

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155777	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/07/2013
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NAME OF PROVIDER OR SUPPLIER  CREASY SPRINGS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1750 S CREASY LN LAFAYETTE, IN 47905
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F000000	<p>This visit was for the Investigation of Complaint # IN00127976.</p> <p>Complaint # IN00127976-Substantiated. Federal/state deficiencies related to the allegations are cited at F282, F309, and F514.</p> <p>Survey dates: May 6 &amp; 7, 2013</p> <p>Facility number: 012285 Provider number: 155777 AIM number: 201006770</p> <p>Survey team: Michelle Carter, RN- TC Rita Mullen, RN</p> <p>Census bed type: SNF: 42 SNF/NF: 20 Residential: 53 Total: 115</p> <p>Census payor type: Medicare: 23 Medicaid: 6 Other: 86 Total: 115</p> <p>Sample: 5</p> <p>These deficiencies reflect state</p>	F000000	The submission of this plan of correction does not indicate an admission by Creasy Springs Health Campus that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to the Residents of Creasy Springs Health Campus. The facility maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities. This plan of correction shall serve as the credible allegation of compliance with all federal and state requirments governing the management of this facility. The provider respectfully request a desk review with paper compliance to be considered in establishing the provider is in substantial compliance	

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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	findings cited in accordance with 410 IAC 16.2.  Quality Review was completed by Tammy Alley RN on May 10, 2013.				

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F000282 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 interview and record review, the facility failed to follow the bowel movement protocol for 2 of 5 residents, in a sample of 5, reviewed for bowel movements. (Residents C and F.)</p> <p>Findings include:</p> <p>1. The clinical record for Resident F was reviewed on 5/6/13 at 11:30 A.M.</p> <p>Diagnoses included, but were not limited to, lumbar spondylolisthesis, lumbar laminectomy, gout, coronary artery disease, carotid artery stenosis, Factor V Leiden deficiency, high blood pressure, arthritis, peripheral neuropathy, gastritis, and benign prostatic hyperplasia.</p> <p>On 2/24/13, Resident F was admitted to the facility after a short stay at the hospital, following back surgery.</p> <p>The bowel movement (BM) tracking record indicated Resident F had a BM on 3/7/13. He did not have a BM on 3/8, 3/9, 3/10, 3/11, or 3/12/13.</p>	F000282	<p>1. On 5/6/13, Resident F did not reside at Creasy Springs Health Campus. Resident C did have a bowel movement on 4/24/13 after receiving an ordered laxative. 2. All Residents have the ability to be affected by this deficient practice.3. Licensed nurses will be in-serviced on the implementation of the bowel protocol per the facility policy.4.The Director of Health Services or designee will review the 'No bowel movement in 48 hours' Resident report daily, seven days per week and provide the report to the applicable nurse. The Residents identified on this report will have the ordered bowel protocol initiated by the nurse. The Director of Health Services or designee will audit the bowel protocol medication administration record to ensure implementation and completion of the bowel protocol for the Residents indentified.Once the Resident has a bowel movement, the bowel protocol will stop and the bowel movement will be documented in the electronic record via Caretracker by nursing staff. The findings of this audit will be reviewed in QAA meeting monthly for 6 months</p>	06/06/2013			

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	<p>Resident F's bowel protocol, dated March 2012, stated if no BM in 72 hours, follow these steps:</p> <ol style="list-style-type: none"> <li>Administer natural laxative, 2 tablespoons, by mouth, twice per day. (a natural laxative= prune juice, fiber, fruit.)</li> <li>If still no results in 24 hours, give Milk of Magnesia (M.O.M), 30 ml (milliliters) by mouth and continue natural laxative.</li> <li>If still no results in 12 hours, use Dulcolax 10 mg (milligram) suppository, rectally.</li> <li>If still no results in 2 hours, give a Fleets enema, rectally.</li> <li>If still no results after Fleets enema, notify physician for further orders.</li> </ol> <p>The March 2013 Medication Administration Record (MAR) indicated M.O.M. (Milk of Magnesia) was administered on 3/11/13 and 3/12/13. Clinical records failed to indicate use of natural laxatives, Dulcolax suppository, or a Fleets enema.</p>		and quarterly thereafter.				

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	<p>Nursing notes, dated 3/12/13, indicated Resident F was complaining of back pain and shortness of breath. The physician was notified and orders were received to send the resident to the emergency department (ED) for further treatment and evaluation.</p> <p>ED and hospital documentation, dated 3/12/13, indicated the resident was admitted with complaints of abdominal pain and back pain. An enema and magnesium citrate were administered prior to physician evaluation. CT scans were ordered. Resident F had spontaneous stool after returning from the CT scan.</p> <p>A CT scan report, dated 3/12/13, indicated no evidence of bowel compromise. The report stated, "No abnormal calcifications are seen within the abdomen. Minimal to moderate gaseous distention ...most likely due to an intestinal ileus. No radiographic evidence to suggest presence of bowel obstruction." Diagnostic impression indicated the following: "1. Mild fluid distention involving much of the colon, suggesting diarrheal illness. 2. Mild sigmoid diverticulosis....."</p> <p>During an interview with the Director of Nursing on 5/6/13 at 3:45 P.M., she</p>						

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	<p>indicated Resident F had a bowel protocol in place but nursing staff failed to follow it. She indicated she did not have an explanation as to a reason it was not followed.</p> <p>2. The clinical record of Resident C was reviewed on 5/7/13 at 10:00 A.M.</p> <p>A Care Plan for "At risk for constipation," dated 11/9/12 and reviewed 2/9/13, indicated a goal of a bowel movement at least every three days. Interventions included, but were not limited to, encourage fluids, encourage mobility and monitor bowel movements for amount and consistency.</p> <p>During a review of the resident's bowel movement record, dated 2/5/13 to 5/6/13, indicated Resident C did not have a bowel movement from 4/18/13 to 4/23/13. This was six days without a bowel movement.</p> <p>A Medication Administration Record, dated for the month of April 2013, indicated Resident C received Milk of Magnesia (a laxative) on 4/21/13, the fourth day without a bowel movement, and 4/23/13, the sixth day without a bowel movement.</p> <p>A "Bowel Protocol" record, dated for</p>			

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	<p>the month of April 2013, indicated the following:</p> <p>"No BM [bowel movement] in 48 hours.</p> <p>Natural laxative 2 tablespoons by mouth twice daily.</p> <p>If still no results in 24 hrs [hours]: MOM [milk of magnesia] 30 ml [milliliters] by mouth and continue natural laxative.</p> <p>If still no results in 12 hrs: Dulcolax 10 mg [milligrams] suppository rectally.</p> <p>If still no results in 2 hrs: fleets enema rectally.</p> <p>If still no results after fleets enema notify MD for further orders."</p> <p>During an interview with the Director of Nursing, on 5/7/13 at 1:30 P.M., she indicated the bowel protocol was not followed.</p> <p>3.1-35(g)(2)</p>				

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F000309 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 interview and record review, the facility failed to follow the bowel movement protocol for 2 of 5 residents, in a sample of 5, reviewed for bowel movements. (Residents F and C)</p> <p>Findings include:</p> <p>1. The clinical record for Resident F was reviewed on 5/6/13 at 11:30 A.M.</p> <p>Diagnoses included, but were not limited to, lumbar spondylolisthesis, lumbar laminectomy, gout, coronary artery disease, carotid artery stenosis, Factor V Leiden deficiency, high blood pressure, arthritis, peripheral neuropathy, gastritis, and benign prostatic hyperplasia.</p> <p>On 2/24/13, Resident F was admitted to the facility after a short stay at the hospital, following back surgery.</p> <p>The bowel movement (BM) tracking</p>	F000309	<p>1. On 5/6/13, Resident F did not reside at Creasy Springs Health Campus. Resident C did have a bowel movement on 4/24/13 after receiving an ordered laxative. 2. All Residents have the ability to be affected by this deficient practice.3. Licensed nurses will be in-serviced on the implementation of the bowel protocol per the facility policy.4.The Director of Health Services or designee will review the 'No bowel movement in 48 hours' Resident report daily, seven days per week and provide the report to the applicable nurse. The Residents identified on this report will have the ordered bowel protocol initiated by the nurse. The Director of Health Services or designee will audit the bowel protocol medication administration record to ensure implementation and completion of the bowel protocol for the Residents indentified.Once the Resident has a bowel movement, the bowel protocol will stop and the bowel movement will be documented in the electronic record via Caretracker by nursing</p>	06/06/2013			

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	<p>record indicated Resident F had a BM on 3/7/13. He did not have a BM on 3/8, 3/9, 3/10, 3/11, or 3/12/13.</p> <p>Resident F's bowel protocol, dated March 2012, stated if no BM in 72 hours, follow these steps:</p> <ol style="list-style-type: none"> <li>1. Administer natural laxative, 2 tablespoons, by mouth, twice per day. (a natural laxative= prune juice, fiber, fruit.)</li> <li>2. If still no results in 24 hours, give Milk of Magnesia (M.O.M), 30 ml (milliliters) by mouth and continue natural laxative.</li> <li>3. If still no results in 12 hours, use Dulcolax 10 mg (milligram) suppository, rectally.</li> <li>4. If still no results in 2 hours, give a Fleets enema, rectally.</li> <li>5. If still no results after Fleets enema, notify physician for further orders.</li> </ol> <p>The March 2013 Medication Administration Record (MAR) indicated M.O.M was administered on 3/11/13 and 3/12/13. Clinical records failed to indicate use of natural laxatives, Dulcolax suppository, or a</p>		<p>staff. The findings of this audit will be reviewed in QAA meeting monthly for 6 months and quarterly thereafter.</p>	

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	<p>Fleets enema.</p> <p>Nursing notes, dated 3/12/13, indicated Resident F was complaining of back pain and shortness of breath. The physician was notified and orders were received to send the resident to the emergency department (ED) for further treatment and evaluation.</p> <p>ED and hospital documentation, dated 3/12/13, indicated the resident was admitted with complaints of abdominal pain and back pain. An enema and magnesium citrate were administered prior to physician evaluation. CT scans were ordered. Resident F had spontaneous stool after returning from the CT scan.</p> <p>A CT scan report, dated 3/12/13, indicated no evidence of bowel compromise. The report stated, "No abnormal calcifications are seen within the abdomen. Minimal to moderate gaseous distention ...most likely due to an intestinal ileus. No radiographic evidence to suggest presence of bowel obstruction." Diagnostic impression indicated the following: "1. Mild fluid distention involving much of the colon, suggesting diarrheal illness. 2. Mild sigmoid diverticulosis....."</p>						

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	<p>During an interview with the Director of Nursing on 5/6/13 at 3:45 P.M., she indicated Resident F had a bowel protocol in place but nursing staff failed to follow it. She indicated she did not have an explanation as to a reason it was not followed.</p> <p>2. The clinical record of Resident C was reviewed on 5/7/13 at 10:00 A.M.</p> <p>A Care Plan for "At risk for constipation," dated 11/9/12 and reviewed 2/9/13, indicated a goal of a bowel movement at least every three days. Interventions included, but were not limited to, encourage fluids, encourage mobility and monitor bowel movements for amount and consistency.</p> <p>During a review of the resident's bowel movement record, dated 2/5/13 to 5/6/13, indicated Resident C did not have a bowel movement from 4/18/13 to 4/23/13. This was six days without a bowel movement.</p> <p>A Medication Administration Record, dated for the month of April 2013, indicated Resident C received Milk of Magnesia (a laxative) on 4/21/13, the fourth day without a bowel movement, and 4/23/13, the sixth day without a</p>			

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	<p>bowel movement.</p> <p>A "Bowel Protocol" record, dated for the month of April 2013, indicated the following:</p> <p>"No BM [bowel movement] in 48 hours.</p> <p>Natural laxative 2 tablespoons by mouth twice daily.</p> <p>If still no results in 24 hrs [hours]: MOM [milk of magnesia] 30 ml [milliliters] by mouth and continue natural laxative.</p> <p>If still no results in 12 hrs: Dulcolax 10 mg [milligrams] suppository rectally.</p> <p>If still no results in 2 hrs: fleets enema rectally.</p> <p>If still no results after fleets enema notify MD for further orders."</p> <p>During an interview with the Director of Nursing, on 5/7/13 at 1:30 P.M., she indicated the bowel protocol was not followed.</p> <p>3.1-37(a)</p>						

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F000514 SS=D	<p>483.75(I)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on record review and interview, the facility failed to document bowel movements in the computer "Care Tracker" record system. 1 of 5 residents reviewed for bowel movements in a sample of 5. (Resident E)</p> <p>Findings include:</p> <p>The clinical record of Resident E was reviewed on 5/6/13 at 2:45 P.M.</p> <p>A Care Plan for "At risk for constipation," dated 3/6/13, indicated a goal of a bowel movement at least every three days. Interventions included, but were not limited to, encourage fluids, encourage mobility and monitor bowel movements for amount and consistency.</p>	F000514	<p>1. Resident E continues to reside in facility and has had his bowel movement record reviewed for completion and accuracy. No further documentation problems with his bowel movement record have been observed.2. All Residents have the ability to be affected by this deficient practice. 3. Nursing staff will be in-serviced on the importance of documenting every bowel movement for all Residents in the computer care tracker record system every shift .4. The Director of Health Services or designee will audit the 'No bowel movement in 48 hours' report daily, 7 days per week. The Residents listed on the report will have the ordered bowel protocol initiated. When the Resident has a bowel movement, it will be documented in the computer caretracker record</p>	06/06/2013	

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NAME OF PROVIDER OR SUPPLIER  CREASY SPRINGS HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 1750 S CREASY LN LAFAYETTE, IN 47905			
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	<p>A review of the bowel movement [BM] record for 2/5/13 to 5/6/13, indicated the resident did not have a BM 4/16/13 to 4/19/13, this was four days without a BM.</p> <p>During an interview with the director of Nursing, on 5/7/13 at 9:45 A.M., she indicated Resident E had two BMs on 4/17/13 but the staff didn't enter them into the Care Tracker system.</p> <p>3.1-50(a)(2)</p>		<p>system and the Resident will no longer appear on the 'No bowel movement in 48 hours' report . The findings of this audit will be reviewed in QAA meeting monthly for 6 months and quarterly thereafter.</p>				