

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155241	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 12/10/2015
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NAME OF PROVIDER OR SUPPLIER FOREST CREEK VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 525 E THOMPSON RD INDIANAPOLIS, IN 46227
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>This visit was in conjunction with the Investigation of Complaints IN00187590, IN00188183, and IN00188346.</p> <p>Survey dates: November 30, December 1, 2, 3, 4, 8, 9, and 10.</p> <p>Facility number: 000145 Provider number: 155241 AIM number: 100275110</p> <p>Census bed type: SNF: 9 SNF/NF: 99 Total: 108</p> <p>Census payor type: Medicare: 8 Medicaid: 79 Other: 21 Total: 108</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Q.R. completed by 14466 on December 14, 2015.</p>	F 0000	The creation and submission of this plan of correction doesnot constitute an admission by this provider of any conclusion set forth in thestatement of deficiencies, or of any violation of regulation The provider respectfully requests that the 2567 plan ofcorrection be considered as the letter of credible allegation and request a desk review on or after, December 28th,2015	

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

TITLE

(X6) DATE

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

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F 0282 SS=D Bldg. 00	<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, record review, and interview, the facility failed to ensure residents' urinary drainage systems were maintained according to their plans of care for 2 residents reviewed for urinary catheters. (Residents # 81 and #152)</p> <p>Findings include:</p> <p>1. The clinical record of Resident #81 was reviewed on 12/4/15 at 3:23 p.m. Diagnoses for the resident included, but were not limited to, pressure ulcer and urinary obstruction.</p> <p>A recapitulated physician's order for December, 2015, with an original order date of 2/26/15, indicated Resident #81 had a urinary catheter (a tube which</p>	F 0282	<p>1)What correctiveactions will be accomplished for those residents found to have been affected bythe deficient practice? Resident # 81 catheter wasaccessed and repositioned properly on wheelchair so it does not touch thefloor. Resident # 152 catheter wasaccessed and repositioned properly on wheelchair so it does not touch thefloor.</p> <p>2) How otherresidents having the potential to be affected by the same deficient practicewill be identified and what corrective actions will be taken? All residents who reside in thefacility and have catheters have the potential to be affected by the allegeddeficient practice. An audit of theresidents with</p>	12/28/2015

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	<p>drains urine from the bladder).</p> <p>A care plan dated 5/18/15 and current through 2/3/16, indicated a problem of, "Resident requires an indwelling urinary catheter." Approaches included, "Do not allow tubing or any part of the drainage system to touch the floor."</p> <p>On 12/1/15 at 11:05 a.m., 12/1/15 at 2:20 p.m., and 12/10/15 at 10:10 a.m., Resident #81's urinary catheter bag was observed lying on the floor in her room.</p> <p>On 12/9/15 at 2:00 p.m., the Executive Director provided policies titled, "Bladder Program," dated 11/20/14, and "Indwelling urinary Catheter...Nursing Policy & Procedure... dated 12/2012, and indicated they were the policies currently used by the facility. The policies did not contain information regarding keeping the urinary catheter drainage system off of the floor.</p> <p>On 12/10/15 at 3:30 p.m., the Executive Director and the Director of Nursing Services indicated it was the facility policy that no part of a urinary drainage system should touch the floor.</p> <p>2. The clinical record review for Resident #152, was completed on 12/8/15 at 10:58 a.m. Diagnoses included, but were not limited to,</p>		<p>catheters found them all to be hanging from bed or wheelchair inprivacy bags that do not touch the ground. The DNS and/or Designee will conduct a staff in-service on catheter careon December 22nd,2015</p> <p>3) What measureswill be put into place or what systemic changes will be made to ensure that thedeficient practice will not recur? The CEC and/or Designee willconduct a staff in-service on catheter care including handling of catheter bagsand positioning of catheter tubing on December 22nd, 2015. The DNS or designee will round each shift toensure catheter tubing is placed appropriately in privacy bags and ensure thetubing does not touch the ground.</p> <p>4) How hecorrective actions will be monitored to ensure the deficient practice will notrecur i.e., what quality assurance program will be put into place To ensure compliancea Catheter CQI audit tool will be completed for six months with audits beingcompleted once weekly for one month, and then monthly for 5 months by a nursemanager or designee. The catheter CQI audit tool will be reviewed monthly bythe CQI Committee for six months after which the CQI team will re-evaluate thecontinued need for the audit. If a 100% threshold is not achieved an actionplan will be developed.</p>				

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	<p>retention of urine and heart failure.</p> <p>A recapitulated physician's order dated 11/4/15, indicated Resident #152 was to have an indwelling urinary catheter in place.</p> <p>A careplan for Resident #152 dated 10/5/15 and current through 1/23/16, indicated resident required an indwelling urinary catheter and is at risk for infection. Interventions included, but were not limited to, "...Do not allow tubing or any part of the drainage system to touch the floor...."</p> <p>During an observation on 12/10/15 at 9:42 a.m., Resident #152's indwelling catheter drainage bag was observed resting on the floor.</p> <p>On 12/9/15 at 2:00 p.m., the Executive Director provided policies titled, "Bladder Program," dated 11/20/14, and, "Indwelling urinary Catheter...Nursing Policy & Procedure... dated 12/2012, and indicated they were the policies currently used by the facility. The policies did not contain information regarding keeping the urinary catheter drainage system off of the floor.</p> <p>On 12/10/15 at 3:30 p.m., the Executive Director and the Director of Nursing</p>		<p>Deficiency in this practice will result in disciplinary action up to and or including termination of the responsible employee.</p>	

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F 0315 SS=D Bldg. 00	<p>Services indicated it was the facility policy that no part of a urinary drainage system should touch the floor.</p> <p>3.1-35(g)(2)</p> <p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on observation, record review, and interview, the facility failed to ensure urinary catheter drainage bags were maintained in a manner to prevent urinary tract infection for 2 of 2 residents observed for care of urinary catheter drainage bags. (Residents #81 and #152)</p> <p>Findings include:</p> <p>1. The clinical record of Resident #81 was reviewed on 12/4/15 at 3:23 p.m. Diagnoses for the resident included, but</p>	F 0315	<p>1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Resident # 81 catheter was accessed and repositioned properly on wheelchair so it does not touch the floor.</p> <p>Resident # 152 catheter was accessed and repositioned properly on wheelchair so it does not touch the floor.</p> <p>2. How other residents having the potential to be affected by</p>	12/28/2015

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	<p>were not limited to, pressure ulcer and urinary obstruction.</p> <p>A recapitulated physician's order for December, 2015, with an original order date of 2/26/15, indicated Resident #81 had a urinary catheter (a tube which drains urine from the bladder).</p> <p>A care plan dated 5/18/15 and current through 2/3/16, indicated a problem of, "Resident requires an indwelling urinary catheter." Approaches included, "Do not allow tubing or any part of the drainage system to touch the floor."</p> <p>On 12/1/15 at 11:05 a.m., 12/1/15 at 2:20 p.m., and 12/10/15 at 10:10 a.m., Resident #81's urinary catheter bag was observed lying on the floor in her room.</p> <p>On 12/9/15 at 2:00 p.m., the Executive Director provided policies titled, "Bladder Program," dated 11/20/14, and, "Indwelling urinary Catheter...Nursing Policy & Procedure... dated 12/2012, and indicated they were the policies currently used by the facility. The policies did not contain information regarding keeping the urinary catheter drainage system off of the floor.</p> <p>On 12/10/15 at 3:30 p.m., the Executive Director and the Director of Nursing</p>		<p>the same deficient practice will be identified and what corrective actions will be taken?</p> <p>All residents who reside in the facility and have catheters have the potential to be affected by the alleged deficient practice. An audit of the residents with catheters found them all to be hanging from bed or wheelchair in privacy bags that do not touch the ground. The DNS and/or Designee will conduct a staff in-service on catheter care on December 22nd, 2015</p> <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice will not recur?</p> <p>The CEC and/or Designee will conduct a staff in-service on catheter care including handling of catheter bags and positioning of catheter tubing on December 22nd, 2015. The DNS or designee will round each shift to ensure catheter tubing is placed appropriately in privacy bags and ensure the tubing does not touch the ground.</p> <p>4. How he corrective actions will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place</p> <p>To ensure compliance a Catheter CQI audit tool will be completed for six months with audits being completed once weekly for one month, and then monthly for</p>	

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	<p>Services indicated it was the facility policy that no part of a urinary drainage system should touch the floor.</p> <p>2. The clinical record review for Resident #152, was completed on 12/8/15 at 10:58 a.m. Diagnoses included, but were not limited to, retention of urine and heart failure.</p> <p>A recapitulated physician's order dated 11/4/15, indicated Resident #152 was to have an indwelling urinary catheter in place.</p> <p>A careplan dated 10/5/15 and current through 1/23/16, indicated Resident #152 required an indwelling urinary catheter and is at risk for infection. Interventions included, but were not limited to, "...Do not allow tubing or any part of the drainage system to touch the floor...."</p> <p>During an observation on 12/10/15 at 9:42 a.m., Resident #152's indwelling catheter drainage bag was observed resting on the floor in resident's room.</p> <p>On 12/9/15 at 2:00 p.m., the Executive Director provided policies titled, "Bladder Program," dated 11/20/14, and "Indwelling urinary Catheter...Nursing Policy & Procedure... dated 12/2012, and indicated they were the policies currently</p>		<p>5 months by a nursemanager or designee. The catheter CQI audit tool will be reviewed monthly bythe CQI Committee for six months after which the CQI team will re-evaluate thecontinued need for the audit. If a 100% threshold is not achieved an actionplan will be developed. Deficiency in this practice will result in disciplinaryaction up to and or including termination of the responsible employee.</p>	

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F 0323 SS=D Bldg. 00	<p>used by the facility. The policies did not contain information regarding keeping the urinary catheter drainage system off of the floor.</p> <p>On 12/10/15 at 3:30 p.m., the Executive Director and the Director of Nursing Services indicated it was the facility policy that no part of a urinary drainage system should touch the floor.</p> <p>3.1-41(a)(2)</p> <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 record review and interview, the facility failed to ensure a resident's falls were reviewed for root cause and new interventions for 1 of 3 residents who met the criteria for review of accidents. (Resident #81)</p> <p>Findings include:</p> <p>The clinical record of Resident #81 was reviewed on 12/4/15 at 3:23 p.m. Diagnoses for the resident included, but were not limited to, muscle weakness.</p>	F 0323	<p>1.What corrective action(s) will be taken for those residents found to have been affected by the deficient practice? Resident #81's falls from 11/2, & 11/23 were reviewed by the IDT team. The root cause was determined, new interventions were put in place and the care plan was reviewed and updated.2. 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 who are at risk for falls have the potential</p>	12/28/2015

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	<p>A care plan for Resident #81, dated 5/18/15 and current through 2/3/16, indicated the resident was at risk for falls due to weakness, insomnia, arthritis and use of psychotropic medications.</p> <p>The resident's record indicated she experienced 4 falls in November, 2015: 11/2, 11/11, 11/12, and 11/23/2015.</p> <p>Progress notes indicated the falls on 11/11/15 and 11/12/15, were reviewed by the Interdisciplinary Team (IDT) for root cause.</p> <p>No information was found in the resident's record which indicated the IDT had reviewed the falls which occurred on 11/2/15 and 11/23/15.</p> <p>On 12/9/15 at 9:45 a.m. the Executive Director (ED) indicated the resident's falls on 11/2/15 and 11/23/15 had not been reviewed by the IDT.</p> <p>On 12/8/15 the ED provided a policy titled, "Fall Management Program," dated 2/2015, and indicated it was the policy currently used by the facility. The policy indicated, "...5. All falls will be discussed by the interdisciplinary team at the 1st IDT meeting after the fall to determine root cause and other possible interventions to prevent future falls...The</p>		<p>tobe affected by the same alleged deficient practice. An audit will be performed DNS or designee on all residentswho had a fall in the last 30 days to ensure IDT reviewed, the root causedetermined and the new interventions were put in place to prevent furtheroccurrences. An IDT note was written andthe care plan was updated. DNS/Designee will in-service IDT on appropriate IDT reviewfor each fall on or before December 23rd, 2015 3. What measures will be put into place orwhat systemic changes will you make to ensure that the deficient practice doesnot recur?</p> <p>1.DNS/Designee will in-service IDT on appropriate IDT review for each fallon or before December 23rd, 2015 DNS / Designee will review resident falls daily. The falls will then bereviewed by the IDT team at the first IDT meeting status post the fall todetermine the root cause and other possible interventions to prevent further falls.</p> <p>2.How the corrective action(s) will bemonitored to ensure the deficient practice will not recur, i.e. what qualityassurance program will be put into place?</p> <p>A Fall CQI audit tool will be completed for six months withaudits being completed once weekly for one month, and then monthly for 5 monthsby a nurse manager or designee. The Fall</p>	

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F 0514 SS=D Bldg. 00	<p>fall event will be reviewed by the team...IDT note will be written...The care plan will be reviewed and updated, as necessary."</p> <p>3.1-45(a)(2)</p> <p>483.75(l)(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 interview and record review, the facility failed to ensure a resident's clinical record contained complete documentation of dialysis event report as indicated by facility policy. (Resident #39).</p> <p>Findings include: A clinical record review for Resident</p>	F 0514	<p>CQI audit tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 100% threshold is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and or including termination of the responsible employee.</p> <p>1.What action has been taken for each resident cited in the alleged deficiency? Resident #39 chart was reviewed and adialysis event was noted present for resident's most recent appointment.</p> <p>2.How will the Provider identify other residents that may be affected by the same alleged deficient practice and what action taken to correct</p>	12/28/2015

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	<p>#39, was completed on 12/4/15 at 9:42 a.m. Diagnoses included, but were not limited to, chronic kidney disease and congestive heart failure.</p> <p>A physician's order dated 11/19/14, indicated Resident #39 has dialysis on Tuesdays, Thursdays, and Saturdays.</p> <p>A review of dialysis event reports (at departure dialysis site and transportation information and upon return assessment of dialysis access site, vital signs, and any new orders from the dialysis center), lacked dialysis event reports for September 10, 15, 19, 22, 29, October 1, 17, 22, November 3, 7, 12, 19, 24, and 26.</p> <p>On 12/9/15 at 2:15 p.m., the Director of Nursing Services (DNS) provided a policy titled Dialysis Care, dated 1/2015, and indicated it was the current policy used by the facility. The policy indicated "...5. A dialysis event will be initiated in EMR [electronic medical record] to include time of transfer and completed on return to the unit..."</p> <p>On 12/9/15 at 4:51 p.m., the DNS indicated no dialysis event reports for September 10, 15, 19, 22, 29, October 1, 17, 22, 29, November 3, 7, 12, 19, 24 or 26 were available for Resident #39. The</p>		<p>this alleged deficient practice. All resident who receive dialysis have thepotential to be affected by the alleged deficient practice. An audit was performed on all residents whoreceive dialysis to ensure a dialysis event was completed for the most recentdialysis appointment. DNS/Designee will complete an in-service ondialysis events on December 22nd, 2015</p> <p>3.What systemic changes will be taken toensure the alleged deficient practice does not recur? DNS/Designee will complete an in-service ondialysis events on December 22nd, 2015. Each dialysis day, the responsible nurse willopen the dialysis appointment event and complete the dialysis transportationsection before sending to dialysis. Upon return, the responsible nurse willopen the dialysis event and complete the return from dialysis appointmentsection, including assessment of site, general condition, and vital signs. DNS/Designee will review allresidents on dialysis daily to ensure dialysis event was open upon going todialysis and then completed upon return. 4. How will the corrective action be monitoredor what quality assurance program implemented to ensure the alleged deficientpractice does not recur? A Dialysis audit tool will be completed for six months withaudits being completed once</p>	

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NAME OF PROVIDER OR SUPPLIER FOREST CREEK VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 525 E THOMPSON RD INDIANAPOLIS, IN 46227		
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	DNS indicated dialysis event reports should have been created and completed on those dates. 3.1-50(a)(1)		weekly for one month, and then monthly for 5 months by a nurse manager or designee. The Dialysis CQI audit tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 100% threshold is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee.		