STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155628	A. BUILDING 00 B. WING	05/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CREEKSIDE HEALTH AND REHABILITATION CENTER	3114 EAST 46TH STREET INDIANAPOLIS, IN 46205

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00379018. Complaint IN00379018 - Substantiated. Federal/State deficiencies related to the allegations are cited at F687, F773, and F697. Survey dates: May 9 and 10, 2022 Facility number: 009569 Provider number: 155628 AIM number: 200139920 Census bed type: SNF/NF: 114 Total: 114 Census payor type: Medicare: 12 Medicaid: 85 Other: 17 Total: 114 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on May 12, 2022	F 0000	**The completion of this plan of correction does not constitute an admission that the alleged deficiency exists. The plan of correction is provided as evidence of the facilities desire to comply with the regulations and continue to provide quality care in a safe environment. The facility is requesting a desk review for compliance.**	
F 0687 SS=D Bldg. 00	483.25(b)(2)(i)(ii) Foot Care §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of			

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

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	practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. Based on interview and record review, the facility failed to ensure a resident's podiatry appointment was scheduled timely for 1 of 3 residents reviewed for hospitalizations. (Resident D) Findings include: The clinical record for Resident D was reviewed on 5/9/22 at 2:41 p.m. Resident D's diagnoses included, but not limited to, peripheral vascular disease, unspecified injury to right foot, anxiety, and history of falls. A nursing note dated 4/9/22 at 3:35 p.m. indicated, Resident D had fallen. She was found "laying on her back in her bathroom". A physician's progress note dated 4/11/2022 at 3:59 p.m. indicated, "Patient seen in her room seated comfortably in her bed. Per discussion with staff as well as chart review, patient did sustain a recent fall. She was found on the bathroom floor by nursing staff. Patient was found lying on her back in the bathroom...Patient denies hitting her head or losing consciousness during her fall. She did have some right foot pain with swelling noted after her fall. A set of right foot plain radiographs was[sic, were] taken and these were reviewed today. Those plain radiographs were without evidence of acute fracture or dislocation. Patient is endorsing some aching type pain at the right foot today. Her pain is aggravated by touch. Her pain is alleviated with rest as well as oral	F 0687	**Requesting an IDR for this deficiency due to data is misrepresented and not all inclusive.** The facility will ensure compliance through the following corrective measures: 1. Resident D's post discharge podiatry appointment was scheduled. Resident D discharged home as scheduled. 2. All other residents have the potential to be affected. See below for corrective measures moving forward. 3. Licensed staff educated on facility protocol on scheduling post discharge appointments. All admission and new admission discharge summaries are reviewed. Admission/readmission audit tools in place to ensure any post discharge appoints have been scheduled. The DON or her designee will review the admission/readmission audit tools 5x weekly for 4 weeks and until 100% compliance is achieved,	05/25/2022

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	medications...". Resident D was discharged from the facility to home with her son on 4/11/22. Resident D was readmitted to the facility following a hospitalization for altered mental status and failure to thrive at home on 4/21/22. A nursing note dated 4/21/22 at 3:06 p.m. indicated, Resident D had bruising noted to her right outer foot and treatment included painting it with betadine and wrap with kerlix daily and as needed. Also noted was, the presence of a blister to the top of right foot. Resident D rated her pain to the right foot as a 9 out of 10. A rating of 10 being the worst pain. A physician's progress note dated 4/22/22 indicated, Resident D had a fluid filled blister at the dorsal aspect of the right foot with surrounding redness as well as bruising to the side of the right foot. A change in condition note dated 4/29/22 at 11:05 a.m. indicated, the wound physician assessed Resident D and requested that Resident D be sent out to the emergency room for further evaluation and treatment related to possible gangrene of the foot ligaments and or tendons. A nursing note dated 5/4/22 at 8:55 p.m. indicated, Resident D was re-admitted to the facility following a hospitalization for right foot pain. A Inpatient Discharge Instruction sheet was accessed via the documents tab in the facility's electronic health record on 5/10/22 at 9:40 a.m. The discharge instruction sheet indicated, under the "What to do next. You need to follow up after discharge" section, Resident D needed to follow		then weekly for 5 months and until 100% compliance is maintained. 4. The findings of these reviews will be presented to the QAPI Committee during the facility's monthly meetings and the plan of action adjusted accordingly.	

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	up with [Podiatrist's name and office information] in 5 to 7 days. A Surgical note was received on 5/10/22 at 9:49 a.m. It indicated, Resident D's right foot required an I&D[incision and debridement) to exsanguinate[sic, remove blood] the 7.9 cm abscess or hematoma which developed as a result of the trauma to the right foot approximately 4 weeks prior. Resident D's clinical record did not indicate if or when the follow-up Podiatry appointment had occurred or was scheduled. An interview with DON (Director of Nursing) was conducted on 5/10/22 at 11:32 a.m. DON indicated, she was not aware that Resident D's follow-up podiatry appointment had not been scheduled previous to today when questioned about it. She wasn't sure why there was a delay in the scheduling a follow up appointment for Resident D. She further stated, it was the responsibility of the admission nurse to, depending on day and time the resident arrived, either schedule the follow up appointment or to place an order for the next business day shift nurse to schedule the follow up appointment. DON indicated the expectation was to have the appointment made or to show the attempts made to schedule the follow-up appointment within 24 hours during normal business hours. This Federal Tag relates to complaint IN00379018. 3.1-47(a)(7) 3.1-37(b)			
F 0697 SS=G	483.25(k) Pain Management			

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Bldg. 00	§483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on interview and record review, the facility failed to timely address a resident's continued pain resulting in a delayed hospitalization with rib fracture and sepsis related to a UTI (urinary tract infection) and to monitor the effectiveness of pain medication timely for 2 of 3 residents reviewed for falls and hospitalization. (Residents B and D) Findings include: 1. The clinical record for Resident B was reviewed on 5/9/22 at 10:50 a.m. The diagnoses included, but were not limited to: heart failure, chronic obstructive pulmonary disease, history of falling, mononeuropathy of right lower limb, BPH (benign prostatic hyperplasia,) obstructive and reflux uropathy, chronic kidney disease, and neuromuscular dysfunction of bladder. The physician's orders indicated to administer one 500 mg tablet of Acetaminophen every 4 hours as needed for pain. The BPH care plan indicated he was at risk for urinary tract infections. The goal was for him to be free from signs and symptoms of a UTI with an intervention for him to report and for the facility to observe for signs and symptoms of a UTI such as burning and pain on urination. The at risk for falls care plan indicated the goal was to minimize his risk for falls resulting in serious injury.	F 0697	**Requesting an IDR for this deficiency due to data is misrepresented and not all inclusive.** The facility will ensure compliance through the following corrective measures: 1. Resident D discharged home as scheduled. 2. All other residents have the potential to be affected. See below for corrective measures moving forward. 3. The Medication Administration and Pain Evaluation policies were reviewed and no changes are indicated. Licensed nursing staff will be educated on the importance of following and signing off medication administration and timely documentation of the effectiveness following the PRN administration . Additionally, the same staff will be educated on the need to assess new complaints of pain or unresolved pain and report to the on-call physician or NP. The DON	05/25/2022

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	The 4/12/22 nurse practitioner note referenced and unwitnessed fall with a skin tear while transferring from the wheel chair to the toilet seat. There was no pain. His vitals were stable, and his neurological checks were within normal limits. The 4/14/22, 9:11 p.m. NP (Nurse Practitioner) note, written by NP 3, indicated he was seen for an acute visit for dysuria (discomfort, pain, or burning when urinating.) He self catheterized and had frequent UTIs. He denied hematuria (blood in urine,) fever, chills, or flank pain. His recent labs showed elevated WBC (white blood cells) from baseline at 10.1. There were no other concerns today. It read, "He reports difficulty urinating and increased urinary frequency but reports no hematuria." The assessment and plan section of the note read, "Dysuria - UA/CS [urinalysis, culture and sensitivity]...Painful micturition [action of urinating.]" The family history section of the note indicated he was married and had a daughter. The 4/15/22, 12:50 p.m. nurse's note read, "Resident called wife and c/o [complained of] lower back pain. Wife called to speak to writer about maybe going to ER [emergency room.] Writer went in to assess resident. Resident stated that if writer could give him Tylenol and obtain urine for a UA he would wait for the results before going to the ER." Urine obtained and Tylenol administered. The April, 2022 MAR (medication administration record) did not indicate any Tylenol was given to Resident B on 4/15/22. The 4/15/22 Urinalysis results indicated the specimen was collected on 4/15/22 at 10:00 a.m.		or her designee will review eMAR/eTAR 5 times weekly for 4 weeks and until 100% compliance is achieved, then weekly for 5 months and until 100% compliance is maintained. The DON or her designee will also review progress notes 5X weekly for 4 weeks and until 100% compliance is achieved to ensure new onset or worsening pain is assessed and the MD or NP is notified, then weekly for 5 months and until 100% compliance is maintained. 4. The findings of these reviews will be presented to the QAPI Committee during the facility's monthly meetings and the plan of action adjusted accordingly.	

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	and reported on 4/16/22 at 1:19 p.m. There were 3 abnormal results of slightly cloudy clarity, 1+ protein, and 1+ bacteria. There was no information in the clinical record to indicate the lower back pain or 4/15/22 urinalysis results were reported to the physician/nurse practitioner. An interview was conducted with the DON (Director of Nursing) on 5/10/22 at 11:59 a.m. She indicated there was no verification the physician/NP was notified of Resident B's lower back pain indicated in the 4/15/22 nurse's note. An interview was conducted with NP 3 on 5/10/22 at 1:44 p.m. She indicated she was not notified of the 4/15/22 UA results until 4/18/22. She was not notified of Resident B's lower back pain either. The facility could have forwarded her the information or used the on call number to notify. She would have wanted to know about the back pain, because it was a symptom of a UTI, a kidney stone, "a lot of different things." Knowing about the back pain would have possibly changed her treatment. It would require an assessment of him. Ideally, she would have assessed him in person. If she couldn't do it physically, she could have given another order for maybe labs to see if there was WBC elevation to order an antibiotic or something. An interview was conducted with CNA (Certified Nursing Assistant) 6 on 5/10/22 at 2:22 p.m. She indicated she worked on 4/15/22 and 4/16/22. Resident B was complaining about hurting. She informed the nurse, but was unsure what was done from there. She stopped by his room to answer his call light. He wanted the nurse to come in, because something was hurting, "his leg or			

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	back or something." The next nurse's note after the 4/15/22, 12:50 p.m. note was on 4/17/22 at 11:28 a.m. It read, "Resident has left LOA [leave of absence] with daughter. Family stated that resident will return at approximately 5:00 p.m." The 4/17/22, 12:59 p.m. nurse's note read, "Daughter placed a call to facility to inform staff that she placed a call to 911 while resident was LOA with family d/t [due to] SOB [shortness of breath,] fatigue and c/o pain from recent fall. Resident has been transported to [name of hospital.]" An interview was conducted with Resident B's wife, Family Member 4, on 5/9/22 at 1:52 p.m. She indicated Resident B recently fell at the facility just before Easter. He went to use the commode and fell nearby it. That's the fall where he broke his rib. The next day or so he kept telling her he was really sore and needed to go to the hospital. Their daughter, Family Member 5, picked up Resident B from the facility for Easter, on 4/17/22. He was so weak, she had to pick him up and put him in the car. He came home and was looking forward to Easter Dinner. She asked him if he wanted to sit in his lounge chair. She then asked him if he could transfer himself into the chair. Resident B informed her he couldn't and needed to go the hospital. He was complaining of pain the entire time, saying not to touch him on his side. It took 4 fireman to pick him up and place him on the stretcher. At the hospital, they told him not to favor that side or hunch down or he'd get pneumonia and now he had pneumonia. He was also diagnosed with a UTI at the hospital. He was in the hospital for a week, and was currently in another facility.			

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	The 4/17/22 Emergency Room note read, "...presenting today with weakness and altered mental status. Per family as well as patient, he was brought from the ECF [extended care facility] that he lives at [name of facility] rehab [rehabilitation] and help [sic] home for Easter dinner with family. Daughter [name of Daughter] stated that the patient was feeling very weak and was unable to get out of his chair and walk around like he normally does. She did also mention that he seemed a bit disoriented. Patient told family that he had an episode of falling down 2 days ago and the ECF did not report that to the family. Patient has been complaining of difficulty breathing as well as right chest wall pain. Patient denied syncope or loss of consciousness with the fall. Apparently he lost his balance and fell forward. On evaluation, patient was alert and oriented x [times] 1. He did mention pain with deep breaths. He also had a cough that he said he developed a couple weeks ago. In addition, patient states that he has had pain with urination with a burning sensation that has been ongoing for a couple days. Patient does have a history of urinary retention and it [sic] has a history of self-catheterization. ...Initial work-up is significant for WBC of 17.8, AST [aspartate aminotransferase] 59, ALT [alanine transaminase] 16, alk phos [alkaline phosphatase] 221, T bili [bilirubin] elevated at 2.5...CTA [computed tomography angiography] of the chest and abdomen showing a posterior right rib fracture as well as a L5 [fifth lumbar] compression fracture....Assessment and Plan [A/P]: Problem 1: Sepsis A/P 1. Patient meets SIRS [systemic inflammatory response syndrome] criteria with an elevated WBC count of 17.8, tachypnea with respiratory rate of 32. Source of infection likely urinary with a UA showing moderate leukocytes,			

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	more than 100 WBCs, moderate leukocytes, marked bacteria. Chest x-ray is normal and lungs are clear to auscultation, unlikely respiratory infection...Continue Rocephin...Problem 3: UTI A/P 3: Patient has clinical signs of urinary tract infection with burning sensation with urination. Patient has a chronic history of urinary retention...Continue antibiotics with Rocephin....Problem 7: Rib Fracture A/P 7: Patient had an episode at his ECF a couple days ago where he lost his balance and fell forward. CT of the chest shows a posterior right 11th rib fracture as well as an L5 compressive fracture that is likely chronic....We will treat for pain."2. The clinical record for Resident D was reviewed on 5/9/22 at 2:41 p.m. Resident D's diagnoses included, but not limited to, peripheral vascular disease, unspecified injury to right foot, anxiety, and history of falls. A nursing note dated 4/9/22 at 3:35 p.m. indicated, Resident D had fallen. She was found "laying on her back in her bathroom". A physician's progress note dated 4/11/2022 at 3:59 p.m. indicated, "Patient seen in her room seated comfortably in her bed. Per discussion with staff as well as chart review, patient did sustain a recent fall. She was found on the bathroom floor by nursing staff. Patient was found lying on her back in the bathroom...Patient denies hitting her head or losing consciousness during her fall. She did have some right foot pain with swelling noted after her fall. A set of right foot plain radiographs was[sic, were] taken and these were reviewed today. Those plain radiographs were without evidence of acute fracture or dislocation. Patient is endorsing some aching type pain at the right foot today. Her pain is aggravated by touch. Her pain is alleviated with rest as well as oral			

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	medications...". Resident D was discharged from the facility to home with her son on 4/11/22. Resident D was readmitted to the facility following a hospitalization for altered mental status and failure to thrive at home on 4/21/22. A nursing note dated 4/21/22 at 3:06 p.m. indicated, Resident D had bruising noted to her right outer foot and the treatment included painting it with betadine and wrap with kerlix daily and as needed. Also noted was, the presence of a blister to the top of right foot. Resident D rated her pain to the right foot as a 9 out of 10. A rating of 10 being the worst pain. A physician's order dated 4/21/22 indicated to give one 4 mg table of hydromorphone (a pain medication) every six hours as needed for pain Resident D's April MAR (Medication Administration Record) was received on 5/10/22 at 1:36 p.m. from DON (Director of Nursing) The MAR indicated the following: - On 4/21/22, Resident D received the hydromorphone at 2:25 p.m. for a pain rating of 4 out of 10. The effectiveness of the medication was not documented until 8:21 p.m. on 4/21/22 which was almost 6 hours after the administration of the medication. - On 4/22/22 at 9 a.m. Resident D received her hydromophone for a pain rating of 3. The effectiveness of the hydromorphone was documented at 10:21 a.m. which was 1 hour and 21 minutes after the administration of the hydromorphone. - On 4/24/22, Resident D was given a hydromorphone tablet at 11:06 a.m. The effectiveness of the hydromorphone was			

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	documented at 11:11 a.m. which was 5 minutes after the administration. - On 4/25/22, it indicated, Resident D was administered a hydromorphone tablet at 9:09 a.m. The effectiveness of the hydromorphone. was documented at 11:49 a.m. which is 2 hours and 40 minutes after the administration. - On 4/26/22, Resident D was given hydromorphone at 10:50 a.m. for a pain level of 9. The effectiveness of the hydromorphone was documented at 10:51 a.m. and was marked as 0, which was one minute after the administration. It was assessed again at 12:56 p.m. as 5, 1 hour and 2 minutes after medication administration. - On 4/ 27/22, Resident D was administered hydromorphone at 7:45 a.m. The effectiveness of the medication was documented at 1:40 p.m., which was 5 hours and 55 minutes later. - On 4/28/22, Resident D was administered hydromorphone at 9:14 a.m. The effectiveness of the medication was documented at 11:04 a.m., 1 hour and 50 minutes later. Resident D was administered hydromorphone at 12:27 p.m. for a pain level of 10. The facility also documented a pain level of 5 at 12:27 p.m. The effectiveness of the medication was documented at 5:28 p.m., which was 5 hours and 1 minute after administration. A copy of Resident D's controlled medication count sheet for hydromorphone was provided on 5/10/22 at 1:36 p.m. from DON. The controlled medication count sheet indicated, the following doses of hydromorphone were administered, but not recorded on the April MAR and lacked documentation of the effectiveness of the medication: - On 4/22/22, 3 p.m. and 8 p.m. - On 4/23/22, 10:30 a.m. - On 4/24/22, 3 p.m.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155628	A. BUILDING 00 B. WING	05/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CREEKSIDE HEALTH AND REHABILITATION CENTER	3114 EAST 46TH STREET INDIANAPOLIS, IN 46205

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	- On 4/26/22, 7:45 p.m. An interview with DON was conducted on 5/10/22 at 2:55 p.m. indicated, monitoring for the effectiveness of a pain medication should be done 30 minutes to an hour after its administration depending on the route in which the medication was given. She further indicated, monitoring for the effectiveness could identify the need to increase a pain medications frequency or increase in the amount of the medication may be needed. An interview with Resident D was conducted on 5/10/22 at 3:24 p.m. Resident D indicated, she enjoyed going to the activities, however she was not able to go when she was in pain. A Pain Evaluation policy was received on 5/10/22 at 3:05 p.m. from Executive Director 1. It indicated, "Purpose: ...To provide optimal comfort through a pain control plan, which is established with the members of the health care team....1. Residents will have a pain evaluation completed upon admission, quarterly, and when the resident experiences new pain in a different location....3. Residents will have pain assessed routinely with each dose of pain medication given therefore a new pain evaluation will not be required after changes in medication. This will include both routine and as needed pain medication...6. Nursing will document any complaints or signs/symptoms of pain in the progress notes as indicated. 7. The pain scale will be used to determine the effectiveness of pain interventions. This Federal Tag relates to complaint IN00379018. 3.1-37(a)			

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F 0773 SS=D Bldg. 00	483.50(a)(2)(i)(ii) Lab Srvcs Physician Order/Notify of Results §483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. Based on interview and record review, the facility failed to ensure physician notification of urinalysis results for 1 of 3 residents reviewed for hospitalization. (Resident B) Findings include: The clinical record for Resident B was reviewed on 5/9/22 at 10:50 a.m. The diagnoses included, but were not limited to: BPH (benign prostatic hyperplasia,) obstructive and reflux uropathy, chronic kidney disease, and neuromuscular dysfunction of bladder. The physician's orders indicated to self catheterize 5 times daily with a 16 French Rubber Tip Catheter, effective 10/25/21. The chronic kidney disease care plan indicated an intervention was for his labs to be obtained as ordered. The 4/14/22, 9:11 p.m. NP (Nurse Practitioner) note, written by NP 3, indicated he was seen for an acute visit for dysuria (discomfort, pain, or	F 0773	**Requesting an IDR for this deficiency due to data is misrepresented and not all inclusive.** The facility will ensure compliance through the following corrective measures: 1. Resident B discharged from facility 2. All other residents have the potential to be affected. See below for corrective measures moving forward. 3. The lab and diagnostic service policy and change of condition policy was reviewed and no changes are indicated. Licensed nursing staff will be educated on the importance of documenting laboratory results and MD	05/25/2022

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	burning when urinating.) He self catheterized and had frequent UTIs. He denied hematuria (blood in urine,) fever, chills, or flank pain. His recent labs showed elevated WBC (white blood cells) from baseline at 10.1. There were no other concerns today. It read, "He reports difficulty urinating and increased urinary frequency but reports no hematuria." The assessment and plan section of the note read, "Dysuria - UA/CS [urinalysis, culture and sensitivity]...Painful micturition [action of urinating.]" The 4/15/22, 12:50 p.m. nurse's note read, "Resident called wife and c/o [complained of] lower back pain. Wife called to speak to writer about maybe going to ER [emergency room.] Writer went in to assess resident. Resident stated that if writer could give him Tylenol and obtain urine for a UA he would wait for the results before going to the ER." Urine obtained and Tylenol administered. The 4/15/22 Urinalysis results indicated the specimen was collected on 4/15/22 at 10:00 a.m. and reported on 4/16/22 at 1:19 p.m. There were 3 abnormal results of slightly cloudy clarity, 1+ protein, and 1+ bacteria. There was no information in the clinical record to indicate the 4/15/22 urinalysis results were reported to the physician/nurse practitioner. An interview was conducted with the DON (Director of Nursing) on 5/10/22 at 11:59 a.m. She indicated there was no verification the physician/NP was notified of Resident B's 4/15/22 UA results until 4/18/22, when NP 3 came back to the facility on Monday, as NP 3 was not in the facility over the weekend.		notification. The DON or her designee will review Lab results and notification documentation 5x times weekly for 4 weeks and until 100% compliance is achieved, then weekly for 5 months and until 100% compliance is maintained. 4. The findings of these reviews will be presented to the QAPI Committee during the facility's monthly meetings and the plan of action adjusted accordingly.	

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	An interview was conducted with NP 3 on 5/10/22 at 1:44 p.m. She indicated she was not notified of the 4/15/22 UA results until 4/18/22. The Lab and Diagnostic Services policy was provided by ED (Executive Director) 1 on 5/10/22 at 9:29 a.m. It read, "Procedure: ...4. The facility will notify the Physician, Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist of any results outside of the normal range provided by the service provider within 24 hours unless the result is critical...7. The nurse will document lab and diagnostic notification in the progress notes of the resident's record." This Federal Tag relates to complaint IN00379018. 3.1-49(f)(2)			