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	06/16/2021

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 Complaints IN00355168 and IN00355300. Complaint IN00355168 - Substantiated. No deficiencies related to the allegations were cited. Complaint IN00355300 - Substantiated. Federal/State deficiencies related to the allegations are cited at F689. Survey dates June 16, 2021 Facility number: 009569 Provider number: 155628 AIM number: 200139920 Census Bed Type: SNF/NF: 108 Total: 108 Census Payor Type: Medicare: 9 Medicaid: 86 Other: 13 Total: 108 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on June 18, 2021	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 0689 SS=G Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that -			

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 determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on interview and record review, the facility failed to ensure a resident did not fall from her bed during resident care that resulted in a fracture with hospitalization and surgical repair for 1 of 3 residents reviewed for accidents. (Resident C) Findings include: The clinical record for Resident C was reviewed on 6/16/21 at 12:00 p.m. The diagnoses included, but were not limited to, hemiplegia and hemiparesis (paralysis of one side of the body) following cerebral infarction (ischemic stroke), muscle weakness, reduced mobility, need for assistance with personal care, and vascular dementia. A Physical Therapy (PT) discharge summary, dated 3/21/21, indicated total dependence with bed mobility, specifically with rolling to the left for Resident C. The interventions included instruction towards staff for optimal technique for bed mobility with cues needed for sequence and Resident C's hand placement. A Quarterly Minimum Data Set (MDS) assessment, dated 5/5/21, indicated Resident C was cognitively intact and marked for the need of extensive assistance with 2 staff persons for bed mobility, transfers, dressing, toilet use, and personal hygiene.	F 0689	1. Resident C has not returned to the facility. This was her first and only incident or injury since admitting to the facility in October of 2017. 2. All residents whose most recent MDS reflect a change in assistance provided with bed mobility have the potential to be affected. A whole house audit was completed to identify those residents at risk, the IDT met and reviewed those residents to determine the amount of assistance required for safe bed mobility, and the care plans were revised as needed. 3. The policy entitled Fall Investigation and Risk Evaluation was reviewed. No changes are indicated. MDS and IDT nurse management staff were educated on this policy and the Care Planning policy. The Regional Nurse or her designee will review all residents with a decline in bed mobility score every 2 weeks and until 100% compliance is achieved to ensure the IDT is reviewing those changes and, if indicated, revising the plan of correction. Reviews will continue for a minimum of 3 months, then	06/18/2021

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	A care plan for activities of daily living (ADLs), revised 12/3/20, indicated the following, "...I need assistance with my ADLS transfers, toileting, eating, bed mobility, bathing, dressing and grooming related to left side hemiplegia/hemiparesis...Interventions...I need physical assist of staff for toileting...I need physical assist of staff with bed mobility...I need physical assistance of staff to cleanse after toileting...." A care plan for falls, revised 6/3/21, indicated the following, "...I am at risk for falls related to impaired balance...Interventions...2 staff members when doing care [bed mobility, toileting and peri (perineal) care] Make sure staff is on both sides of the bed [added on 6/3/21]...Mechanical lift and assist of 2 staff with transfers...." A progress note, dated 6/2/21 at 11:22 p.m., indicated the following, "...while receiving patient care resident was turned onto left side and rolled onto the floor...Stat [urgent] x-ray ordered...." A document reported to the Indiana State Department of Health Survey Report System, dated 6/3/21, indicated the following, "...Staff was providing care and assisted resident to roll on her side. Resident's weaker leg fell forward, causing her to roll off bed on to floor. X-ray of left hip was obtained...Type of Injury...Acute moderately displaced fracture left subcapital femoral neck...Follow-up added -- 6/8/2021 Resident remains at hospital and expect to discharge to another facility. CNA is [Name of CNA 4]...Is completing check-off's and re-education on repositioning residents while in bed...." A fall interdisciplinary team (IDT) note, dated 6/3/21 at 10:00 a.m., indicated the following,		change to monthly for 3 months and until 100% compliance is maintained. 4. The findings of these audits will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly. Creekside Health & Rehabilitation Center respectfully requests an Informal Dispute Resolution conducted face to face related to this citation. **Informal Dispute Resolution** **Creekside Health & Rehabilitation** **3114 E. 46th Street** **Indianapolis, IN 46205** Re; Survey Event ID ETBD11 Cycle Start Date: May 19, 2021 Creekside Health & Rehabilitation would like to formally request a Face to Face IDR for F689, cited with a G scope and severity. The argument for this IDR request is outlined below. Resident C was admitted to Creekside in October of 2017 from another facility following a hospital stay for a new stroke. She admitted with a flaccid left affected side. The PT discharge summary referenced in the survey findings dated 3/2/21 indicated total	

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	"...while receiving patient care resident was turned onto left side and rolled onto the floor out of bed...X-ray of Left hip ordered. Results Acute fracture of left hip. Patient to be sent to hospital for evaluation...Root cause of fall: Patient rolled out of bed during care...Intervention...Two person assist during care for bed mobility and pericare [perineal care]...." A hospital note, dated 6/3/21, indicated the following, "...patient [Resident C] was being cleaned and while she was being turned in the presence of her caregivers at the nursing home, fell out of bed onto her left side...x-ray of the left hip was done this morning on 6/3 which showed left femoral neck fracture...." A hospital note, dated 6/7/21, indicated the following, "...Plan...Admit to Hospitalist. Once the patient is appropriately cleared from the standpoint of other treating physicians, major surgery is planned...Planned Procedure...L [left] hip hemiarthroplasty [surgical procedure that replaces one half of the hip joint with a prosthetic, while leaving the other half intact]...." An interview conducted with Qualified Medication Aide (QMA) 8, on 6/16/21 at 10:50 a.m., indicated she would always have a second staff person come to assist with the care of Resident C. She required total assistance with ADLs. An interview conducted with Nurse Consultant 5, on 6/16/21 at 2:05 p.m., indicated Resident C should have been a two-person assist. Her leg was heavier, and the weight would have made it more of a risk in the bed with bed mobility. That's why we made her a two-person assist after the incident.		dependence with bed mobility, specifically with rolling to the left. Interventions included instructing staff for optimal technique for bed mobility with cues needed for sequence and Resident C's hand placement. This has not changed since admission. In speaking with facility therapy manager, Caitlyn O'Connor, she reiterated she was dependent for bed mobility, but that therapy defines total assistance differently than the RAI manual. The task cannot be completed without nursing staff assistance in placing or cueing the resident to place her right hand on the bed rail. Once that is completed, the resident is able to assist with the turning and holding herself over on her side. The RAI requires that a resident must be coded totally dependent, a "4," for performance (the first part of the ADL score), if there was full staff performance of an activity with no participation by the resident for any aspect of the ADL activity and the activity occurred 100% of the time. The fact that Resident C is able to and does hold on to the rail excludes her from the category of total dependence and puts her in the category of extensive assistance, "3." Resident C has not once been coded on any MDS since admission as totally dependent for bed mobility.	

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	An interview conducted with Certified Nursing Assistant (CNA) 6, on 6/16/21 at 2:53 p.m., indicated she went into the bathroom to prepare washcloths for perineal care of Resident C. She went back towards Resident C's bed and proceeded to turn her on her left side and her right leg went over the side of the bed, towards the window, and Resident C fell onto the floor from the bed. She attempted to hold onto Resident C to prevent her from falling off of the bed but was unsuccessful. She was working evening shift and there were only 2 CNAs scheduled instead of the usual 3 on the 400-hallway. There were usually 2 staff members to assist with the care of Resident C and each staff member would be on either side of Resident C's bed. CNA 6 indicated there was a possibility that Resident C was too far over and not "center" on the bed enough that could have played a role with the incident. A policy titled "Fall Investigation and Risk Evaluation", revised 2/2020, was provided by the Assistant Director of Nursing on 6/16/21 at 3:50 p.m. The policy indicated the following, ""...It is the policy of this facility to provide an environment that is free from accident hazards over which the facility has control and provides supervision and assisted devices to prevent avoidable accidents..."Avoidable Accident" means that an accident occurred because the facility failed to: Identify environmental hazards and /or assess individual resident risk of an accident, including the need for supervision and/or assistive devices...Implement interventions, including adequate supervision and assistive devices, consistent with a resident's needs, goals, care plan and current professional standards of practice in order to eliminate the risk, if possible, and, if not, reduce the risk of an		Having established Resident C is accurately coded as an extensive assist, then the facility has to determine the ADL support provided. The second part of the ADL score reflecting ADL Support is defined by the RAI Manual as coding for the most support provided over all shifts. Code regardless of how column 1 ADL Self-Performance is coded. "Do NOT record the type and level of assistance that the resident "should" be receiving according to the written plan of care. The level of assistance provided is not determined according to the "rule of three" as is ADL Self-performance, but is coded, according to the RAI manual "for the most support provided over all shifts. Code regardless of how Column 1 ADL Self-Performance is coded." According to this guidance, a resident only needs to receive 2+ person assistance once in the look-back period to code this level. The attached exhibits A1-A*** are all MDS's (quarterly, annual and significant change) completed since admission and corresponding Bed Mobility ADL grids completed during the assessment reference periods used to determine ADL coding for bed mobility. To summarize related to the MDS, this resident can fluctuate on her MDS's from being an extensive assist of 1 and an extensive assist	

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	accident...." This Federal tag relates to Complaint IN00355300. 3.1-45(a)(1) 3.1-45(a)(2)		of 2. Being coded as an assist of 2 on the MDS does not mean that the resident should be care planned for an assist of 2 for bed mobility. It is dependent upon many factors which could include the stature of the person assisting the resident, which specific tasks are being performed, if the resident is feeling poorly, and even habit. Some staff, writer included, prefer to work in pairs when completing bed checks, which would result in coding as a 2. This resident is also a mechanical lift for transfers and sometimes may required to be cleansed due to incontinence prior to of after mechanical lift transfers, with the second staff member choosing to stay and assist to complete the task quicker. The factors do not indicate that the task *requires* 2 staff. The fall care plan referenced in the findings was indeed revised as indicated on 6/3/21 to indicate that staff are to use 2 persons for bed mobility. This was the intervention put into place following the fall on 6/2/21. This was not required prior to the addition of this intervention, which is evidenced by since residing at Creekside Health & Rehabilitation since October 2017, Resident C has gone without one single incident or accident. She has experienced no falls, no skin tears, no lacerations, nothing	

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			which would fall under the category of an accident. This, along with evidence that based on the recent May 2021 MDS there was NO decline in the resident's level of functioning, shows that the plan of care in place for Resident C at the time of the incident and the care being provided up to that point was appropriate based upon assessment and had been effective. Further, had the resident returned to the facility, the facility had already reviewed the plan and revised it based upon these events. The last question, based on the listed findings is related to staff interviews. This writer, referred to in the findings as Nurse Consultant 5, did not indicate the resident should have been a two-person assist. This writer did indicate the resident would be a two-person assist upon return and follow therapy recommendations thereafter. The facility acknowledges that it is utilizing all resources at this current time to supplement facility staff. It is not unusual for staff who are unfamiliar with a resident to use another staff member to assist them. All are provided with access to a handheld device that provides details which enables staff to safely provide care, including if a resident requires assistance with particular ADL's. Facility staff are	

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			also picking up extra shifts and are sometimes working with residents on different units. Again, handheld devices are used to convey resident specific care-related details but, often times staff will tell you until they have a comfort level, they prefer taking another staff member with them. CNA 6 contends that when interviewed she said that the resident only requires an assist of 1 for bed mobility but that she usually takes a second person when there are 3 aides meaning that she prefers to work in pairs, it is “easier.” QMA 8 does not routinely provide ADL care for this resident, rather she passes her medications. The Unit Manager, Betty Jackson RN, iterates that she provides care for Resident C and that she was not a difficult 1 person assist with bed mobility. The resident did actively participate with holding herself onto her left side. It is also important to note that facility census has been significantly lower post-COVID than prior to and therefore staffing levels would be adjusted as there have been less residents to provide care for. In summary, Creekside Health & Rehabilitation contends that the Resident C’s plan of care was accurate, was followed and had been successful in outcomes for almost three years, evidenced by	

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			the fact that the resident had no prior events. She had not exhibited a decline. Staff performed bed mobility in a manner that was appropriate, and an accident occurred. The facility response to the accident was also appropriate and timely.	