</p> <p>The clinical record for Resident #F was</p>		<p>provided as necessary. Skills validations tests were completed for CNA's for toileting and peri-care. An inservice was held by DNS with a post-test given on 3/13/12 for the clinical staff to re-educate on the toileting policy.</p> <p>3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? -The DNS held an inservice for clinical staff on 3/13/12 regarding the toileting program policy and a post test was administered to all attendees. The charge nurse on every shift will conduct rounds to ensure residents are toileted according to their plan of care per monitoring tool. 4. 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? - -The CQI Toileting Plan Monitoring Audit tool will be utilized by the DNS/designee to monitor compliance with toileting in accordance with each residents' toileting plan of care. Audits will be completed weekly x four weeks, bi-weekly x two weeks and quarterly x two quarters. The results of these audits will be presented to the CQI committee monthly to review for compliance and follow-up. If threshold of 95% is not met, an action plan will be developed. The CQI Charge Nurse Toileting Monitoring audit tool will be utilized by the charge</p>		

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	<p>reviewed on 2/21/12 at 1:10 P.M.</p> <p>Diagnoses included, but were not limited to, senile dementia--Alzheimer's type, metabolic encephalopathy, osteoporosis, hyperglycemia, macular degeneration, and hearing deficit.</p> <p>A significant change M.D.S. [Minimum Data Set] assessment, dated 8/12/11, and a quarterly M.D.S. assessment, dated 1/30/12, indicated the resident made poor decisions and required cues/supervision related to daily care decisions; required extensive physical assistance for transfers and toileting; and was always incontinent of bowel and bladder.</p> <p>On 1/11/12, the attending physician ordered "Calmoseptine to reddened area on buttocks every shift and P.R.N. [as needed]." Nurse's Notes on 1/28 and 2/6/12 indicated the resident had "reddened buttocks."</p> <p>One Care Plan entry, dated 8/10/11, addressed a problem of "Resident is incontinent due to poor cognition, declining condition." The approaches included: "Assess and document skin condition weekly and as needed; Assist with incontinent care as needed; Check every 2 hours for incontinence...."</p> <p>In an interview on 2/20/12 at 11:30 A.M.,</p>		nurse to monitor compliance with toileting in accordance with each residents' toileting plan of care. Audits will be completed weekly x four weeks, bi-weekly x two weeks and quarterly x two quarters . If threshold of 95% is not met, an action plan will be developed. The facility alleges date of compliance on March 14, 2012.		

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	<p>L.P.N. #3 indicated the "Resident Care/Need Sheet" forms were used as communication with the assigned C.N.A. to direct care given to each resident.</p> <p>The "Resident Care/Need Sheet" entry for Resident #F indicated "Incontinent- -Check and change every 2 hours;" and "BR [Bathroom] every 2 hours when awake...."</p> <p>This Federal tag relates to Complaint IN00103026.</p> <p>3.1-38(a)(3)</p>				

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F0323 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.</p> <p>Based on observation and interviews the facility failed to ensure the resident environment was free from unsecured chemicals to prevent accidents. This affected 2 of the 4 locked dementia/altered mental status resident units, and 23 mobile residents of 53 residents.</p> <p>Findings include:</p> <p>On 2/20/12 at 2:35 P.M. on the Chatham Arch unit, a linen cart was observed in the residential hallway. It had shampoo, cleansing spray, and body lotion accessible to residents. Shampoo= 8.5 ounces. Array periwash cleansing spray =300 milliliters. The shampoo and Array periwash cleansing spray had warning labels on product container.</p> <p>During environmental tour on 2/21/12 at 1:45 P.M., with the Maintenance Supervisor and the Housekeeping Supervisor on Chatham Arch hall, the same linen cart in the residential hallway had the following items accessible to</p>	F0323	<p>F323§483.25(h) Accidents. <b>The facility must ensure that (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents.</b> 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? -The personal care items that were found in the linen cart on the hallway were immediately removed and taken to a secured area. The laundry service room/soiled utility room door lock was changed on 2/22/12 from a keyed lock to a keypad lock. 2. How will you identify other residents having the potential to be affected by these same deficient practice and what corrective action will be taken? -All residents will have the potential to be affected. The Unit Manager or designee has been assigned periodic environmental rounds, which includes observing for and removing any personal care items that are accessible to residents. This assignment was added to their daily duty</p>	03/14/2012

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	<p>residents: 1 Array periwash cleansing spray= 300 milliliters, 3 deodorants= 1.5 ounces each, 2 shampoo = 8.5 ounces each, 1 peri cleanser= 8.5 ounces. All items had warning labels stating "for external use only", "keep out of reach of children", and "avoid eye contact". Out of 22 residents on Chatham Arch hall, this had potential to impact 8 residents.</p> <p>During environmental tour on 2/21/12 at 1:45 P.M., with the Maintenance Supervisor and the Housekeeping Supervisor on Meridian hall, a key was found in the door lock to the laundry services room. Inside the laundry service room, which was not locked, a half full spray bottle of Comet with bleach, 945 milliliters, was found in an unlocked cabinet. This hazard potentially impacted 15 out of 31 residents.</p> <p>During an interview on 2/21/12 at 1:55 P.M., L.P.N. #2 indicated Chatham Arch had 8 ambulatory/mobile residents that could access the unsecured chemicals. There was a total of 22 residents on Chatham Arch hall. Meridian Hall had 15 ambulatory/mobile residents that could access the unlocked laundry service room. There was a total of 31 residents on Meridian Hall.</p> <p>3.1-45(a)(1)</p>		<p>checklist. The DNS held an inservice for all departments and a post –test was given on 3/13/12 and provided re-education related to environmental hazards, including personal care items being kept out of the reach of residents. The Maintenance Director changed the keyed door handle lock on the laundry service room/soiled utility room door to a keypad lock that is accessible only with a code. 3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? -The Unit Manager/designee has been assigned periodic environmental rounds to ensure that items that have the potential to be hazardous to residents are kept out of residents' reach , which includes observing for and removing any personal care items that are accessible to residents. This assignment was added to their daily duty checklist. All departments were inserviced by DNS and a post-test was given on 3/13/12 and re-education provided related to environmental hazards. An audit was performed by the ED and Maintenance Director on 2/22/12 to ensure that doors to rooms with items with the potential to be hazardous to residents have the appropriate lock system in place. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what</p>				

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			quality assurance program will be put into place? -The CQI Unit manager/Weekend manager designee audit monitoring tool will be utilized by the DNS/ designee to monitor compliance with the unit rounding for observing for and removing of potentially hazardous items. The management staff members are assigned specific rooms for daily care/concerns/environmental issues and their audit tools are turned in to the ED Monday through Friday. This will be an ongoing monitoring program. 5. The facility alleges date of compliance on March 14, 2012.		

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F0371 SS=C	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation and interview, the facility failed to thoroughly clean stainless steel steam serving tables in the dining rooms after meal services. This affected 4 of 4 dining room steam tables. This had the potential to affect 104 of 105 residents who received meals served from the steam tables.</p> <p>Findings include:</p> <p>During an observation, on 2/20/12 at 2:00 P.M., of stainless steel steam tables on Brickyard, Mapleton, Meridian, and Chatham units had food debris and residue present on the stainless steel counters and on the inside of the front and side splash shields, following the lunch meal served between 11:15 A.M. and 12:10 P.M.</p> <p>During an interview 2/21/12 at 9:50 A.M., the Dietary Manager indicated the server at each dining room was responsible for cleaning the stainless steel steam table after each meal service in</p>	F0371	<p><b>F371§483.35(i) - Sanitary Conditions The facility must – §483.35(i)(1) - Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and §483.35(i)(2) - Store, prepare, distribute and serve food under sanitary conditions 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? -The steam tables were thoroughly cleaned immediately. The routine cleaning of the steam tables has been implemented. The dietary and housekeeping departments will share the responsibility, based on the meal being served and the day of the week. 2. How will you identify other residents having the potential to be affected by these same deficient practice and what corrective action will be taken? -All residents will have the potential to be affected. The routine cleaning of the steam tables will be part of the dietary and housecleaning departments' cleaning schedule. 3. What</b></p>	03/14/2012

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	<p>each of the 4 dining rooms. The last lunch meal service was scheduled to begin at 12:10 P.M.</p> <p>During the environmental tour on 2/21/12 at 1:45 P.M., with the Maintenance Supervisor and the Housekeeping Supervisor, 3 out 4 stainless steel steam serving tables were observed to be soiled with food debris and residue on the stainless steel counters and on the inside of the front and side splash shields. During an interview at that time, the Housekeeping supervisor indicated the kitchen/dietary staff were responsible for cleaning the stainless steel steam serving tables.</p> <p>3.1-21(i)(2)</p>		<p>measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? -A routine system has been put in place for cleaning the steam tables by the dietary and housekeeping departments. The department head/designee will ensure cleaning is completed with the cleaning of the dining room after each meal. Department heads/designee have been assigned to oversee the dining room processes for all meals, including the cleaning of the steam tables after each meal. The facility staff were inserviced on the cleaning schedule and the proper method of cleaning of the steam tables by the Certified Dietary Manager on 3/13/12 and the department heads' dining room responsibilities on 3/13/12.</p> <p>4. 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? -The CQI Dept Head/Designee Dining Room monitor Checklist monitoring tool will be utilized by the ED to monitor compliance with the cleaning of the steam tables. Audits will be completed weekly x four weeks, bi-weekly x two weeks and quarterly x two quarters. Also, the Registered Dietician will perform routine monthly sanitation inspections, which will include observing the steam tables for cleanliness. 5.</p>		

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F9999	<p>STATE FINDINGS</p> <p>3.1-18 INFECTION CONTROL PROGRAM</p> <p>1. (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to provide a resident with a tuberculin skin test upon admission. The deficient practice impacted 1 of 21 residents reviewed. [Resident #105]</p> <p>Findings include:</p> <p>On 2/21/12 at 9:50 A.M., Resident #105's record was reviewed. Resident #105 was admitted on 6/23/11. Diagnoses included, but were not limited to, delirium, Alzheimer's disease, and hypertension.</p> <p>An "Immunization Record and</p>	F9999	<p>STATE FINDINGS3.1-18 INFECTION CONTROL PROGRAM1. (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read.1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? -All residents will have a tuberculin skin test/ tuberculin screen assessment completed upon admission and will be read within 48 to 72 hours after admission. 2. How will you identify other residents having the potential to be affected by these same deficient practice and what corrective action will be taken? -All residents have the potential to be affected. A chart audit was performed on all in-house residents to ensure compliance with the tuberculin skin testing policy upon admission. The DNS held an inservice for clinical staff on 3/13/12 to re-educate on the tuberculin skin testing upon admission policy. 3. What measures will be put into place or what systemic changes you will make to ensure that the deficient</p>	03/14/2012	

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  02/24/2012	
NAME OF PROVIDER OR SUPPLIER  HARRISON TERRACE				STREET ADDRESS, CITY, STATE, ZIP CODE 1924 WELLESLEY BLVD INDIANAPOLIS, IN 46219			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>Tuberculosis Screening Risk Assessment" included, but was not limited to, "Mantoux Tests: 8/7/11 [date given] Apisol 0.1 milliliter [given].. 8/10/11 [date read] 0.0 millimeters... 8/29/12 [date given] Apisol 0.1 milliliter [given]... 9/1/11 [date read] 5 millimeters..."</p> <p>In an interview with the Director of Nursing [DoN] on 2/21/12 at 3:15 P.M., she indicated Resident #105 was admitted from a hospital and a tuberculin skin test should have been completed by the facility.</p> <p>On 2/23/12 at 9:30 A.M., the DoN provided a copy of Resident #105's admission tuberculin skin test. The "Immunization Record and Tuberculin Screening Risk Assessment" did not include additional tuberculin skin testing.</p> <p>Resident #105 was admitted on 6/23/11 to the facility and was given his first tuberculin skin test on 8/10/11.</p> <p>In an interview on 2/23/12 at 9:30 A.M., the DoN indicated she did not have any additional documentation of Resident #105's tuberculin skin testing.</p> <p>3.1-18(e)</p>		<p>practice does not recur? -The DNS held an inservice for clinical staff on 3/13/12 to re-educate on the tuberculin skin testing upon admission policy. The IDT team will review all admissions/ readmissions the following business day for the administration of and scheduled reading of the tuberculin skin test per the IDT Admission/Readmission Review form. 4 .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? -The DNS/Designee will audit all admissions/readmissions the following business day per the IDT Admission/Readmission Review Form to ensure compliance with the administration of the tuberculin skin test/ tuberculin screening assessment form. 5. The facility alleges compliance on March 14, 2012</p>				