STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155714	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/17/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK VILLAGE INC	200 W FOURTH ST OAKTOWN, IN 47561

(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
F000000	This visit was for the Investigation of Complaint IN00129325 and Complaint IN00130252. Complaint IN00129325 - Unsubstantiated, due to lack of evidence. Complaint IN00130252 - Substantiated, Federal/State deficiencies related to the allegations are cited at F315. Survey dates: June 13 and 17, 2013 Facility number: 000517 Provider number: 155714 AIM number: 100266770 Survey team: Anne Marie Crays RN Census bed type: SNF/NF: 28 Total: 28 Census payor type: Medicare: 3 Medicaid: 18 Other: 7	F000000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	Total: 28 Sample: 12 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on June 17, 2013, by Jodi Meyer, RN			

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F000315 SS=G	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. Based on interview and record review, the facility failed to ensure a resident with a suprapubic catheter received appropriate care, in that the wrong port was used to flush the catheter, resulting in pain and discomfort, and also resulted in the need for a surgical procedure to be performed to remove a piece of a catheter balloon lodged in the bladder, for 1 of 1 residents reviewed with urinary catheters, in a sample of 12. Resident A Findings include: 1. On 6/13/13 at 11:00 A.M., LPN # 2 indicated Resident A was the only resident in the facility who had a urinary catheter.	F000315	F315 The corrective action taken for Resident A is that attending physician was notified. A new 18 Foley catheter was inserted into suprapubic site using sterile technique. Resident had patent draining with clear yellow urine. Resident tolerated well. Director of Nursing, and Administrator notified. Message was left for family member. On 5-20-2013 resident's urologist was notified by nursing staff. Administrator spoke with urologist on 5-20-13 and urologist stated that resident was in no danger and it would not result in any undue pain. Cystourethroscopy was scheduled	06/21/2013

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	The clinical record of Resident A was reviewed on 6/13/13 at 3:55 P.M. Diagnoses included, but were not limited to, neurogenic bladder and history of urinary retention. Physician orders, initially dated 6/22/11 and on the May 2013 orders, indicated, "Flush suprapubic cath with 60 ml normal saline each night," and "Flush suprapubic cath [with] 10 ml normal saline as needed to maintain patency." A physician's order, initially dated 11/25/12 and on the May 2013 orders, indicated, "Change 18 Fr [catheter size] 5 cc [balloon size, indicating 5 cc of liquid is to be instilled in the balloon] Suprapubic cath every month & RN [as needed]." An additional physician's order, dated May 15, 2013, indicated, "May flush SP [suprapubic] cath with saline or water prn up to QID [four times daily], change SP cath monthly." Nurses notes included the following notations: 5/19/13 at 7:30 P.M.: "Res. [resident] c/o [complains of] feeling a 'pop' when cath flushed the last time et [and] now		and performed on 6-4-13 and remnant of catheter bulb was removed without incident. Red tape is applied to the bulb installation port as a visual reminder of caution. The corrective action taken for other residents having the potential to be affected is that no other residents were identified. The measures and systemic changes that were made is that all RNs and LPNs were in-serviced one on one by the Interim Director of Nursing. All newly hired RNs and LPNs will be in-serviced as to proper flushing and changing of catheters as appropriate. The action taken to monitor the proper flushing and changing of the suprapubic catheter is that a Performance Improvement tool was implemented. This tool will be completed by nursing with each flush and change of catheter; daily times three weeks, weekly times three weeks, monthly times three months and quarterly times three quarters. Tool will be monitored daily, weekly, monthly and quarterly by DON or her designee. This tool will be reviewed in QA meetings to see if further action is warranted.	

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	having extensive pain et discomfort. Foley catheter [changed]. Noted that bulb on Foley did not appear to be intact. Notified [primary physician]. N.O. [new order] UA C&S [urinalysis, culture and sensitivity], contact urology in AM. Notified DON [Director of Nursing]. New 18F Foley inserted into suprapubic site using sterile technique, patent draining clear yellow urine...." 5/20/13 at 2:00 P.M.: "Called [Urologist] R/T [related to] res cath et bulb [not] intact. [Urologist] will do cystoscopy on 6/4/13 @ noon. Will order 3 way cath for res et [and] inservice nurses individually on flush procedure...." 5/22/13 at 1:00 P.M.: "Paged [primary physician] resident c/o burning and feeling like she has to void constantly...." 5/22/13 at 3:15 P.M.: "[Primary physician] return [sic] call. New order Levaquin [antibiotic]...for UTI [urinary tract infection]...." 6/3/13 at 5:00 P.M.: "Res in pain [with] catheter, flushed x 3, changed drsg [dressing] had odor...red around site...."			

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	6/4/13 at 1:45 P.M.: "Return from hospital had a piece of cath in bladder was removed no new orders...." A hospital operating record, dated 6/4/13, indicated, "...presents with a history of suprapubic catheter. Recently at the nursing home her catheter was irrigated but irrigated through the wrong port. The balloon was inflated, popped, and when the catheter was removed there was a piece of balloon missing. She is brought at this time for cystourethroscopy and removal of the piece of the balloon...Cystourethroscopy was performed...A piece of latex was identified in the bladder consistent with the piece from her catheter balloon...." On 6/17/13 at 10:00 A.M., during interview with the Urologist, he indicated he was informed by the facility staff that a young nurse instilled water into the balloon port and a piece of the balloon ruptured. He indicated he removed the balloon piece, and "she should be fine." The Urologist indicated the facility had informed him the nurse was a young nurse who "didn't have a lot of Foley catheter experience."			

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	On 6/17/13 at 10:45 A.M., during interview with the current DON, she indicated she had been at the facility for approximately 3 weeks, and was not present during the incident with Resident A. She indicated she had been told that a nurse new to the facility, but not a "new nurse," flushed the wrong port on Resident A's catheter, causing the balloon to rupture. The DON indicated she did not know if LPN # 1 was nervous, or if it was dark in the room, or what the exact circumstances were. The DON indicated she was informed that LPN # 1 and all of the nurses were inserviced on the proper procedure of flushing a catheter, and that different catheters were ordered. 2. On 6/17/13 at 1:30 P.M., the DON provided a document, dated 5/21/13, which included: "[LPN # 1] was inserviced this dated in a one-to-one inservice by [RN # 1] DON regarding the proper flush procedure for [Resident A's] supra pubic catheter. DON demonstrated in a step by step fashion the proper procedure and port with which to flush [Resident A's] catheter without actually flushing the catheter. [LPN # 1] repeated process back to DON and flushed [Resident A's] catheter while being monitored. No errors were made and resident			

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	tolerated flush well without complaints." This federal tag relates to Complaint IN00130252. 3.1-41(a)(1)			