

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155784	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/16/2015
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NAME OF PROVIDER OR SUPPLIER  CREEKSIDE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1420 E DOUGLAS RD MISHAWAKA, IN 46545
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F 0000  Bldg. 00	<p>This visit was for the Investigation of Complaint IN00184037.</p> <p>Complaint IN00184037 - Substantiated. Federal/State deficiencies related to the allegation are cited at F157 and F315.</p> <p>Survey date: November 16, 2015</p> <p>Facility number: 012329 Provider number: 155784 AIM number: 201002500</p> <p>Census bed type: SNF/NF: 73 Total: 73</p> <p>Census payor type: Medicare: 10 Medicaid: 41 Other: 22 Total: 73</p> <p>Sample: 3</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review completed by 14454 on November 21, 2015.</p>	F 0000	<p><b>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 any violation of regulation.</b></p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

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

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F 0157 SS=D Bldg. 00	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p>			

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	<p>Based on record review and interview, the facility failed to ensure the physician was contacted prior to anchoring a Foley catheter for a resident to obtain a urine sample for a urinalysis for 1 of 1 residents reviewed for catheters in a sample of 3. (Resident "D")</p> <p>Finding includes:</p> <p>The record of Resident "D" was reviewed on 11/16/15 at 11:30 a.m. Resident "D" was admitted to the facility, on 04/02/14, with diagnoses including, but not limited to, CVA (Cerebral-Vascular Accident: stroke), dementia, BPH (Benign Prostate Hypertrophy: enlarged prostate) and depression.</p> <p>The nurses "Progress Notes" indicated: "07/06/15 1050 [10:50 a.m.] Dr. [Urologist] office called [urology] stating that [Resident's spouse] called their office stating that resident is having issues c [with] urinary incontinence &amp; [and] is requesting a urine sample be tested. New order received per Dr. [Urologist] to obtain a U/A [Urinalysis] C&amp;S [Culture &amp; Sensitivity] if indicated."</p> <p>The Physician Orders indicated: "07/06/15 1050 [10:50 a.m.] U/A C&amp;S if indicated. Dx [Diagnosis]: urinary incontinence."</p>	F 0157	<p><b>Notify of change (Injury, decline, room changes) It is the practice of this facility to assure that the physician is contacted prior to anchoring a foley catheter for a resident to obtain a urine sample.</b></p> <p><b>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b></p> <p>1. Resident "D" has been discharged from the facility.</p> <p><b>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;</b></p> <p>1. All residents that have an order to collect a urine sample have the potential to be affected by this alleged deficient practice.</p> <p>2. 100% of residents that receive an order to obtain a urine sample will be audited for appropriate physician order regarding collection of the specimen.</p> <p><b>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</b></p> <p>1. All licensed nurse in-service will be held on or before 12/16/2015 regarding contacting a physician prior to anchoring a foley catheter for a resident to obtain a urine sample.</p>	12/16/2015			

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	<p>The next physician order read: "07/09/15 0230 [2:30 a.m.] Send to [hospital name] ER for eval/tx [evaluate/treat]. Res pulled foley catheter out."</p> <p>There was no documentation in the record in regard to obtaining an order for a catheter, when the catheter was inserted or who inserted the catheter.</p> <p>The DNS (Director Nursing Services) was interviewed on 11/16/15 at 12:15 p.m. The DNS indicated at the time of the incident she was a staff nurse and was unaware there was no order to catheterize Resident "D." The DNS indicated staff should have obtained an order and document the procedure and assessments.</p> <p>RN #5 was interviewed on 11/16/15 at 2:35 p.m. RN #5 indicated she called the Urologist's office on 07/06/15, for the order for the U/A C&amp;S. RN #5 indicated there was no order, at the time, to catheterize Resident "D."</p> <p>On 11/16/15 at 2:00 p.m., the DNS provided the current corporate Policy &amp; Procedure, "BLADDER PROGRAM: 11/2014," which indicated:</p> <p>"Policy: It is the policy of American</p>		<p>2.DNS/Designee will review the 24 hour communication books and new physician orders daily.</p> <p><b>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;</b></p> <p>1.To ensure compliance, the DNS/designee is responsible for the completion of the Catheter Assessment CQI tool weekly times 4, bi-weekly times 2, and monthly times 6 and then quarterly until continued compliance is maintained. The results of these audits will be reviewed by the CQI Committee overseen by the ED. If 95% compliance is not achieved an action plan will be developed.</p> <p><b>5.By what date the systemic changes will be completed.</b></p> <p>1.Completed by 12/16/2015.</p>	

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F 0315 SS=G Bldg. 00	<p>Senior Communities to promote independence and dignity with an appropriate bladder program based upon each resident's ability."</p> <p>"...Residents with Foley Catheters...3. If it is determined an indwelling catheter IS medically necessary, obtain a physician's order with size of catheter and balloon, frequency of changing, and the diagnosis of condition to support the use."</p> <p>This Federal tag relates to Complaint IN00184037.</p> <p>3.1-5(a)(3)</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 record review and interview, the facility failed to accurately assess and monitor a resident prior to and following</p>	F 0315	<b>NoCatheter, Prevent UTI, Restore Bladder Itis the practice of this facility to accurately assess and monitor a residentprior to and</b>	12/16/2015

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	<p>the insertion of a Foley catheter which resulted in the Resident pulling out the catheter resulting in a traumatic urethral injury and hospitalization. This deficiency affected 1 of 3 residents reviewed for Foley catheters. (Resident "D")</p> <p>Finding includes:</p> <p>The record of Resident "D" was reviewed on 11/16/15 at 11:30 a.m. Resident "D" was admitted to the facility, on 04/02/14, with diagnoses including, but not limited to, CVA (Cerebral-Vascular Accident: stroke), dementia, BPH (Benign Prostate Hypertrophy: enlarged prostate) and depression.</p> <p>The nurses "Progress Notes" indicated: "07/06/15 1050 [10:50 a.m.] Dr. [Urologist] office called [urology] stating that [Resident's spouse] called their office stating that resident is having issues c [with] urinary incontinence &amp; [and] is requesting a urine sample be tested. New order received per Dr. [Urologist] to obtain a U/A [Urinalysis] C&amp;S [Culture &amp; Sensitivity] if indicated...."</p> <p>"07/09/15 See SBAR [Situation Background Appearance Review &amp; Notify] for discharge note."</p>		<p><b>following the insertion of a foley catheter.</b></p> <p><b>1.Whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice;</b></p> <p>1.Resident "D" has been dischargedfrom the facility.</p> <p><b>2.Howother residents having the potential to be affected by the same deficientpractice will be identified and what corrective action(s) will be taken;</b></p> <p>1.Allresidents with a foley catheter have to potential to be affected by thisalleged deficient practice.</p> <p>2.100%audit of residents with a foley catheter will be completed to ensureappropriate physician order including size of catheter and balloon, frequencyof changing, the diagnosis to support the use, and appropriate care plan.</p> <p><b>3.Whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur;</b></p> <p>1.Alllicensed nurse in-service will be held on or before 12/16/2015 regardingaccurately assessing and monitoring a resident prior to and following theinsertion of a foley catheter.</p> <p>2.DNS/Designee will review the 24 hour communication books</p>	

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	<p>The SBAR indicated: "07/09/15 Catheter was placed approx [approximately] 12:30 a.m. to collect a U/A. Res [Resident] has been incontinat [sic] and unable to provide a clean catch. This writer observed there still was no output p [after] 1 hr [hour] and attempted to check cath [catheter] placement. Res call-light and bed control were wrapped around cath and knotted together. Unable to deflate baloon [sic]. Cath cut and still no fluid output. Cath not moving when attempted to reposition. Nurse notified manager, res. [resident's] wife and Dr. [Primary Physician]. When returning to res. [resident] room, res. state he pulled it out himself. Foley out &amp; intact. Sm. [small] amount of bleeding from penis. Sent to [hospital name] ER for eval [evaluation]...."</p> <p>The Physician Orders indicated: "07/06/15 1050 [10:50 a.m.] U/A C&amp;S if indicated. Dx [Diagnosis]: urinary incontinence."</p> <p>The next Physician Order read: "07/09/15 0230 [2:30 a.m.] Send to (hospital name) ER for eval/tx [evaluate/treat]. Res pulled foley catheter out."</p> <p>There was no documentation in the record in regards to obtaining an order for</p>		<p>and new physician orders daily. 3.DNS/Designee will review all new admissions/re-admissions for placement of foley catheter and ensure that appropriate physician order including size of catheter and balloon, frequency of changing, the diagnosis to support the use, and appropriate care plan are in place.</p> <p><b>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;</b> 1.To ensure compliance, the DNS/designee is responsible for the completion of the Catheter Assessment CQI tool weekly times 4, bi-weekly times 2, and monthly times 6 and then quarterly until continued compliance is maintained. The results of these audits will be reviewed by the CQI Committee overseen by the ED. If 95% compliance is not achieved an action plan will be developed. 2.IDT will complete Admission/Re-admission Review and Care Plan Initiation Update tool daily for all new admissions.</p> <p><b>5.By what date the systemic changes will be completed.</b> 1.Complete by 12/16/2015.</p>		

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	<p>a catheter, when the catheter was inserted, or who inserted the catheter.</p> <p>Review of the Acute Care Facility [hospital] History &amp; Physical indicated: "07/09/15...CHIEF CONCERN: Traumatic urethral injury [urethral tear].</p> <p>HISTORY OF PRESENT ILLNESS: The patient is a very poor historian and cannot tell me any reliable history... Wife has been requesting a urine sample. However, the nursing home cannot get a clean catch. Foley catheter is then ordered. However, the patient tried to pull it out after insertion. The Foley catheter then got stuck. Nursing home staff has to cut the Foley catheter and finally managed to get it out. The patient then had hematuria from the traumatic Foley removal...</p> <p>IMPRESSION: 1. Urethral injury due to traumatic Foley removal...</p> <p>PLAN: 1. Anticipating less than 2 midnights of hospitalization and the patient will be admitted as an observation status...."</p> <p>The DNS (Director Nursing Services) was interviewed on 11/16/15 at 12:15 p.m. The DNS indicated at the time of the incident she was a staff nurse and was</p>			

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	<p>unaware there was no order to catheterize Resident "D." The DNS indicated staff should have obtained an order and document the procedure and assessments.</p> <p>RN #5 was interviewed on 11/16/15 at 2:35 p.m. RN #5 indicated she called the Urologist's office on 07/06/15 for the order for the U/A C&amp;S. RN #5 indicated there was no order, at the time, to catheterize Resident "D."</p> <p>On 11/16/15 at 3:00 p.m. the DNS provided the current corporate Policy &amp; Procedure, "BLADDER PROGRAM: 11/2014," which indicated:</p> <p>"Policy: It is the policy of American Senior Communities to promote independence and dignity with an appropriate bladder program based upon each resident's ability."</p> <p>"...Residents with Foley Catheters...3. If it is determined an indwelling catheter IS medically necessary, obtain a physician's order with size of catheter and balloon, frequency of changing, and the diagnosis of condition to support the use."</p> <p>This Federal tag relates to Complaint IN00184037.</p> <p>3.1-41(a)(1)</p>			

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